AMA Integrated Physician Practice Section

2018 Annual Meeting

Hyatt Regency Chicago
151 E. Wacker Drive
Chicago, IL
June 8

Meeting agenda

Meeting app

Our people

- IPPS governing council
- CME planning committee

CME programs

- **Value-based care: Understanding models of risk**
  - Speaker bios: Nguyen, Glenn, Murali, Wulf, Benton, Wald
- **Understanding CMS's new BPCI Advanced Model**
  - Speaker bios: Farmer, Mutharasan
- **Claim your CME credit**

IPPS policy discussion

- IPPS Report A

Looking ahead

- Upcoming elections
- Upcoming IPPS meetings

After the IPPS meeting

- NEW - Joint Sections CME programming
- AMA member center

AMA Integrated Physician Practice Section

Return home

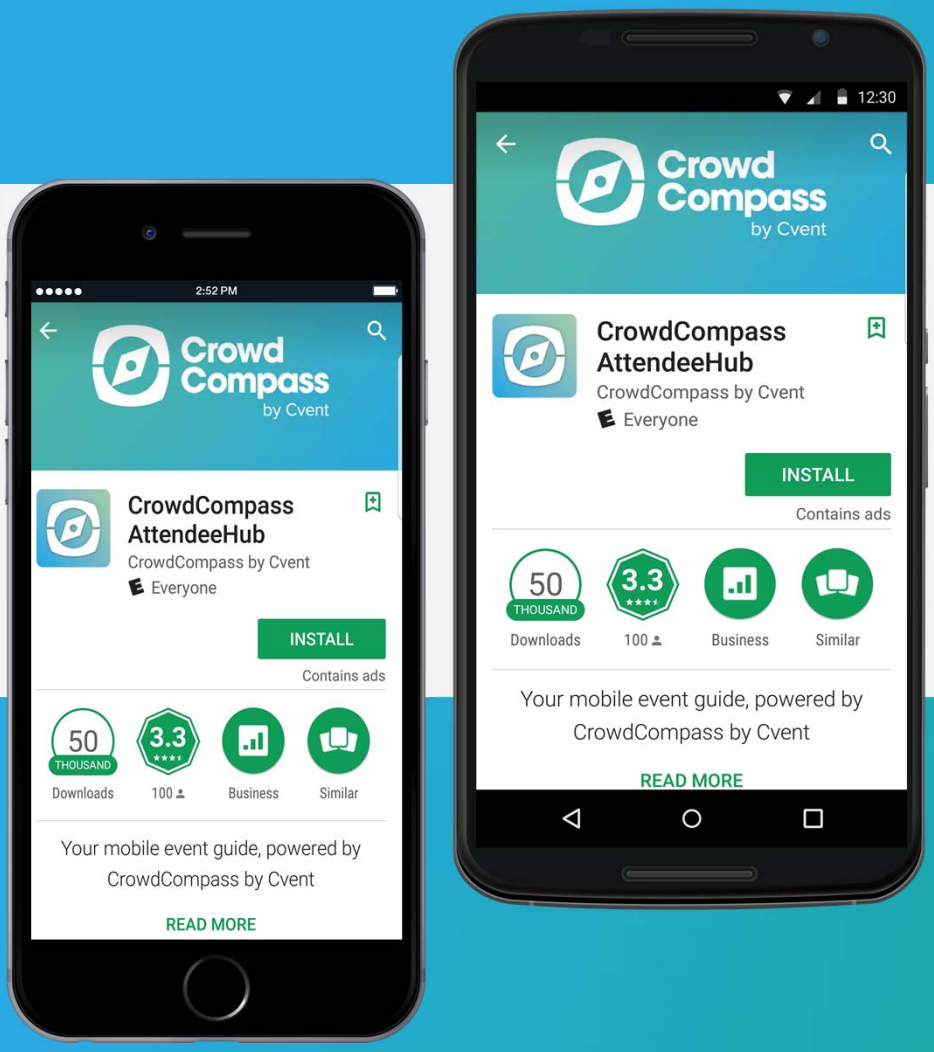
2018 Annual Meeting
Hyatt Regency Chicago
Chicago, IL
June 8

Friday, June 8		
8:00 – 8:30 a.m.	Continental breakfast	Crystal Ballroom A, West Tower
8:30 – 8:45 a.m.	IPPS opening session	"
8:45 a.m. – 10:45 a.m.	Value based care: Understanding models of risk *Sponsored in collaboration with America's Physician Groups* • Bundles – *Michael Glenn, MD, Virginia Mason Medical Center* • MSSP Track 1 - *Narayana Murali, MD, Marshfield Clinic* • Primary Care Model – *Bill Wulf, MD, Central Ohio Primary Care Physicians* • Professional Risk – *Ruth Benton, New West Physicians* • Full Risk – *Bart Wald, MD, America's Physician Grps Consulting*	"
10:45 – 11:45 a.m.	Roundtable discussions	"
11:45 – 12:15 p.m.	Roundtable highlights	"
12:15 – 1:15 p.m.	Networking lunch	Stetson Restaurant East Tower
1:15 – 1:30 p.m.	Afternoon opening session	
1:30 – 3:00 p.m.	Understanding BPCI Advanced • *Steven Farmer, MD, PhD, CMMI* • *R. Kannan Mutharasan, MD, Northwestern University Feinberg School of Medicine* • Reaction panel, *Peter Rutherford, MD, Confluence Health; Barbara Spivak, MD, Mount Auburn Cambridge IPA; Randall Gibb, MD, Billings Clinic*	Crystal Ballroom A, West Tower
3:00 – 3:15 p.m.	Break	"
3:15 – 4:30 p.m.	IPPS policy discussion and closing	"

CrowdCompass by Cvent

Download the Mobile App Now!

https://crowd.cc/ama2018



Scan this code with a QR reader to easily download the app.

Return home

IPPS Governing Council

Peter Rutherford, MD
Chair
Chief Executive Officer
Confluence Health, WA

Michael Glenn, MD
Vice-Chair
Chief Medical Officer
Virginia Mason Medical Center, WA

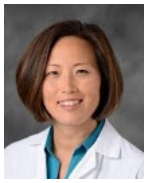
Thomas Eppes, Jr., MD
Immediate Past Chair
Founding Partner, Board Member
Central Virginia Family Physicians, VA

Russell Libby, MD
Delegate
Founder and President,
HealthConnect IPA, VA

Devdutta Sangvai, MD
Alternate Delegate
Executive Director, Duke
Connected Care, Duke Health, NC

Susan Pike, MD
Member at-Large
Director, Division of Plastic and Reconstructive Surgery, Baylor/Scott & White, TX

Barbara Spivak, MD
Member at-Large
President and Board Chair
Mount Auburn Cambridge IPA, MA



Betty Chu, MD
Large group slotted seat
Chief Medical Officer & Vice President of Medical Affairs, Henry Ford West Bloomfield Hospital, MI

Randall Gibb, MD
Small/Medium group slotted seat
CEO, Billings Clinic, MT

Return home

Special thanks to our CME Planning Committee

1. Kathleen Blake, MD, MPH, Vice President, Healthcare Quality, Practice Sustainability, AMA CME Program Committee Representative
2. Donald Crane, JD, President and CEO, America's Physician Groups
3. Michael Glenn, MD, Vice Chair, IPPS Governing Council, CMO, Virginia Mason Medical Center
4. Lura Hawkins, Director, Membership, America's Physician Groups
5. Peter Rutherford, MD, Chair, IPPS Governing Council member, CEO, Confluence Health, WA
6. Keith Voogd, MPH, Director, Organized Physician Practice Section, AMA
7. Carrie Waller, Manager, Integrated Physician Practice Section, AMA

Return home

Integrated Physician Practice Section
Value-based care: Understanding models of risk
June 7, 9:00a-12:15p, Crystal A

Value-based care is receiving growing and broad support within the medical community and in the policy arena on both sides of the aisle. Some physician organizations have already fully transitioned from fee-for-service to various risk models that support value-based care; but many are still trying to figure how to dip a toe in the water. In this program, experts detail five risk models (bundles, CPC+, MSSP, professional risk and full risk); the skills and infrastructure needed to succeed; and the pros and cons of each. AMA IPPS is partnering with America's Physician Group (formerly CAPG) to present a full morning of interactive programming to help learners of all levels make the next move in their "risk bearing" journey.

Learning objectives: Upon completion of this session, you will be able to:

1. Differentiate five risk models, the infrastructure needed to succeed, and pros and cons of each;
2. Identify which model(s) best meet(s) the needs of your specific practice setting;
3. Discuss next steps to advance your risk bearing journey

Program schedule

9:00 –9:40a	Bundles & MSPP Track 1
9:40 – 9:55a	Q&A/Break (15 mins)
9:55 – 10:50a	Primary Care Model, Professional Risk, Full Risk
10:50 – 11:00a	Q&A/Break (10 mins)
11:00 – 11:45a	Roundtable discussions on risk models
11:45a– 12:15p	Roundtable highlights report to full assembly

Accreditation Statement:

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit designation Statement:

The American Medical Association designates this live activity for a maximum of 2.75 *AMA PRA Category 1 Credit(s)* ^{TM}. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Return home

Amy Nguyen Howell, MD, MBA, FAAFP

Dr. Nguyen Howell is a board-certified family practice physician. She oversees all clinical programs at America's Physician Groups and supports advocacy work in Sacramento, California, and Washington, DC. Dr. Nguyen actively serves on the Measure Applications Partnership (MAP) Clinician Workgroup, providing input to the Coordinating Committee at the National Quality Forum (NQF) on matters related to the selection and coordination of measures for clinicians, particularly in the office setting. Additionally, she contributes to the technical expert panel on MACRA measure development; the Steering Committee for the Core Quality Measures Collaborative; the Healthcare Payment and Learning Action Network Population-Based Payment Work Group; Population Health Management, Clinical Programs, and Patient-Centered Specialty Practice advisory committees at the National Committee for Quality Assurance; and the Board of Directors of the California Healthcare Performance Information System. She serves on steering committees for the California Quality Collaborative of the Pacific Business Group on Health and for the California Maternal Quality Care Collaborative, as well as on the Alternative Payment Model Infrastructure Taskforce of the Healthcare Information Management Systems Society. These national committees provide structure for an innovative, coordinated delivery model focused on payment reform and integrated, high-quality, patient-centric care. Dr. Nguyen is a faculty member at University of Southern California Sol Price School of Public Policy and continues to serve as a family physician in Playa Vista, California.

Return home

Michael G. Glenn, MD, FACS

Dr. Michael Glenn is the Chief Medical Officer of the Virginia Mason Health System, a fully integrated physician practice and health system in Washington State. He is active in numerous professional organizations with particular contributions in the areas of physician engagement & leadership development, quality improvement and patient safety.

Originally from Reno, Nevada, he graduated from UC, Davis and received his medical degree from the UC, San Francisco in 1981. He completed residency training at Stanford University, and he spent the first decade of his professional career in Seattle at the University of Washington, before moving to Virginia Mason in 1995. He remains clinically active as a head and neck cancer reconstructive surgeon, in addition to his administrative responsibilities.

He currently serves as vice-chair of the governing council of the AMA Integrated Physician Practice Section.

Return home

Narayana S. Murali, MD, FACP

Dr. Narayana Murali is Executive Vice President of Care Delivery and Chief Clinical Strategy Officer of Marshfield Clinic Health System. He is Executive Director of Marshfield Clinic, and President/CEO of Marshfield Clinic Health System Hospitals, Inc. In these roles, Dr. Murali works in coordination with the Marshfield Clinic Health System's Chief Executive Officer and oversees the entire clinical and hospital delivery arm of MCHS.

Dr. Murali joined Marshfield Clinic in 2006 as a nephrologist, having practiced specialty medicine globally across three continents. He was Chief of Staff of Ministry Saint Joseph's Hospital from 2011-12; Marshfield Clinic Corporate Secretary from 2012-14; and Chair of Marshfield Clinic's Board of Directors from 2014-2015.

He earned his medical degree from the University of Madras, India, and then completed a three-year post-graduate training in general medicine leading to the award of the Diplomat of the National Board in General Medicine in India.

He furthered his medical career in Australia. He subsequently completed an internal medicine residency at Mayo School of Graduate Medical Education, a National Institutes of Health-sponsored Clinician Investigator Training Program and fellowship in kidney disease at Mayo Clinic College of Medicine, Rochester, Minnesota. He is a principal investigator of federally-funded studies, a recipient of national, regional and institutional awards for scientific work and teaching. He has authored several scientific papers and reviews in basic and clinical science in addition to several book chapters and serving as an associate editor of a reputed textbook – The Mayo Clinic textbook of Internal of Medicine. He has also served as a panel expert and/or guest lecturer at multiple national and regional organizations such as the AMA and AMGA.

Dr. Murali is a resident of Marshfield, Wisconsin with strong commitment to education and enrichment programs in the school district as well as the Boy Scouts of America.

Return home

J. William Wulf, MD

Dr. Bill Wulf is the first physician Chief Executive Officer of Central Ohio Primary Care (COPC) assuming this position in 2013. Prior to this role, he served as the Corporate Medical Director of COPC for seven years. Bringing over 30 years of medical and leadership experience, he was a leader among the founding physicians that helped establish COPC, Inc. in 1996. COPC has grown to 380 physicians in 65 locations in central Ohio.

Dr. Wulf previously operated a private practice in Columbus and continues to serve as the COPC Laboratory Medical Director.

Dr. Wulf is on the board of directors for The Health Collaborative of Central Ohio, The Ohio Patient Centered Primary Care Collaborative, agilon Health, The Ohio Health Information Partnership and America's Physician Groups (APG).

As an internist, he received his Doctor of Medicine from the Medical College of Ohio in Toledo.

Return home

Ruth N. Benton

Chief Executive Officer (1994 to Present)
New West Management Services Organization, Inc.
New West Physicians, P.C.
Founder and owner of New West (a primary care group practice) and is the chief business officer responsible to the Board of Directors. The company has grown to $60 million in revenue, has 100 physicians and mid-level providers, 365 employees at 18 locations in Denver Metro Area; caring for 200,000 Denver Metro citizens.

PRIOR EXPERIENCE
Vice President, Operations and Managed Care, ***HealthOne*** (1990-1994)
Responsible for the insurance contracts, for five IPA's and four hospitals in the system; In addition, was a hospital administrator for Swedish Medical Center in charge of the women's program, surgery services, laboratory services, medical records, admissions, emergency room and the risk management.
Vice President, Administration, *HealthCare United* (1987-1990)
Managed the operations of an HMO placed under supervision of the Insurance Commissioner. Stabilized the financial performance and operations and managed the insolvency for the State Attorney General's office.
Vice President, Finance and Operations, *HMO Colorado* (1979-1987) One of the f0unders of Blue Cross Blue Shield's HMO
Various management positions in Blue Cross and Blue Shield (1971-1987)

AWARDS
Distinguished Alumni Award, 2000, CSU College of Business
Entrepreneur in Residence, CSU College of Business
"Most Influential Health Care Leaders in Colorado" – DBJ – Last 5 years
DBG Champions in Health Care Award – TOP Health Care Manager, 2008

EDUCATION
MBA, Colorado State University, 1994

OTHER
Denver Chamber Board Member, 2015
Board of Trustees, Colorado Health Institute, 2010 to Present
Research Partner – Dartmouth College and Brookings Institute – 2012 to present
Colorado Executive HC Forum
Chairman, C3 Investment Committee 2015/16 – Denver Chamber of Commerce
Board of Directors – Denver Chamber of Commerce

Return home

Bart Wald, MD, MBA

Dr. Bart Wald is President of PA Healthcare Leadership Consultants and Medical Director of the California Quality Collaborative (CQC). Bart was most recently Physician Chief Executive of Providence Health and Services California where he led the efforts to develop, consolidate and integrate its physician groups and foundations. Bart has extensive executive experience in health plans, hospitals and physician groups. As the founding CEO of Physician Associates Medical Group, he led the group to become one of the most innovative and high performing in California and then through its merger with HealthCare Partners Medical Group.

Bart has also served as Medical Director for DaVita-HealthCare Partners Medical Group, Chief Medical Officer of UniMed Physician Services, Medical Director for Health Net of California, and Vice President of Medical Affairs for Children's Hospital Los Angeles, where he also held the position of Clinical Professor of Pediatrics.

Bart has served as chairman of the board of the California Association of Physician Groups (CAPG), chaired the Integrated Healthcare Association's (IHA) Pay for Performance Governance Committee and served on the executive committee of the California Collaborative for Healthcare Research and Improvement (CCHRI) and the California Healthcare Performance Information System (CHPI). Bart is on the faculty of USC's School of Public Policy and an advisor to health care innovation and technology companies.

Bart received his MD from the SUNY-Downstate, an MBA from Pepperdine University and is board certified in pediatrics and pediatric hematology-oncology. He has extensive experience in developing complex care systems including comprehensive care programs for medically complex patients and has consulted extensively on health care executive leadership, physician group development and governance, physician group – hospital affiliations, population health management systems, healthcare quality and physician incentive programs.

Return home

Integrated Physician Practice Section
Understanding CMS's new BPCI Advanced Model
June 8, 1:30-3:00p, Crystal A

The Center for Medicare & Medicaid Innovation (CMMI) recently announced the administration's first new Medicare alternative payment model, Bundled Payments for Care Improvement Advanced (BPCI Advanced). This voluntary model includes 29 inpatient and 3 outpatient clinical episodes, and operates under a total-cost-of-care concept. Dr. Steven Farmer from Center for Medicare & Medicaid Innovation and Dr. R. Kannan Mutharasan from Bluhm Cardiovascular Institute, Northwestern Memorial Hospital, will discuss the BPCI Advanced and traditional models respectively, followed by a reaction panel of physician leaders who will consider the potential pros and cons from their organization's perspective.

Learning objectives: Upon completion of this session, you (physician) will be able to:

- Discuss key components of the BPCI Advanced model
- Evaluate potential pros and cons of the model

Program schedule

1:30 -2:00p	BPCI Advanced program overview
2:00 – 2:30p	Reaction panel
2:30 – 3:00p	Q&A

Accreditation Statement:

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit designation Statement: *(Provide number of credits commensurate with learning time within activity.)*

The American Medical Association designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Return home

Steven A. Farmer, MD, PhD, FACC, FASE
Senior Advisor and Senior Medical Officer
Center for Medicare and Medicaid Innovation

Dr. Steven A. Farmer is Senior Advisor and Senior Medical Officer at the Center for Medicare and Medicaid Innovation (CMMI). He advises the center on development, implementation, and refinement of alternative payment models that link healthcare payments with value. He is a practicing noninvasive cardiologist and remains an Associate Professor of Medicine and Health Policy and Management at George Washington University. He is also Adjunct Associate Professor of Medicine and Business Strategy and distinguished fellow of Law, Regulation, and Economic Growth at Northwestern University. He previously served as Merkin Fellow and Visiting Scholar in Economic Studies at the Brookings Institution and Senior Advisor to the Duke-Margolis Center for Health Policy. Along with Mark McClellan, he recently co-chaired a writing group that developed a conceptual approach to Primary Care - Cardiology Collaborative Models of Care, an effort supported by the American College of Cardiology, the American College of Physicians, the American Academy of Family Physicians, and the American College of Osteopathic Family Physicians.

He graduated from Stanford University with a degree in International Relations and an emphasis in international public health. He completed his PhD at the London School of Hygiene and Tropical Medicine as a British Marshall Scholar and his MD at Yale University. He completed his residency in internal medicine and fellowship in cardiology at the University of Pennsylvania.

Return home

R. Kannan Mutharasan, MD

R. Kannan Mutharasan, MD is an Assistant Professor of Medicine and a Cardiologist in the Bluhm Cardiovascular Institute. He serves as the medical director of the Heart Failure Bridge and Transition (BAT) team, a multidisciplinary program designed to facilitate care transitions from the inpatient to the outpatient setting. He graduated from Northwestern University Feinberg School of Medicine in 2003 after earning a BS in Biomedical Engineering from Northwestern University McCormick School of Engineering.

Dr. Mutharasan's current operations and research work is in health services and clinical outcomes, focused on implementing quality care for heart failure patients. The heart failure group at Northwestern uses quantitative and qualitative methods, and draws lessons from operations research through collaborations with the Kellogg School of Management to identify and overcome hurdles in delivery of care. The Heart Failure Bridge and Transition team embraces Lean approaches to effect process improvement.

CME Credit and the AMA Education Center

Return home

Thank you for attending the **2018 AMA Annual Meeting.** We hope you found the presentation informative.

Instructions to receive your *AMA PRA Category 1 Credit* ™ can be found below.

Program	Access code
Value-based care: Understanding models of risk	9000
Understanding CMS's new BPCI Advanced Model	1111

Follow these instructions to complete the activity evaluation and claim credit on the AMA Education Center:

1. Visit: https://www.ama-assn.org/education-center
2. In the search bar, enter the title of the program
3. Select the program that you attended from the search results
4. Click the "Register" button located on the right of the screen.
5. Enter your AMA username and password or create an account.
6. Unlock the activity by entering the access code (above) where prompted and click the "Submit" button. This access code is valid through **July 31, 2018**. If you are interested in claiming credit or a certificate of participation for this activity, you must do so before **July 31, 2018**.
7. Scroll to the bottom of the "Overview" tab. Then click on "Continue" to advance to the next tab.
8. Click on the "Launch" button in the "Evaluation" tab. Complete the evaluation in order to proceed to your certificate. Click on the "Submit" button at the bottom of the Evaluation when completed.
9. Upon completing the evaluation, click "Continue" to advance to the "Certificate" tab.
10. You should now see a hyperlink under "Credit Type" which you will be able to view, save and/or download your certificate. Adobe Acrobat Reader is required to access your certificate.

If you have any **questions, please contact us at (800) 621-8335** or olcsupport@ama-assn.org

Note: Your certificate will remain stored in your transcript in the AMA Education Center

REPORT OF THE INTEGRATED PHYSICIAN PRACTICE SECTION
GOVERNING COUNCIL

GC Report A-A-18

Subject: IPPS Review of House of Delegates Resolutions & Reports

Presented by: Peter Rutherford, MD, Chair

IPPS Governing Council Report A identifies resolutions and reports relevant to integrated health care delivery groups or systems that have been submitted for consideration by the AMA House of Delegates (HOD) at the 2018 AMA Annual Meeting. This report is submitted to the Assembly for further discussion and to facilitate the instruction of the IPPS Delegate and Alternate Delegate regarding the positions they should take in representing the Section in the HOD.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS (AMA CONSTITUTION, AMA BYLAWS, ETHICS)

No items under consideration by the Reference Committee on Amendments to Constitution and Bylaws.

REFERENCE COMMITTEE A (MEDICAL SERVICE)

(1) Resolution 112 - Enabling Attending Physicians to Waive the Three-Midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs
Introduced by the AMDA - The Society for Post-Acute and Long-Term Care Medicine

RESOLVED, That our American Medical Association support provisions that allow attending physicians caring for Medicare recipients in any setting be allowed to waive the three midnight inpatient stay requirement for initiation of skilled nursing care in a facility when the attending physician and the skilled nursing facility are both part of a downside risk sharing arrangement with Medicare--such as a Track 1+ or higher Medicare Accountable Care Organization or an Advanced Bundled Payments for Care Improvement Program. (New HOD Policy)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to support the intent of Resolution 112.

REFERENCE COMMITTEE B (LEGISLATION)

(2) Resolution 212 - Value-Based Payment System
Introduced by the New York Delegation

RESOLVED, That our American Medical Association work to repeal the law that conditions a portion of a physician's Medicare payment on compliance with the Medicare Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM) programs (Directive to Take Action); and be it further

RESOLVED, That our AMA continue advocating for a reduction in the administrative burdens of compliance with value-based programs and that these programs comply with evidence-based standards. (Directive to Take Action)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to oppose the intent of Resolution 212.

(3) Resolution 235 - Hospital Consolidation
Introduced by the Washington Delegation

RESOLVED, That our American Medical Association actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets (New HOD Policy); and be it further

RESOLVED, That our AMA study the benefits and risks of hospital rate setting commissions in states where highly concentrated hospital markets currently exist. (Directive to Take Action)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to oppose the intent of Resolution 235.

REFERENCE COMMITTEE C (MEDICAL EDUCATION)

No items under consideration by the Reference Committee C.

REFERENCE COMMITTEE D (PUBLIC HEALTH)

No recommendations on items under consideration by Reference Committee D.

REFERENCE COMMITTEE E (SCIENCE AND TECHNOLOGY)

No recommendations on items under consideration by Reference Committee E.

REFERENCE COMMITTEE F (AMA FINANCE AND GOVERNANCE)

No recommendations on items under consideration by Reference Committee F.

REFERENCE COMMITTEE G (MEDICAL PRACTICE)

(4) Board of Trustees Report 31 - Physician Burnout and Wellness Challenges, Physician and Physician Assistant Safety Net, Identification and Reduction of Physician Demoralization

The AMA Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 601-I-17, 604-I-17 and 605-I-17, and that the remainder of the report be filed:

1. That our American Medical Association reaffirm the following policies:
    a. H-405.957, "Programs on Managing Physician Stress and Burnout;"
    b. H-405.961, "Physician Health Programs;"
    c. D-405.990, "Educating Physicians About Physician Health Programs;"
    d. H-95.955, "Physician Impairment;" and
    e. H-295.858, "Access to Confidential Health Services for Medical Students and Physicians." (Reaffirm HOD Policy)
2. That our AMA amend existing Policy D-310.968, "Physician and Medical Student Burnout," to add the following directives (Modify Current HOD Policy):
    1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
    2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
    3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
    4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
    5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
    6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
    7. Our AMA will encourage hospitals to confidentially survey physicians to identify factors that may lead to physician demoralization.
    8. Our AMA will continue to develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
    9. Our AMA will continue to (1) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (2) develop and promote mechanisms by which organizations and physicians can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being at the system level.

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to support the intent of Board of Trustees Report 31.

(5) Resolution 701 - Employed Physicians Bill of Rights
Introduced by the Illinois Delegation

RESOLVED, That our American Medical Association adopt an "Employed Physician's Bill of Rights (New HOD Policy);" and be it further

RESOLVED, That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational endeavors and preparation, committee participation, student/resident activities and administrative responsibilities (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that physicians should not be solely responsible for data entry, coding and management of the use of electronic medical record systems (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that clinical activity should be evaluated only through the peer review process and judged only by clinicians, not corporate executives (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that physician activities performed outside of defined employed-time boundaries are the sole prerogative of the individual physician and not the employer organization unless it directly conflicts with or increases risk to the organization (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that conflict-of-interest disclosures should be limited to physician activities that directly affect the organization and should only be disclosed to entities that directly reimburse the physician during their employed time period (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that restrictive covenants should be limited only to physicians with partnership stakes in the organization and should not apply to salary-based physicians (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that resources should be appropriately allocated by the organization for continuing medical education as defined by state licensure guidelines (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that employed physicians have the right to the collective bargaining process as outlined in the National Labor Relations Act of 1935 (The Wagner Act) (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that all physicians be empowered to first be the patient's advocate and be allowed to adhere to the spirit of the Hippocratic Oath allowing patient privacy, confidentiality and continuity of a patient's health care and dignity. (New HOD Policy)

Recommendation: The Governing Council recommends that the AMA-IPPS Assembly discuss Resolution 701.

(6) Resolution 702 - Basic Practice Professional Standards of Physician Employment

Introduced by the Indiana Delegation

RESOLVED, That our American Medical Association support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.
2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.
3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.
4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other “greater societal good” organizations.
5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region. (New HOD Policy)

Recommendation: The Governing Council recommends that the AMA-IPPS Assembly discuss Resolution 702.

Return to Report A

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-18)

Introduced by: AMDA - The Society for Post-Acute and Long-Term Care Medicine

Subject: Enabling Attending Physicians to Waive the Three-Midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs

Referred to: Reference Committee A
(Jonathan D. Leffert, MD, Chair)

Whereas, Medicare beneficiaries who need skilled nursing care in a nursing facility are required to have an inpatient stay in a hospital lasting for three midnights at a minimum before they are eligible for such care; and

Whereas, Even as skilled nursing care is expensive, such care is essential to maintain wellness and wellbeing of our aging population, especially after bouts of acute illness; and

Whereas, Programs that participate in a downside risk sharing arrangement with Medicare-such as a Track 1+ or higher Accountable Care Organizations (ACO) or the Advanced Bundled Payments for Care Improvement Programs - have an inherent incentive to be good stewards of the Medicare program and generate savings for the Government; and

Whereas, Some Medicare ACOs (Track 1+ and above) are allowed to waive three midnight stay requirements, the process is not uniform, nor is it Physician centric; therefore be it

RESOLVED, That our American Medical Association support provisions that allow attending physicians caring for Medicare recipients in any setting be allowed to waive the three midnight inpatient stay requirement for initiation of skilled nursing care in a facility when the attending physician and the skilled nursing facility are both part of a downside risk sharing arrangement with Medicare--such as a Track 1+ or higher Medicare Accountable Care Organization or an Advanced Bundled Payments for Care Improvement Program. (New HOD Policy)

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

Received: 05/01/18

Return to Report A

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-18)

Introduced by: New York

Subject: Value-Based Payment System

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, The Merit-based Incentive Payment System (MIPS) was created as part of the Quality Payment Program (QPP) under the Medicare Access CHIP Reauthorization Act of 2015 (MACRA) to institute a new "value-based" payment system for physicians; and

Whereas, MIPS adjusts payments based on performance in the categories of: Quality; Cost; Meaningful Use; and Improvement activities; and

Whereas, Compliance with this program involves the navigation of a labyrinth of rules and regulations; and an alphabet soup of acronyms that constitutes an unreasonable burden on physicians; taking time and energy away from the care of patients; and

Whereas, The "value-based" payment system involves a huge bureaucracy which results in the waste of health care dollars; and

Whereas, There is no evidence that this system of payment helps physicians to care for patients or improves the health of patients, which is the true mission of our profession; therefore be it

RESOLVED, That our American Medical Association work to repeal the law that conditions a portion of a physician's Medicare payment on compliance with the Medicare Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM) programs (Directive to Take Action); and be it further

RESOLVED, That our AMA continue advocating for a reduction in the administrative burdens of compliance with value-based programs and that these programs comply with evidence-based standards. (Directive to Take Action)

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

Received: 04/25/18

RELEVANT AMA POLICY

MACRA and the Independent Practice of Medicine H-390.837
1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.
2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.
3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.
Alt. Res. 206, A-17

MIPS and MACRA Exemption H-390.838
Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.
Res. 208, I-16 Reaffirmation: A-17 Reaffirmation: I-17

Return to Report A

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-18)

Introduced by: Washington

Subject: Hospital Consolidation

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, Hospital consolidation has increased substantially over the last 5 years and as many as 20% of all US hospitals will seek a merger in the next 5 years; and

Whereas, None of the geographic health care markets in the US are considered "highly competitive," and 90 percent of metropolitan areas have highly concentrated hospital markets;[1] and

Whereas, Highly concentrated hospital markets increase hospital prices, reduce choice, and reduce physician practice options;[2] and

Whereas, The market power of hospital conglomerates in many, if not most, geographic health care markets far exceeds health insurance plans' market power resulting in excessive hospital cost inflation; and

Whereas, Conglomerate chain hospitals can make decisions about the regional care offerings without respect for the individual patient's preferences; and

Whereas, Hospital rate setting commissions, like in Maryland, can reduce total expenditures and excessive hospital cost inflation without shifting costs to other parts of the health care system;[3] therefore be it

RESOLVED, That our American Medical Association actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets (New HOD Policy); and be it further

RESOLVED, That our AMA study the benefits and risks of hospital rate setting commissions in states where highly concentrated hospital markets currently exist. (Directive to Take Action)

REFERENCES
[1] B. D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," Health Affairs, Sept.
2017 36(9):1530–38.
[2] CMS Rep. 5, A-17
[3] Giuriceo, K. Evaluation of the Maryland All-Payer Model. RTI International. Aug 2017. Access at https://innovation.cms.gov/Files/reports/md-all-payer-secondannrpt.pdf

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

Received: 05/02/18

RELEVANT AMA POLICY

Specialty Hospitals and Impact on Health Care H-215.968
Our AMA supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care.
Citation: BOT Rep. 15, I-04; Reaffirmation A-09; Reaffirmed: CMS Rep. 05, A-17

Return to Report A

REPORT OF THE BOARD OF TRUSTEES

B of T Report 31-A-18

Subject: Physician Burnout and Wellness Challenges, Physician and Physician Assistant Safety Net, Identification and Reduction of Physician Demoralization (Resolution 601-I-17; Resolution 604-I-17; Resolution 605-I-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

INTRODUCTION

At the 2017 Interim Meeting, three resolutions (601-I-17, "Physician Burnout and Wellness Challenges," 604-I-17, "Physician and Physician Assistant Safety Net," and 605-I-17, "Identification and Reduction of Physician Demoralization") with shared components of a central issue were referred for report back together at the 2018 Annual Meeting. This report addresses the overarching topic and each resolution as it relates to the issue, and presents recommendations accordingly.

Resolution 601-I-17, "Physician Burnout and Wellness Challenges," was introduced by the International Medical Graduates Section and the American Association of Physicians of Indian Origin. Resolution 601-I-17 asks the American Medical Association (AMA) to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness.

Resolution 604-I-17, "Physician and Physician Assistant Safety Net," was introduced by the Oregon Medical Association and asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Such safety net services would be provided by doctorate level mental health clinicians experienced in treating physicians. Resolution 604-I-17 also directs the AMA to advocate that funding for such safety net programs be sought from such entities as foundations, hospital systems, medical clinics, and donations from physicians and physician assistants.

Resolution 605-I-17, "Identification and Reduction of Physician Demoralization," was introduced by the Organized Medical Staff Section and asks that the AMA: (1) recognize that physician demoralization, defined as a consequence of externally imposed occupational stresses, including but not limited to electronic health record (EHR)-related and administrative burdens imposed by health systems or by regulatory agencies, is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness.

BACKGROUND

Today's physicians are experiencing burnout at increasing rates, expressing feelings of professional demoralization, professionally under-valued and overburdened by an ever-changing health care system.[1-3] Over 54 percent of practicing physicians report experiencing at least one symptom of burnout, a near 10 percent increase in three years.[4] Practicing physicians are not alone in reported symptoms of burnout; resident and medical student burnout is also on the rise. It is recognized that with growing numbers of physicians, residents and medical students experiencing burnout, health care costs will continue to rise and patient safety will suffer.[5] Stress, depression and burnout can lead to suicidal ideation and sometimes suicide. While no resolute number has been verified, it is estimated and often cited that 300 to 400 physicians per year die by suicide[6], and physician suicide rates are historically higher than the general population.[7] Resources such as safety nets and hotlines exist for individuals experiencing suicidal ideation and are available from a number of national and reputable sources.

AMA POLICY

Our AMA recognizes the importance of addressing and supporting physician satisfaction as well as the impact physician burnout may have on patient safety, health outcomes and overall costs of health care. This commitment to physician satisfaction and well-being is evidenced by AMA's ongoing development of targeted policies and tools to help physicians, residents and medical students, and its recognition of professional satisfaction and practice sustainability as one of its three strategic pillars.

The AMA supports programs to assist physicians in early identification and management of stress. The programs supported by the AMA concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, as well as when to seek professional assistance for stress-related difficulties (Policy H-405.957, "Programs on Managing Physician Stress and Burnout"). AMA policy and the Code of Ethics acknowledge that when physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided (Code of Ethics 9.3.1, "Physician Health & Wellness"). Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness (Policy H-405.961, "Physician Health Programs"). Educating physicians about physician health programs is greatly important to the AMA. The AMA will continue to work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members about the availability of and services provided by state physician health programs to ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory. Our AMA will continue to collaborate with other relevant organizations on activities that address physician health and wellness. Our AMA, in collaboration with the FSPHP, develops state legislative guidelines to address the design and implementation of physician health programs, as well as messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training (Policy D-405.990, "Educating Physicians About Physician Health Programs").

The AMA recognizes physical or mental health conditions that interfere with a physician's ability to engage safely in professional activities can put patients at risk, compromise professional relationships and undermine trust in medicine. While protecting patients' well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care (Code of Ethics 9.3.2, "Physician Responsibilities to Impaired Colleagues").

AMA policy defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities. The AMA in the same policy encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians and to develop case finding mechanisms for all types of physicians (Policy H-95.955, "Physician Impairment"). Access to confidential health services for medical students and physicians is encouraged by the AMA to provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services. Our AMA will continue to urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: (a) be available to all medical students on an opt-out basis; (b) ensure anonymity, confidentiality, and protection from administrative action; (c) provide proactive intervention for identified at-risk students by mental health and addiction professionals; and (d) inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and, (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education (Policy H-295.858, "Access to Confidential Health Services for Medical Students and Physicians").

The AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem not only with practicing physicians, but among residents, fellows, and medical students. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets. In addition, our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students. The AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community. Finally, our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements (Policy D-310.968, "Physician and Medical Student Burnout").

DISCUSSION

Our AMA is committed to upholding the tenets of the Quadruple Aim: Better Patient Experience, Better Population Health, Lower Overall Costs of Health Care, and Improved Professional

Satisfaction.[8] This is evidenced by AMA policy supporting the "Triple Aim" and requesting that it be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers (Policy H-405.955, "Support for the Quadruple Aim"). In order to achieve the fourth aim, the AMA acknowledges that interventions at both system and individual levels are necessary for enhancing physician satisfaction and reducing burnout. The work carried out through the AMA's Professional Satisfaction and Practice Sustainability strategic focus area is dedicated to this objective.

Resolution 601-I-17 asks the AMA to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness. The AMA has been actively and directly engaged with health care organizations, including state and county medical societies, to build awareness and support for addressing physician burnout. The AMA partnered with the RAND Corporation in 2013 to identify and study the factors that influence physician professional satisfaction, as well as understand the implications of these factors for patient care, health systems, and health policy.[9] This seminal work informed subsequent initiatives and a long-term strategy for AMA's Professional Satisfaction and Practice Sustainability unit. Key accomplishments and offerings have been realized through launching the free, online, STEPS Forward™ practice transformation platform. This online resource offers over 50 modules of content developed by subject matter experts and is specifically designed for physicians, practices, and health systems. The STEPS Forward platform has been openly shared with leadership of many state and specialty societies, as well as presented to their membership in various forums. In addition, the AMA has partnered with health systems, large practices, state medical societies, state hospital associations and graduate medical education programs to deploy and assess physician burnout utilizing the Mini-Z Burnout Assessment.[10] The assessment offers organizations a validated instrument that provides an organizational score for burnout, along with two subscale measures for "Supportive Work Environment" and "Work Pace and EMR Frustration." In addition to the organizational dashboard, the assessment is able to provide a comprehensive data analysis complete with medical specialty and clinic level benchmarking. The trends and findings from the assessment are shared and targeted interventions are recommended to the surveying organization. The interventions and suggested solutions are curated from existing STEPS Forward content and through specific best practices identified through AMA collaborators.

Resolution 604-I-17 asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Testimony heard in the reference committee hearing further clarified the request for a task force to research, collect, publish and administer a repository of information about programs and strategies that optimize physician wellness. The AMA, through its ongoing work in the Professional Satisfaction and Practice Sustainability strategy unit, acknowledges the importance of addressing and supporting physician mental health and has developed and published resources to help physicians manage stress and prevent and reduce burnout. The AMA supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.

In addition, our AMA will review relevant modules of the STEPS Forward program and also identify validated student-focused, high-quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these

resources to medical students. The STEPS Forward platform currently provides relevant modules to address physician well-being, specifically the modules "Preventing Physician Distress and Suicide," "Improving Physician Resiliency" and "Physician Wellness: Preventing Resident and Fellow Burnout." In conjunction with STEPS Forward modules, the Mini-Z Burnout Assessments provide participating organizations the option to embed the PHQ-2 Depression Screening Tool. This allows organizations to gain a deeper understanding of those physicians experiencing more severe levels of depression and disinterest and correlate those responses to burnout. The survey also offers a free text section for physicians in need of services to self-identify and receive direct outreach and support. Additionally, the Mini-Z tool provides information on the National Suicide Prevention Lifeline for organizations to utilize in their physician wellness and burnout efforts.

It is demonstrated through current efforts and strategic priorities that the AMA recognizes the importance of assessment and attention to depression in physicians, residents and medical students, as well as the relationship that depression can have with suicidal ideation. Current AMA research and strategic initiatives are focused on enhancing workflows within the system and clinical setting with the intent to scale efficiency and reduce feelings of burnout amongst physicians. The AMA's role in sharing burnout and depression screening data is to assist physician employers in understanding individual physician burnout and connecting physicians with employee assistance resources. Considering the AMA's current efforts and ongoing commitment to providing resources on the topics of burnout, distress and suicide prevention, stress reduction, and wellness, convening an exclusive task force separate from the AMA staff already dedicated to this work would be duplicative. While an online search indicates there is no current, easily identifiable suicide prevention line exclusively for physicians or health care workers, there are hotlines available that are open to all individuals regardless of profession. Studying these hotlines as described in the resolution would be resource intensive and the results of such study may not prove applicable to the AMA's primary audiences; however, making existing relevant AMA resources available to physicians seeking help can be accomplished, and is part of current AMA practices. The AMA will continue to direct physicians to our current resources to learn about strategies, programs and tools related to this topic, and will further explore options for providing more direct assistance for physicians in need.

Resolution 605-I-17 asks the AMA to (1) recognize that physician demoralization is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness. Testimony in the reference committee hearing recognized that "burnout" is a commonly used term favored by many physicians, and while there is some preference for the use of another term instead of "burnout," there was no consensus on what that term should be. Our AMA recognizes that burnout is characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness. These feelings can manifest as a result from a multitude of driving factors, such as administrative burden, excessive EHR documentation and systemic cultural deficiencies leading to demoralization of physicians. The term "burnout" is often used to encompass the multiple driving factors of physician dissatisfaction as well as the resultant feelings and behaviors associated with being overworked, excessively scrutinized and overburdened with unnecessary tasks. As the term "burnout" is used broadly, this allows for many variations in the interpretation of its meaning. Our AMA does not define the term "burnout" as an individual "resilience deficiency" or character flaw. Our AMA supports and voices a position that burnout is derived from system and environmental issues, not from the individual physician. This position is evidenced by AMA resources and services targeted at system-level approaches to intervention.

In addition, the AMA will continue to advocate for organizations to confidentially survey physicians to understand local levels of burnout and opportunities for strategic improvement. It should be noted that the AMA's Mini-Z Burnout Assessment is deployed confidentially and takes protective safeguards very seriously to ensure accurate and safe reporting of results. Through leveraging ongoing AMA media channels, hosting educational webinars, live speaking engagements, and the Transforming Clinical Practices Initiative (TCPI) grant through the Centers for Medicare and Medicaid Services (CMS), the AMA is striving to scale awareness and intervention to advance physician satisfaction and help address the burnout epidemic.

CONCLUSION

The AMA is committed to enhancing joy in practice for physicians, residents and medical students. Our AMA will continue its focus on research, advocacy and activation to address the issues presented in each of the resolutions discussed herein. The AMA will continue to work diligently to address the issues through our existing work, partnerships, resource development and policies. We present the following recommendation to not only emphasize the work already being done, but also to further address the issues brought forth in these three resolutions.

RECOMMENDATION

The AMA Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 601-I-17, 604-I-17 and 605-I-17, and that the remainder of the report be filed:

1. That our American Medical Association reaffirm the following policies:
    a. H-405.957, "Programs on Managing Physician Stress and Burnout;"
    b. H-405.961, "Physician Health Programs;"
    c. D-405.990, "Educating Physicians About Physician Health Programs;"
    d. H-95.955, "Physician Impairment;" and
    e. H-295.858, "Access to Confidential Health Services for Medical Students and Physicians." (Reaffirm HOD Policy)

2. That our AMA amend existing Policy D-310.968, "Physician and Medical Student Burnout," to add the following directives (Modify Current HOD Policy):

    1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.

    2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

    3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.

    4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

7. Our AMA will encourage hospitals to confidentially survey physicians to identify factors that may lead to physician demoralization.

8. Our AMA will continue to develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.

9. Our AMA will continue to (1) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (2) develop and promote mechanisms by which organizations and physicians can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being at the system level.

Fiscal note: Minimal – less than $1,000

REFERENCES

1. Firth-Cozens, J. and R.L. Payne, *Stress in Health Professionals: Psychological and Organisational Causes and Interventions*. 1999: Wiley; Available from: https://www.wiley.com/en-us/Stress+in+Health+Professionals%3A+Psychological+and+Organisational+Causes+and+Interventions-p-9780471998761
2. Balch, C.M., J.A. Freischlag, and T.D. Shanafelt, *Stress and burnout among surgeons: understanding and managing the syndrome and avoiding the adverse consequences.* Arch Surg, 2009. 144(4): p. 371-6; Available from: https://jamanetwork.com/journals/jamasurgery/fullarticle/404847
3. Lee, F.J., M. Stewart, and J.B. Brown, *Stress, burnout, and strategies for reducing them What's the situation among Canadian family physicians?* Canadian Family Physician, 2008. 54(2): p. 234-235; Available from: http://www.cfp.ca/content/54/2/234.long
4. Shanafelt, T.D., et al., *Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014.* Mayo Clinic Proceedings, 2015. 90(12): p. 1600-1613; Available at: http://www.mayoclinicproceedings.org/article/S0025-6196(15)00716-8/abstract
5. Dyrbye, L.N., et al., *Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care.* NAM Perspectives, 2017; Available from: https://nam.edu/burnout-among-health-care-professionals-a-call-to-explore-and-address-this-underrecognized-threat-to-safe-high-quality-care/
6. Eckleberry-Hunt, J. and D. Lick, *Physician Depression and Suicide: A Shared Responsibility.* Teach Learn Med, 2015. 27(3): p. 341-5; Available from: https://www.ncbi.nlm.nih.gov/pubmed/26158336
7. Schernhammer, E.S. and G.A. Colditz, *Suicide rates among physicians: a quantitative and gender assessment (meta-analysis).* Am J Psychiatry, 2004. 161(12): p. 2295-302; Available from: https://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.161.12.2295?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed
8. Bodenheimer, T. and C. Sinsky, *From triple to quadruple aim: care of the patient requires care of the provider.* Ann Fam Med, 2014. 12(6): p. 573-6; Available from: http://www.annfammed.org/content/12/6/573.full
9. Friedberg, M.W., et al., *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy.* RAND Corporation, 2013; Available from: https://www.rand.org/pubs/research_reports/RR439.html
10. Linzer, M., et al., *Physician stress: results from the physician worklife study.* Stress and Health, 2002. 18(1): p. 37-42; Available from: http://onlinelibrary.wiley.com/doi/10.1002/smi.917/abstract

Return to Report A

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-18)

Introduced by: Illinois

Subject: Employed Physicians Bill of Rights

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

Whereas, The continuing consolidation of healthcare by hospital mergers and practice acquisitions has resulted in the majority of physicians now being employed by corporations and healthcare systems, which leads to physician practice uncertainty and disputes that are likely to grow as career options become more limited; and

Whereas, The past several years have witnessed a shift of the practice of medicine by transforming physicians from clinical decision makers to salaried technicians with a job description that includes data entry, coding/billing, transcribing, medical guideline implementation, and patient care coordination so as to enhance revenue reimbursement for their employer; and

Whereas, Employed physicians have increasingly become merely revenue generators, resulting in individual contract negotiations becoming one-sided under the direction of corporate executives and managers with no leverage for the physicians; and

Whereas, This relationship is modeled after the hotel/hospitality industry standards of short-term occupancy, centralized decision making, customer relations and structured pricing that is then taught in hospital administration programs; and

Whereas, During the period from 1970 to 2016, there has been a doubling of the number of physicians to match the same increase of the population of the United States but a 3000% rise in hospital executives, and a corresponding 2300% increase in healthcare spending per capita; and

Whereas, The increasing need for revenue generation from employed physicians by medical corporate interests has led to the systematic devaluation of medical inquiry, experience, independence and professional growth leading to despondency within the profession of medicine; therefore be it

RESOLVED, That our American Medical Association adopt an “Employed Physician’s Bill of Rights” (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational endeavors and preparation, committee participation, student/resident activities and administrative responsibilities (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that physicians should not be solely responsible for data entry, coding and management of the use of electronic medical record systems (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that clinical activity should be evaluated only through the peer review process and judged only by clinicians, not corporate executives (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that physician activities performed outside of defined employed-time boundaries are the sole prerogative of the individual physician and not the employer organization unless it directly conflicts with or increases risk to the organization (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that conflict-of-interest disclosures should be limited to physician activities that directly affect the organization and should only be disclosed to entities that directly reimburse the physician during their employed time period (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that restrictive covenants should be limited only to physicians with partnership stakes in the organization and should not apply to salary-based physicians (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that resources should be appropriately allocated by the organization for continuing medical education as defined by state licensure guidelines (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that employed physicians have the right to the collective bargaining process as outlined in the National Labor Relations Act of 1935 (The Wagner Act) (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that all physicians be empowered to first be the patient’s advocate and be allowed to adhere to the spirit of the Hippocratic Oath allowing patient privacy, confidentiality and continuity of a patient’s health care and dignity. (New HOD Policy)

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

Received: 12/04/17

Return to Report A

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-18)

Introduced by: Indiana

Subject: Basic Practice Professional Standards of Physician Employment

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

Whereas, A shortage of physicians is present in the U.S.; and

Whereas, Physicians have the longest standard duration of education, representing both significant societal and personal investment; and

Whereas, Physicians have, at different points in their careers, different factors they must consider to maintain a work-life balance; and

Whereas, Currently, about 80 percent of Indiana physicians are employed by non-physician owned hospitals/businesses; and

Whereas, This resolution should also be considered by the Organized Medical Staff Section, which has an interest in the relationship between medical staff and hospital administration; therefore be it

RESOLVED, That our American Medical Association support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.
2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.
3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.
4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other “greater societal good” organizations.
5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region. (New HOD Policy)

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

Received: 02/12/18

Return home

Future IPPS elections

Elections for the IPPS Governing Council are held every two years. The next scheduled election will be in June 2019 at which time all seats will be open for election or re-election. For more information, please contact carrie.waller@ama-assn.org

Return home

Future IPPS Meetings

2018

- Interim Meeting – Gaylord National, National Harbor, Maryland
  Friday, November 9, IPPS Assembly Meeting

2019

- Annual Meeting - Hyatt Regency Chicago, IL
  Friday, June 7, IPPS Assembly Meeting

- Interim Meeting – Manchester Grand Hyatt, San Diego, CA
  Friday, November 15, IPPS Assembly Meeting

2020

- Annual Meeting - Hyatt Regency Chicago, IL
  Friday, June 5, IPPS Assembly Meeting

- Interim Meeting – Manchester Grand Hyatt, San Diego, CA
  Friday, November 13, IPPS Assembly Meeting

Return home

If you're staying after the IPPS meeting, consider attending this new Joint-Section programming.

Saturday, June 9, Joint-Section Sessions

8:30–9:30 a.m.
Session: Improving Health Outcomes for Vulnerable Patient Populations
Crystal Ballroom B

9:45–10:45 a.m.
Session: #MeToo: Sexual Harassment and Discrimination in Medicine
Regency D

10:45 a.m. –Noon
Session: From Disruption to Reform: Learn to Spark Change and Move Medicine Forward
Columbus CD

11 a.m. –Noon
Session: Health Care Change Agents: Traditional and Non-traditional Players Fuel the Fire
Crystal Ballroom C

11 a.m. –Noon
Session: Small Changes, Big Results: Innovations in Patient-centered Technology
Regency ABC

Noon–1:30 p.m
Session: How to Successfully Transition Out of Medicine and Into Retirement
Columbus KL

Return home

Visit the AMA Member Center

Located just outside the Grand Ballroom, East Tower

Five new activities:

1. Update your AMA account to customize your news subscriptions
2. Take a selfie and post on our Instagram launch
3. Rest and recharge your devices
4. Learn how to spread the word about the AMA to your peers
5. Share your story for #MembersMoveMedicine