



**MEMBERSHIP  
MOVES  
MEDICINE™**

**2019 AMA Integrated Physician Practice Section  
Annual Meeting  
Hyatt Regency Chicago  
June 7**

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## AMA Integrated Physician Practice Section

2019 Annual Meeting

Hyatt Regency Chicago

June 7

### The future of quality

Thursday, June 6		Location
6:00 – 7:00 p.m.	IPPS Welcome Reception	Crystal Foyer, West Tower, Lobby Level
<b>Friday, June 7</b>		
7:30 – 8:00 a.m.	Continental breakfast	Crystal Ballroom A, West Tower, Lobby Level
8:00 – 8:15 a.m.	IPPS opening session - IPPS elections	“
8:15 – 11:15 a.m.	<b>Scale versus quality: Systems and the physician leadership challenge</b>  James Orlikoff, President, Orlikoff & Associates  8:15 – 9:15a, presentation 9:15 – 9:45a, Q&A 9:45 - 10:00a, break 10:00 – 10:45a, roundtable discussion 10:45 – 11:15a, roundtable reports	
11:15 – 11:30 a.m.	Break	
11:30 a.m. – 1:00 p.m.	<b>What's the future of Medicare quality measurement? CMS has a vision</b>  Michelle Schreiber, MD, CMS, Director, Quality Measurement and Value-Based Incentives Group  <i>Reaction panel:</i> Moderator: Michael Glenn, CMO, Virginia Mason Medical Center William Conway, EVP, Henry Ford Health System, CEO, Henry Ford Medical Group Narayana Murali, MD, EVP of Care Delivery and Chief Clinical Strategy Officer, Marshfield Clinic Health System, Executive Director of Marshfield Clinic Donna Smith, MD, Executive Medical Director, Clinics, Virginia Mason Medical Center	

1:00 – 2:00 p.m.	Networking Luncheon	
2:00 – 3:00 p.m.	<b>A new integrated primary care model for Medicare adults: Oak Street Health</b>  David Buchanan, MD, Chief Clinical Officer, Oak Street Health	
3:00 – 4:00 p.m.	IPPS Policy discussions	
4:00 p.m.	Meeting adjourned	



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## Meeting logistics

### Wi-fi information

Network name: 2019ANNUAL

Password: 2019ANNUAL

### Hotel map

### Meeting app information

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# HYATT REGENCY CHICAGO

## GUEST MAP

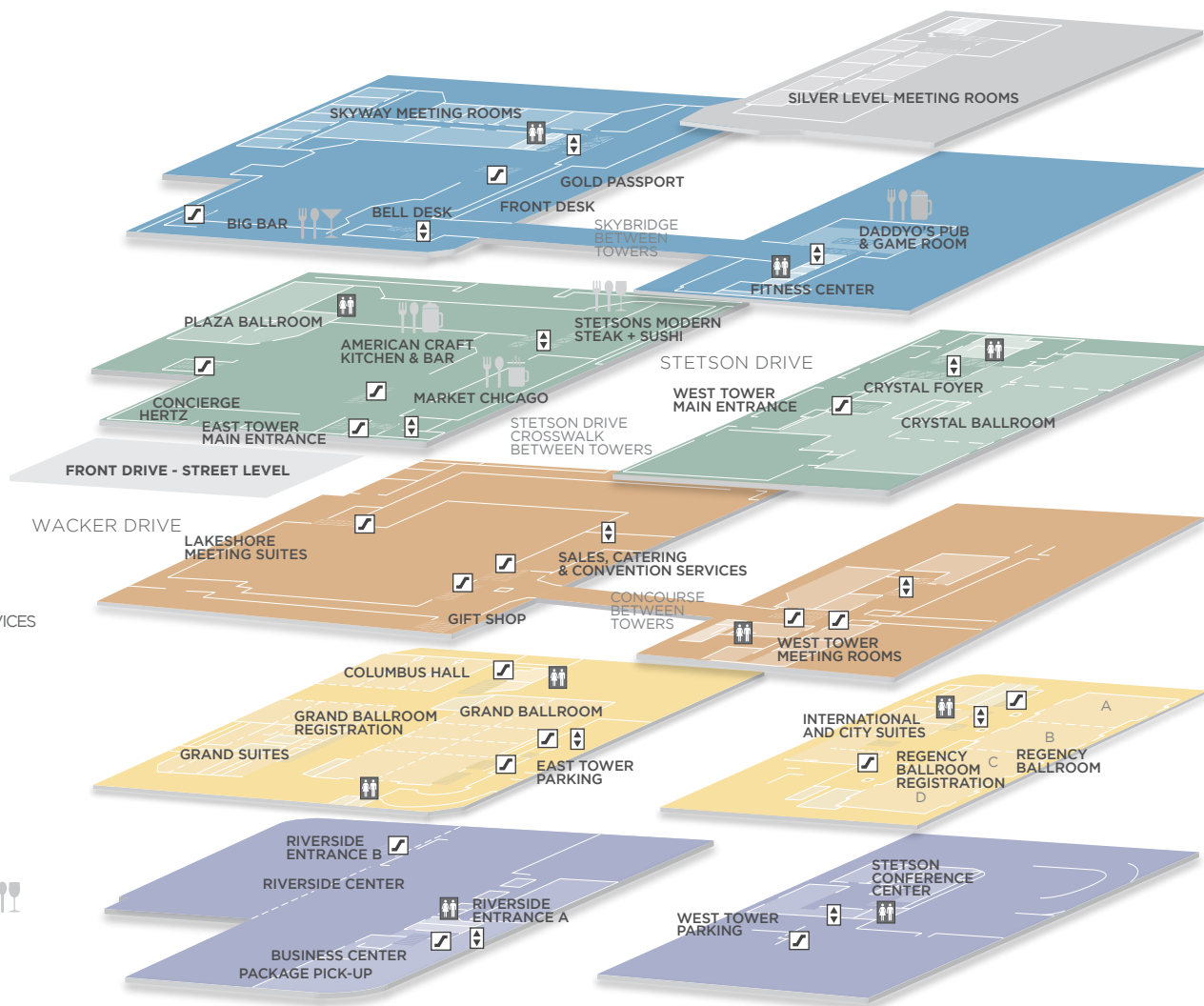


**WELCOME TO HYATT REGENCY CHICAGO.** Meeting rooms, ballrooms, restaurants and guest amenities are listed in alphabetical order and color coded by floor. For help, dial Guest Services at Extension 4460.

ACAPULCO West Tower, Gold Level	HAYMARKET West Tower, Bronze level
ADDAMS West Tower, Silver Level	HERTZ East Tower, Green Level
AMERICAN CRAFT KITCHEN & BAR East Tower, Green Level	HONG KONG West Tower, Gold Level
ATLANTA West Tower, Gold Level	HORNER West Tower, Silver Level
BELL DESK East Tower, Blue Level	LAKESHORE MEETING SUITES East Tower, Bronze level
BIG BAR East Tower, Blue Level	MARKET CHICAGO East Tower, Green Level
BUCKINGHAM West Tower, Bronze level	MCCORMICK West Tower, Silver Level
BURNHAM West Tower, Silver Level	NEW ORLEANS West Tower, Gold Level
BUSINESS CENTER East Tower, Purple Level	OGDEN West Tower, Silver Level
COLUMBIAN West Tower, Bronze Level	PACKAGE PICK-UP East Tower, Purple Level
COLUMBUS HALL (ROOMS A-L) East Tower, Gold Level	PICASSO West Tower, Bronze Level
COMISKEY West Tower, Bronze Level	PLAZA BALLROOM East Tower, Green Level
CONCIERGE East Tower, Green Level	REGENCY BALLROOM West Tower, Gold Level
CRYSTAL BALLROOM West Tower, Green Level	RIVERSIDE CENTER East Tower, Purple Level
DADDY'S PUB & GAME ROOM West Tower, Blue Level	SALES, CATERING & CONVENTION SERVICES East Tower, Bronze Level
DUSABLE West Tower, Silver Level	SAN FRANCISCO West Tower, Gold Level
EAST TOWER MAIN ENTRANCE East Tower, Green Level	SANDBURG West Tower, Silver Level
EAST TOWER PARKING East Tower, Gold Level	SKYWAY MEETING ROOMS East Tower, Blue Level
FIELD West Tower, Silver Level	SOLDIER FIELD West Tower, Bronze Level
FITNESS CENTER West Tower, Blue Level	STETSON CONFERENCE CENTER West Tower, Purple Level
FRONT DESK East Tower, Blue Level	STETSONS MODERN STEAK + SUSHI East Tower, Green Level
GIFT SHOP East Tower, Bronze Level	TORONTO West Tower, Gold Level
GOLD COAST West Tower, Bronze Level	WATER TOWER West Tower, Bronze Level
GOLD PASSPORT East Tower, Blue Level	WEST TOWER PARKING West Tower, Purple Level
GRAND BALLROOM East Tower, Gold Level	WRIGHT West Tower, Silver Level
GRAND BALLROOM REGISTRATION East Tower, Gold Level	WRIGLEY West Tower, Bronze Level
GRAND SUITES East Tower, Gold Level	

### EAST TOWER

### WEST TOWER



**ESCALATORS, ELEVATORS AND RESTROOMS** are indicated on each floor. Elevators are conveniently located throughout the hotel for guests with disabilities or where no escalator is present.

**CROSSING BETWEEN TOWERS:** Cross between towers via the **Blue Level** Skybridge or the Concourse on the **Bronze Level**. You may also cross on the **Green Level** via the crosswalk on Stetson Drive.



# Downloading the App

## Get the app

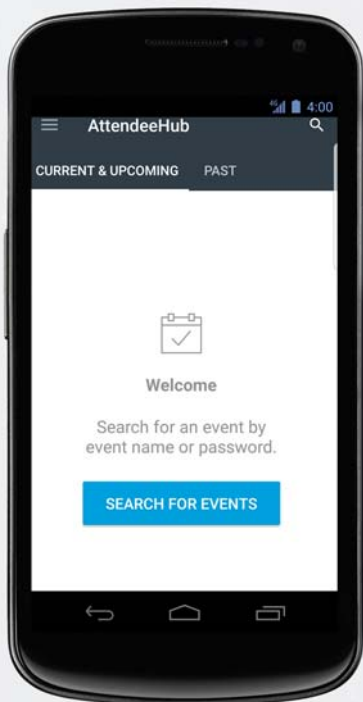
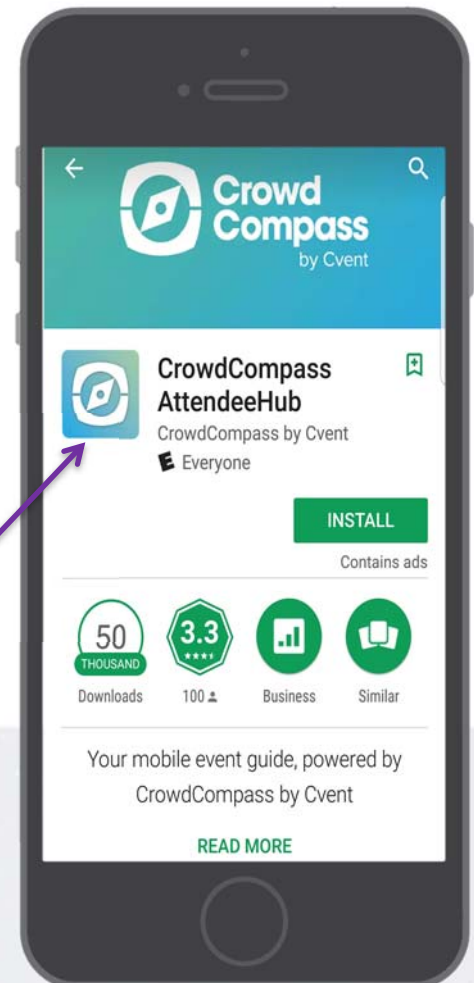
**1. Go to the right store.** Access the App Store on iOS devices and the Play Store on Android.

*If you're using a Blackberry or Windows phone, skip these steps. You'll need to use the web version of the app found here:*

<https://event.crowdcompass.com/amaannual2019>

**2. Install the app.** Search for CrowdCompass AttendeeHub. Once you've found the app, tap either **Download** or **Install**.

After installing, a new icon will appear on the home screen.



## Find your event

**1. Search the AttendeeHub.** Once downloaded, open the AttendeeHub app and enter **AMA 2019 Annual Meeting**

**2. Open your event.** Tap the name of your event to open it.



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## Policy materials

### Section resolutions

Resolution 1, Stakeholder Input to Reports of the House of Delegates

### Section reports

IPPS Report A, A-19

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AMERICAN MEDICAL ASSOCIATION INTEGRATED PHYSICIAN PRACTICE SECTION

Resolution: 1  
(A-19)

Introduced by: Integrated Physician Practice Section

Subject: Stakeholder Input to Reports of the House of Delegates

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Whereas, House of Delegates (HOD) reports generated by the AMA Councils and Board of Trustees, produce important AMA policies which have potentially far-reaching impact in terms of AMA initiatives and advocacy efforts; and

Whereas, The majority of AMA Council and Board reports originate from HOD resolutions that are “referred” for report or decision; and

Whereas, Once an HOD resolution is referred, the Board of Trustees assigns the referred resolution to one of the seven AMA Councils (Council on the Constitution & Bylaws; Council on Ethical & Judicial Affairs; Council on Legislation; Council on Long Range Planning & Development; Council on Medical Education; Council on Medical Service; and Council on Science & Public Health) or to the AMA Board of Trustees; and

Whereas, The assigned entity (council or Board) works with AMA staff to thoroughly research and prepare a comprehensive report for release to the HOD at a specified time, at which time the report will be debated and either adopted, adopted as amended, not adopted, or referred; and

Whereas, AMA policy G-615.030 states in part that “[AMA] Councils should actively seek stakeholder input into all items of business. . . .and that councils make draft reports available online for comment when time and circumstances permit”; and

Whereas, The AMA sections and representative societies in the HOD may be able to provide important perspectives and expertise; and

Whereas, Some AMA councils proactively seek input from key stakeholders, others offer transparency and a role for engagement at stakeholders’ request, and others prefer a more closed process and categorically do not share any draft reports; and

Whereas, There is no clear path for sections or other stakeholders represented in the HOD to know what council or Board reports are under development or to offer input until the reports are final and presented in the online forum, HOD handbook, reference committee or House floor at which time meaningful input is difficult to consider, possibly resulting in referral and delay in taking timely action on defining policy, therefore be it

RESOLVED, That our American Medical Association study and propose a process for interested stakeholders represented in the House of Delegates to view an online list of AMA Council and Board reports under development and a mechanism for stakeholder input on draft reports, and report back at the 2019 Interim Meeting. (Directive to Take Action)



Fiscal note: Less than \$500

Received:

**Relevant AMA Policy:**

**G-615.030 Council Activities**

AMA policy on the activities of its Councils includes the following:

- (1) The Councils should actively seek stakeholder input into all items of business;
- (2) Individual AMA Councils are allowed to prioritize tasks assigned to their respective work subject areas taking into consideration established AMA strategic priorities and the external regulatory, business, and legislative environment affecting our AMA membership and the health care system in which we provide care to our patients; and
- (3) Online tools and the AMA web site will be used to provide ways for members of the HOD, other AMA parties (eg, councils, sections, etc.), AMA members, and other invited parties, to provide comments on the activities and work of the AMA councils on a timely basis, and that councils make draft reports available online for comment when time and circumstances permit.

References: N/A

REPORT OF THE INTEGRATED PHYSICIAN PRACTICE SECTION  
GOVERNING COUNCIL

GC Report A-A-19

Subject: IPPS Review of House of Delegates Resolutions & Reports

Presented by: Peter Rutherford, MD, Chair

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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 2019 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.

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

**(1) Resolution 010-A-19: Covenants Not to Compete**

Introduced by New Mexico

RESOLVED, That our American Medical Association consider as the basis for model legislation the New Mexico statute allowing a requirement that liquidated damages be paid when a physician partner who is a part owner in practice is lured away by a competing hospital system (Directive to Take Action); and be it further

RESOLVED, That our AMA ask our Council on Ethical and Judicial Affairs to reconsider their blanket opposition to covenants not to compete in the case of a physician partner who is a part owner of a practice, in light of the protection that liquidated damages can confer to independent physician owned partnerships, and because a requirement to pay liquidated damages does not preclude a physician from continuing to practice in his or her community. (Directive to Take Action)

***Recommendation: The Governing Council recommends that the AMA-IPPS Assembly discuss Resolution 010.***

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**REFERENCE COMMITTEE A (MEDICAL SERVICE)**

**(2) Resolution 111-A-19: Practice Overhead Expense and the Site-of-Service Differential**

Introduced by Ohio

RESOLVED, That our American Medical Association appeal to the US Congress for legislation to direct the Centers for Medicare and Medicaid Services (CMS) to eliminate any

1 site-of-service differential payments to hospitals for the same service that can safely be  
2 performed in a doctor's office (Directive to Take Action); and be it further

3  
4 RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS in  
5 regards to any savings to Part B Medicare, through elimination of the site-of-service  
6 differential payments to hospitals, (for the same service that can safely be performed in a  
7 doctor's office), be distributed to all physicians who participate in Part B Medicare, by means  
8 of improved payments for office-based Evaluation and Management Codes, so as to  
9 immediately redress underpayment to physicians in regards to overhead expense (Directive to  
10 Take Action); and be it further

11  
12 RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS to make  
13 Medicare payments for the same service routinely and safely provided in multiple outpatient  
14 settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate  
15 data regarding the actual costs of providing the service in each setting. (Directive to Take  
16 Action)

17  
18 ***Recommendation: The Governing Council recommends that the AMA-IPPS Assembly discuss***  
19 ***Resolution 111.***

20  
21  
22 **(3) Resolution 205-A-19: Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied**  
23 **to Employed Physician Salary**

24 Introduced by Illinois

25  
26 RESOLVED, That our American Medical Association adopt policy opposing any association  
27 between anonymous patient satisfaction scores (e.g. "loyalty scores") or the coworkers'  
28 observation reporting system, and employed physicians' salaries (New HOD Policy); and be it  
29 further

30  
31 RESOLVED, That our AMA adopt policy opposing any publication of anonymous patient  
32 satisfaction scores or coworkers' observation reporting system information directed at an  
33 individual physician (New HOD Policy); and be it further

34  
35 RESOLVED, That our AMA adopt policy opposing the use of any anonymous patient  
36 satisfaction scores or any individually and anonymously posted patient or co-worker comments  
37 in formulating or impacting employed physician salaries or in relation to any other physician  
38 compensation program. (New HOD Policy)

39  
40 ***Recommendation: The Governing Council recommends that the AMA-IPPS Assembly discuss***  
41 ***Resolution 205.***

42  
43  
44  
45 **REFERENCE COMMITTEE B (LEGISLATION)**

46  
47 **(4) Resolution 240-A-19: Formation of Collective Bargaining Workgroup**

48 Introduced by Hawaii

49  
50 RESOLVED, That our American Medical Association form a workgroup to outline the legal  
51 challenge to federal antitrust statute for physicians (Directive to Take Action); and be it further

1 RESOLVED, That this workgroup engage the state medical associations and other physician  
2 groups as deemed appropriate (Directive to Take Action); and  
3

4 RESOLVED, That our AMA report by the 2020 Annual Meeting on the viability of a strategy  
5 for the formation of a federal collective bargaining system for all physicians and, to the extent  
6 viable, a related organizational plan. (Directive to Take Action)  
7

8 ***Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the***  
9 ***AMA House of Delegates be instructed to oppose the intent of Resolution 240.***  
10

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11  
12 **REFERENCE COMMITTEE C (MEDICAL EDUCATION)**  
13

14 ***No items under consideration by the Reference Committee C.***  
15

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16  
17 **REFERENCE COMMITTEE D (PUBLIC HEALTH)**  
18

19 **(5) BOT 16-A-19: Developing Sustainable Solutions to Discharge of Chronically-Homeless**  
20 **Patients**  
21

22 1. That our American Medical Association partner with relevant stakeholders to educate  
23 physicians about the unique healthcare and social needs of homeless patients and the  
24 importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role  
25 therein, in addressing these needs. (Directive to Take Action)  
26

27 2. That our AMA encourage the development of holistic, cost-effective, evidence-based  
28 discharge plans for homeless patients who present to the emergency department but are not  
29 admitted to the hospital. (New HOD Policy)  
30

31 3. That our AMA encourage the collaborative efforts of communities, physicians, hospitals,  
32 health systems, insurers, social service organizations, government, and other stakeholders to  
33 develop comprehensive homelessness policies and plans that address the healthcare and social  
34 needs of homeless patients. (New HOD Policy)  
35

36 4. That our AMA reaffirm Policy H-160.903, Eradicating Homelessness, which "supports  
37 improving the health outcomes and decreasing the health care costs of treating the chronically  
38 homeless through clinically proven, high quality, and cost-effective approaches which  
39 recognize the positive impact of stable and affordable housing coupled with social services."  
40 (Reaffirm HOD Policy)  
41

42 5. That our AMA reaffirm Policy H-160.978, The Mentally Ill Homeless, which states that  
43 "public policy initiatives directed to the homeless, including the homeless mentally ill  
44 population, should...[promote] care that is sensitive to the overriding needs of this population  
45 for food, clothing, and residential facilities." (Reaffirm HOD Policy)  
46

47 6. That our AMA reaffirm Policy H-160.942, Evidence-Based Principles of Discharge and  
48 Discharge Criteria, which "calls on physicians, specialty societies, insurers, and other involved  
49 parties to join in developing, promoting, and using evidence-based discharge criteria that are

1 sensitive to the physiological, psychological, social, and functional needs of patients."  
2 (Reaffirm HOD Policy)  
3

4 7. That our AMA reaffirm Policy H-130.940, Emergency Department Boarding and Crowding,  
5 which "supports dissemination of best practices in reducing emergency department boarding  
6 and crowding." (Reaffirm HOD Policy)  
7

8 8. That our AMA reaffirm Policy H-270.962, Unfunded Mandates, which "vigorously opposes  
9 any unfunded mandates on physicians." (Reaffirm HOD Policy)  
10

11 ***Recommendation: The Governing Council recommends that the AMA-IPPS Assembly discuss***  
12 ***BOT 16.***  
13

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14  
15 **REFERENCE COMMITTEE E (SCIENCE AND TECHNOLOGY)**  
16

17 **No items under consideration by the Reference Committee E.**  
18

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19  
20 **REFERENCE COMMITTEE F (AMA GOVERNANCE AND FINANCE)**  
21

22 **(6) Resolution 603-A-19: Creation of an AMA Election Reform Committee**

23 Introduced by Connecticut  
24

25 RESOLVED, That our American Medical Association appoint a House of Delegates Election  
26 Reform Committee to examine ways to expedite and streamline the current election and voting  
27 process for AMA officers and council positions (Directive to Take Action); and be it further  
28

29 RESOLVED, That such HOD Election Reform Committee consider, at a minimum, the  
30 following options:  
31

- 32 - The creation of an interactive election web page;
- 33 - Candidate video submissions submitted in advance for HOD members to view;
- 34 - Eliminate all speeches and concession speeches during HOD deliberations, with  
35 the exception of the President-Elect, Speaker and Board of Trustee positions;
- 36 - Move elections earlier to the Sunday or Monday of the meeting;
- 37 - Conduct voting from HOD seats (Directive to Take Action); and be it further  
38

39 RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns  
40 (Directive to Take Action); and be it further  
41

42 RESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019  
43 Interim Meeting with a list of recommendations. (Directive to Take Action)  
44

45 ***Recommendation: The Governing Council recommends that the AMA-IPPS Assembly support***  
46 ***the intent of Resolution 602.***

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**REFERENCE COMMITTEE G (MEDICAL PRACTICE)**

**(7) CMS 10-A-19: Alternative Payment Models and Vulnerable Populations**

1. That our American Medical Association (AMA) support alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities. (New HOD Policy)

2. That our AMA continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations. (New HOD Policy)

3. That our AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. (New HOD Policy)

4. That our AMA reaffirm Policy H-385.913 stating that APMs should limit physician accountability to aspects of spending and quality that they can reasonably influence; APMs should understand their patient populations, including non-clinical factors; and support new data sources that enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-385.908 stating that the AMA should continue advocating for APMs limiting the financial risk requirements to costs that physicians participating in an APM have the ability to control or influence and work with stakeholders to design risk adjustment systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as severity of illness, access to health care services, and socio-demographic factors. Moreover, Policy H-385.908 recognizes that technology should enable the care team and states that the AMA should work with stakeholders to develop information technology (IT) systems that support and streamline clinical participation and enable IT systems to support bi-directional data exchange. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-350.974 recognizing that racial and ethnic health disparities is a major public health problem, stating that the elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA, and supporting education and training on implicit bias, diversity, and inclusion. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-35.985 supporting physician-led, team-based care recognizing that interdisciplinary physician-led care teams are well equipped to provide a whole-person health care experience. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy D-350.995 promoting diversity within the workforce as one means to reduce disparities in health care. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-440.828 on community health workers (CHWs) recognizing that they play a critical role as bridgebuilders between underserved communities

1 and the health care system and calling for sustainable funding mechanisms to financial CHW  
2 services. (Reaffirm HOD Policy)

3  
4 10. That our AMA reaffirm Policy H-450.924 supporting that hospital program assessments  
5 should account for social risk factors so that they do not have the unintended effect of  
6 financially penalizing safety net hospitals and physicians that exacerbate health care disparities.  
7 (Reaffirm HOD Policy)

8  
9 11. That our AMA reaffirm Policy H-280.945 supporting better integration of health care and  
10 social services and supports. (Reaffirm HOD Policy)

11  
12 12. That our AMA reaffirm Policy H-160.896 calling to expand payment reform proposals that  
13 incentivize screening for social determinants of health and referral to community support  
14 systems. (Reaffirm HOD Policy)

15  
16 ***Recommendation: The Governing Council recommends that the AMA-IPPS Assembly support***  
17 ***the intent of CMS 10.***

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010  
(A-19)

Introduced by: New Mexico

Subject: Covenants Not to Compete

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(William Reha, MD, MBA, Chair)

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1 Whereas, Covenants not to compete have been used to force physicians to leave communities  
2 if they leave hospital employment; and  
3

4 Whereas, Recruiting and promoting new partners, building their referral bases, and purchasing  
5 necessary equipment is a significantly expensive undertaking; and  
6

7 Whereas, Practices endure significant financial harm when a hospital can lure a partner away,  
8 and a requirement to pay liquidated damages when that happens mitigates the financial harm  
9 without requiring the partner to leave the community; and  
10

11 Whereas, New Mexico passed a statute that prohibits covenants not to compete for employed  
12 physicians but allows for liquidated damages to be paid when a partner who is a part owner in a  
13 practice is lured away by a competing hospital system; and  
14

15 Whereas, The New Mexico statute is a model that could be used by the AMA Council on  
16 Legislation as an example for other states; and  
17

18 Whereas, The AMA Council on Ethical and Judicial Affairs opposes covenants not to compete in  
19 all circumstances; therefore be it  
20

21 RESOLVED, That our American Medical Association consider as the basis for model legislation  
22 the New Mexico statute allowing a requirement that liquidated damages be paid when a  
23 physician partner who is a part owner in practice is lured away by a competing hospital system  
24 (Directive to Take Action); and be it further  
25

26 RESOLVED, That our AMA ask our Council on Ethical and Judicial Affairs to reconsider their  
27 blanket opposition to covenants not to compete in the case of a physician partner who is a part  
28 owner of a practice, in light of the protection that liquidated damages can confer to independent  
29 physician owned partnerships, and because a requirement to pay liquidated damages does not  
30 preclude a physician from continuing to practice in his or her community. (Directive to Take  
31 Action)

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

Received: 05/09/19



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111  
(A-19)

Introduced by: Ohio

Subject: Practice Overhead Expense and the Site-of-Service Differential

Referred to: Reference Committee A  
(John Montgomery, MD, Chair)

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Whereas, In the 17-year period from 2001-2017, Medicare Part B payments to physicians increased only 6% while Medicare's index of inflation measuring the cost of running a medical practice increased 30%, (AMA Council on Medical Service (CMS) Report 4, I-18); and

Whereas, After adjustment for inflation in practice costs, physician pay has declined 19%, thus failing to match increases in office overhead costs (CMS Report 4, I-18); and

Whereas, In the 17-year period from 2001-2017, Medicare hospital payments increased roughly 50%, including average annual increases of 2.6% for inpatient services and 2.5% per year for outpatient services (CMS Report 4, I-18); and

Whereas, Hospitals have thus received payment increases more than 8-fold greater than payment adjustments to physicians in the period from 2001-2017; and

Whereas, Much of this disparate payment to hospitals is due to annual year-over-year increases in payments for services rendered in hospital outpatient facilities, where Medicare pays a so-called site-of-service differential amounting to, on average, approximately 360% of Medicare's payment for the same mix of services when they are performed in a physician's office; therefore be it

RESOLVED, That our American Medical Association appeal to the US Congress for legislation to direct the Centers for Medicare and Medicaid Services (CMS) to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor's office (Directive to Take Action); and be it further

RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that can safely be performed in a doctor's office), be distributed to all physicians who participate in Part B Medicare, by means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense (Directive to Take Action); and be it further

RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. (Directive to Take Action)

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

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205  
(A-19)

Introduced by: Illinois

Subject: Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to  
Employed Physician Salary

Referred to: Reference Committee B  
(Charles Rothberg, MD, Chair)

---

1 Whereas, Patient or coworker observation experience surveys are increasingly used by  
2 healthcare centers in evaluating physician clinical care and are often tied to physician salaries;  
3 and  
4

5 Whereas, These patient surveys focus on patient perspectives and brand management while  
6 not addressing any specific quality metrics of complicated clinical care; and  
7

8 Whereas, Coworker observation metrics have not been validated as a reliable monitoring tool  
9 for patient care or clinical professional behavior; and  
10

11 Whereas, Patient or coworker experience surveys depend upon active responses and thus may  
12 exhibit reporting bias due to complaints frequently unrelated to the providers' actual clinical  
13 care; and  
14

15 Whereas, It has been demonstrated that higher patient satisfaction scores are associated with  
16 higher health care and prescription expenditures; and  
17

18 Whereas, Patient satisfaction utilization can promote job dissatisfaction, attrition, and  
19 inappropriate clinical care (the very opposite of high-value clinical care); and  
20

21 Whereas, Patient surveys or coworker observation metrics are not conducted nor evaluated in a  
22 peer-review environment; and  
23

24 Whereas, These surveys and metrics are performed anonymously and thus cannot be  
25 adequately addressed by the clinician; and  
26

27 Whereas, These metrics are usually utilized only to negatively impact an employed physician's  
28 salary in a punitive manner (with no potential for positive impact); and  
29

30 Whereas, A clinician's overall work product cannot be distilled to a few numerical metrics; and  
31

32 Whereas, Health care centers may publish the results of patient or coworker surveys regarding  
33 individual providers in an effort to be "transparent"; and  
34

35 Whereas, It is apparent that patient satisfaction surveys or coworkers' observation reporting  
36 symptoms produce "scores" that are not related to any clinical quality metric, have questionable  
37 validity, and are often taken out of context; therefore be it

1 RESOLVED, That our American Medical Association adopt policy opposing any association  
 2 between anonymous patient satisfaction scores (e.g. "loyalty scores") or the coworkers'  
 3 observation reporting system, and employed physicians' salaries (New HOD Policy); and be it  
 4 further

5  
 6 RESOLVED, That our AMA adopt policy opposing any publication of anonymous patient  
 7 satisfaction scores or coworkers' observation reporting system information directed at an  
 8 individual physician (New HOD Policy); and be it further

9  
 10 RESOLVED, That our AMA adopt policy opposing the use of any anonymous patient  
 11 satisfaction scores or any individually and anonymously posted patient or co-worker comments  
 12 in formulating or impacting employed physician salaries or in relation to any other physician  
 13 compensation program. (New HOD Policy)  
 14

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

Received: 04/25/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240  
(A-19)

Introduced by: Hawaii

Subject: Formation of Collective Bargaining Workgroup

Referred to: Reference Committee B  
(Charles Rothberg, MD, Chair)

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1 Whereas, The mission of the AMA and affiliated state medical associations is to promote the art  
2 and science of medicine, and the betterment of public health; and  
3

4 Whereas, There is a current consolidation of the health insurance markets wherein 73% of  
5 markets are highly concentrated and 46% have a single predominant carrier with greater than  
6 50% of the market; and  
7

8 Whereas, These predominant carriers control the market to the extent that independent  
9 physician practices cannot survive if they do not participate with these carriers; and  
10

11 Whereas, These carriers are unilaterally establishing practice algorithms and reporting  
12 requirements which direct the physician work environment; and  
13

14 Whereas, There is increasing national sentiment toward the development of a single payer  
15 health care system; and  
16

17 Whereas, Independent physicians are currently barred from collective bargaining activities by  
18 federal antitrust law; therefore be it  
19

20 RESOLVED, That our American Medical Association form a workgroup to outline the legal  
21 challenge to federal antitrust statute for physicians (Directive to Take Action); and be it further  
22

23 RESOLVED, That this workgroup engage the state medical associations and other physician  
24 groups as deemed appropriate (Directive to Take Action); and be it further  
25

26 RESOLVED, That our AMA report by the 2020 Annual Meeting on the viability of a strategy for  
27 the formation of a federal collective bargaining system for all physicians and, to the extent  
28 viable, a related organizational plan. (Directive to Take Action)

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

Received: 05/09/19

## RELEVANT AMA POLICY

### Collective Bargaining for Physicians H-385.946

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.

Citation: (Res. 239, A-97; Reaffirmation I-98; Reaffirmation A-01; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10)

### Collective Bargaining and the Definition of Supervisors D-383.988

Our AMA will support legislative efforts by other organizations and entities that would overturn the Supreme Court's ruling in *National Labor Relations Board v. Kentucky River Community Care, Inc., et al.*

Citation: (BOT Action in response to referred for decision Res. 248, A-01; Modified: BOT Rep. 22, A-11)

### Physician Collective Bargaining H-385.976

Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.

(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.

(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.

(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.

(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

Citation: (BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12)

### Collective Bargaining: Antitrust Immunity D-383.983

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy.

Citation: BOT Action in response to referred for decision Res. 209, A-07 and Res. 232, A-07; Reaffirmed: Res. 215, A-11

### Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

Citation: (Res. 229, A-12)

### Employee Associations and Collective Bargaining for Physicians D-383.981

Our AMA will study and report back on physician unionization in the United States.

Citation: (Res. 601, I-14)

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-19

Subject: Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients  
(Resolution 826-I-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee D  
(Diana Ramos, MD, MPH, Chair)

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At the 2018 Interim Meeting, the House of Delegates referred Resolution 826, Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients, which was introduced by the Resident and Fellow Section. Resolution 826 asked that our AMA “work with relevant stakeholders in developing sustainable plans for the appropriate discharge of chronically-homeless patients from hospitals.” The resolution further asked that our AMA reaffirm Policy H-270.962, Unfunded Mandates, and Policy H-130.940, Emergency Department Boarding and Crowding.

This report (1) explores how homelessness contributes to emergency department (ED) overuse and hospitalization, (2) outlines current regulatory requirements related to homelessness and discharge planning, and (3) describes the need for broader efforts to address the unique healthcare and social needs of homeless patients.

### BACKGROUND

Homeless individuals are more likely than the general population to experience behavioral health disorders, acute and chronic conditions, and injuries resulting from assaults and accidents. This increased prevalence, in concert with lack of insurance or access to a usual source of medical care, leads homeless individuals to seek care at EDs at a high rate and increases their rates of hospitalization. Indeed, as many as two-thirds of homeless individuals visit an ED each year, as compared to just one-fifth of the general population, and the hospitalization rate for homeless individuals is as much as four times higher than that for non-homeless individuals.<sup>1-6</sup>

Not only are homeless patients more likely to visit an ED, but they are also more likely to re-visit an ED. Indeed, an analysis of national ED utilization rates found that homeless patients were more than three times as likely as non-homeless patients to have been evaluated in the same ED within the previous three days, and were more than twice as likely to visit an ED within a week of discharge from the hospital.<sup>7</sup>

ED utilization is not uniform across the homeless population, with one study representative of the literature on the topic finding that a small proportion of frequent users (7.9%) account for an outsized proportion of total use (54.5%).<sup>5</sup> Anecdotal accounts, which are not uncommon, cite cases of individual homeless patients with more than 100 ED visits in a year and total costs topping \$1 million.<sup>8,9</sup>

## DISCUSSION

### *Discharge planning and ED overuse*

As suggested by Resolution 826-I-18, hospital and ED discharge planning plays a key role in ending the revolving door of ED visits, hospitalizations, and readmissions, especially among homeless frequent users. Specifically, evidence shows that well-coordinated case management (the development and initiation of which is a key outcome of discharge planning) may reduce ED use and costs, and improve both clinical and social outcomes for homeless patients.<sup>10-12</sup> Despite these findings, discharge planning for homeless patients remains rare: one analysis found that 64% of ED visits resulted in homeless patients being discharged back to the street, with only 4% having a discharge plan addressing their housing status.<sup>13</sup>

Current approaches to discharge planning also overlook important opportunities to improve the health of homeless patients in areas unrelated to their ED visits. For example, given that the CDC Advisory Committee on Immunization Practices now recognizes “homelessness” as an indication for hepatitis A vaccination,<sup>14</sup> patient encounters in the ED present an excellent opportunity to assess immunization status and need for vaccination, and to administer vaccines or refer patients for vaccination.<sup>15</sup> As an added bonus, this holistic approach ensures that homeless patients are immunized, which helps keep them well and out of the ED.

### *Hospital requirements for discharge planning*

Recognizing the value of discharge planning in preventing hospital readmissions, the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) include comprehensive discharge planning requirements for hospitals participating in the Medicare or Medicaid programs. These requirements include:

- (1) Identifying inpatients for whom discharge planning is necessary;\*
- (2) Providing a discharge plan evaluation to each identified patient, which “must include an evaluation of the likelihood of a patient’s capacity for selfcare or of the possibility of the patient being cared for in the environment from which he or she entered the hospital;”
- (3) Developing and “[arranging] for the initial implementation of the patient’s discharge plan;”
- (4) Transferring or referring the patient, “along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care;” and
- (5) Reassessing the discharge planning process “on an on-going basis;” which must include “a review of discharge plans to ensure that they are responsive to discharge needs.”<sup>16</sup>

The CoPs do not require discharge planning for ED visits without hospital admission, which are categorized as outpatient visits. However, in recent revisions to its interpretive guidelines for discharge planning, CMS observes that “many of the same concerns for effective posthospital care coordination arise [for outpatients] as for inpatients” and therefore recommends that “hospitals

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\* Note that “in the absence of a finding by the hospital that a patient needs a discharge plan, the patient’s physician may request a discharge plan...[and] the hospital must develop a discharge plan for the patient.”



might consider utilizing, on a voluntary basis, an abbreviated post-hospital planning process for certain categories of outpatients...and for certain categories of emergency department discharges.”<sup>17</sup>

At the state level, in 2018 California adopted regulations requiring more stringent discharge planning requirements and services for homeless patients. Set to take effect July 1, 2019, these new regulations require California hospitals to “include a written homeless patient discharge planning policy and process within the hospital discharge policy.”<sup>18</sup> The law further requires hospitals to perform a variety of specific tasks and in a specific manner, including but not limited to:

- logging all discharges of homeless patients;
- providing a meal, clothing, medication, and transportation upon discharge;
- coordinating with social service agencies; and
- discharging homeless patients only during the daytime.<sup>19,20</sup>

The California law was met with concern by many in the healthcare community, including the California chapter of the American College of Emergency Physicians and the California Hospital Association.<sup>20,21</sup> While recognizing the importance of and supporting appropriate discharge planning and protocols, critics questioned the feasibility of many aspects of the law—for example, how exactly would a hospital go about maintaining a supply of clothing for homeless patients? They also pointed to severe unintended consequences of the law—for example, that prohibiting overnight discharges would further exacerbate ED overcrowding and constrain hospitals’ capacity to provide timely, lifesaving care to those patients who need it most. And, at the broadest level, they questioned why the societal costs of homelessness should be borne by hospitals, especially safety net hospitals that treat a disproportionately large share of homeless patients and are least able to comply with unfunded mandates.

### *Moving beyond discharge planning*

Effective ED and hospital discharge planning constitutes just one component of what ought to be a more comprehensive approach to addressing the unique healthcare needs of homeless patients—one which, as stated by CMS in its interpretive guidelines for discharge planning, “moves away from a focus primarily on a patient’s hospital stay to consideration of transitions among the multiple types of patient care settings that may be involved at various points in the treatment of a given patient.”<sup>17</sup>

Central to these more comprehensive efforts is housing security, an area in which, in the absence of comprehensive state and local homelessness strategies, hospitals and health systems have been obligated to take action in recent years. In 2017, for example, the American Hospital Association published a guidebook, *Housing and the Role of Hospitals*, identifying how hospitals can address this particular social determinant of health. This resource outlines strategies and provides case studies on:

- neighborhood revitalization;
- home assessment and repair programs;
- medical care for the homeless;
- medical respite care; and
- transitional or permanent supportive housing.<sup>22</sup>

The last of these strategies has received considerable attention, with hospitals and health systems investing an estimated \$75 to \$100 million in housing for homeless patients.<sup>23</sup> Insurers and local units of government also have contributed to these efforts, typically in partnership with hospitals

1 and health systems.<sup>24-26</sup> Initial outcomes data on these endeavors suggest that providing housing for  
2 homeless patients can decrease ED use and hospitalizations while yielding net savings on  
3 combined expenditures for healthcare and social services.<sup>27</sup> Despite these outcomes, the long-term  
4 desirability and feasibility of this approach is uncertain, as questions of appropriate resource  
5 allocation (is there a better way to spend these monies?), cost-sharing (is it appropriate to ask  
6 hospitals to cover the cost of social services for homeless patients?), and society's overall approach  
7 to eliminating homelessness remain unresolved.

#### 8 9 *AMA policy on discharge planning and care for homeless patients*

10  
11 AMA policy recognizes the link between housing security and health outcomes, and supports a  
12 coordinated, collaborative approach to care for homeless patients that combines clinical and social  
13 services. For example, Policy H-160.903, Eradicating Homelessness, "supports improving the  
14 health outcomes and decreasing the health care costs of treating the chronically homeless through  
15 clinically proven, high quality, and cost-effective approaches which recognize the positive impact  
16 of stable and affordable housing coupled with social services."

17  
18 Furthermore, Policy H-160.978, The Mentally Ill Homeless, avers that "public policy initiatives  
19 directed to the homeless, including the homeless mentally ill population, should...[promote] care  
20 that is sensitive to the overriding needs of this population for food, clothing, and residential  
21 facilities."

22  
23 Finally, the AMA's comprehensive Evidence-Based Principles of Discharge and Discharge Criteria  
24 (Policy H-160.942), while not explicitly addressing homelessness, "calls on physicians, specialty  
25 societies, insurers, and other involved parties to join in developing, promoting, and using evidence-  
26 based discharge criteria that are sensitive to the physiological, psychological, social, and functional  
27 needs of patients."

#### 28 29 **CONCLUSION**

30  
31 Homelessness is an exacerbating factor in ED overuse, excess hospitalization, and preventable  
32 readmissions. Hospital discharge planning for homeless patients, with a holistic focus on case  
33 management that coordinates clinical and social services, has been shown to alleviate some of these  
34 problems. Despite this evidence, focused discharge planning remains rare for homeless ED  
35 patients. Our AMA should educate physicians about the importance of discharge planning for  
36 homeless patients, and encourage the development of holistic, cost-effective, evidence-based  
37 discharge plans for homeless patients who present to the emergency department but are not  
38 admitted to the hospital.

39  
40 While critical, discharge planning alone will not prevent unnecessary ED visits and hospitalizations  
41 for homeless individuals. Instead, a more comprehensive approach to addressing the unique  
42 healthcare and social needs of homeless patients is required, with efforts reaching beyond the  
43 hospital and into the community. Our AMA should encourage collaborative efforts to address  
44 homelessness that do not leave hospitals and physicians alone to bear their costs.

1 RECOMMENDATIONS

2  
3 The Board of Trustees recommends that the following be adopted in lieu of Resolution 826-I-18  
4 and that the remainder of the report be filed:

- 5  
6 1. That our American Medical Association partner with relevant stakeholders to educate  
7 physicians about the unique healthcare and social needs of homeless patients and the  
8 importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role  
9 therein, in addressing these needs. (Directive to Take Action)  
10  
11 2. That our AMA encourage the development of holistic, cost-effective, evidence-based discharge  
12 plans for homeless patients who present to the emergency department but are not admitted to  
13 the hospital. (New HOD Policy)  
14  
15 3. That our AMA encourage the collaborative efforts of communities, physicians, hospitals,  
16 health systems, insurers, social service organizations, government, and other stakeholders to  
17 develop comprehensive homelessness policies and plans that address the healthcare and social  
18 needs of homeless patients. (New HOD Policy)  
19  
20 4. That our AMA reaffirm Policy H-160.903, Eradicating Homelessness, which "supports  
21 improving the health outcomes and decreasing the health care costs of treating the chronically  
22 homeless through clinically proven, high quality, and cost-effective approaches which  
23 recognize the positive impact of stable and affordable housing coupled with social services."  
24 (Reaffirm HOD Policy)  
25  
26 5. That our AMA reaffirm Policy H-160.978, The Mentally Ill Homeless, which states that  
27 "public policy initiatives directed to the homeless, including the homeless mentally ill  
28 population, should...[promote] care that is sensitive to the overriding needs of this population  
29 for food, clothing, and residential facilities." (Reaffirm HOD Policy)  
30  
31 6. That our AMA reaffirm Policy H-160.942, Evidence-Based Principles of Discharge and  
32 Discharge Criteria, which "calls on physicians, specialty societies, insurers, and other involved  
33 parties to join in developing, promoting, and using evidence-based discharge criteria that are  
34 sensitive to the physiological, psychological, social, and functional needs of patients."  
35 (Reaffirm HOD Policy)  
36  
37 7. That our AMA reaffirm Policy H-130.940, Emergency Department Boarding and Crowding,  
38 which "supports dissemination of best practices in reducing emergency department boarding  
39 and crowding." (Reaffirm HOD Policy)  
40  
41 8. That our AMA reaffirm Policy H-270.962, Unfunded Mandates, which "vigorously opposes  
42 any unfunded mandates on physicians." (Reaffirm HOD Policy)

Fiscal Note: \$5,000

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## AMA POLICIES RECOMMENDED FOR REAFFIRMATION

### **H-160.942 Evidence-Based Principles of Discharge and Discharge Criteria**

- (1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.
- (2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.
- (3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.
- (4) The AMA promotes the local development, adaption and implementation of discharge criteria.
- (5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.
- (6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.
- (7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
  - (a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
  - (b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
  - (c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii)

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

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

#### **H-160.978 The Mentally Ill Homeless**

- (1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components:
  - (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons);
  - (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities);
  - (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development);
  - (d) educational needs;
  - (e) housing needs; and
  - (f) research needs.
- (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences.



- (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.

#### **H-160.903 Eradicating Homelessness**

Our American Medical Association:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; and
- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603  
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire,  
Rhode Island, Vermont

Subject: Creation of an AMA Election Reform Committee

Referred to: Reference Committee F  
(Greg Tarasidis, MD, Chair)

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1 Whereas, Members of our AMA House of Delegates cherish our democratic process; and

2  
3 Whereas, Our current election and voting process for AMA officers and council positions  
4 consumes a lot of time and financial resources; and

5  
6 Whereas, Election reform would allow for more time for policy and debate during HOD sessions;  
7 and

8  
9 Whereas, Cost barriers are often an impediment to candidate elections; and

10  
11 Whereas, There are significant technological advances that could allow for an expedited  
12 process of elections and debate; therefore be it

13  
14 RESOLVED, That our American Medical Association appoint a House of Delegates Election  
15 Reform Committee to examine ways to expedite and streamline the current election and voting  
16 process for AMA officers and council positions (Directive to Take Action); and be it further

17  
18 RESOLVED, That such HOD Election Reform Committee consider, at a minimum, the following  
19 options:

- 20  
21 - The creation of an interactive election web page;  
22 - Candidate video submissions submitted in advance for HOD members to view;  
23 - Eliminate all speeches and concession speeches during HOD deliberations, with the  
24 exception of the President-Elect, Speaker and Board of Trustee positions;  
25 - Move elections earlier to the Sunday or Monday of the meeting;  
26 - Conduct voting from HOD seats (Directive to Take Action); and be it further

27  
28 RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns  
29 (Directive to Take Action); and be it further

30  
31 RESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019  
32 Interim Meeting with a list of recommendations. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is between \$15K-\$25K.

Received: 04/12/19

REPORT 10 OF THE COUNCIL ON MEDICAL SERVICE (A-19)  
Alternative Payment Models and Vulnerable Populations  
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates referred Resolution 712, which was introduced by the New England Delegation and assigned to the Council on Medical Service for study. Resolution 712-A-18 asked: That our American Medical Association (AMA): (1) study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and (2) advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

Health care disparities often occur in the context of wider inequality. It has been shown that if patients' basic needs are not met, they are not likely to stay healthy regardless of the quality of health care received. And because APMs are typically designed to be flexible to compensate for care that is not traditionally reimbursed, they present an opportunity to better care for and serve vulnerable populations. However, as Resolution 712 points out, value-based payment programs can disproportionately penalize physicians serving the poorest and most vulnerable populations. Therefore, the Council offers a set of recommendations that it hopes mitigates these negative outcomes, penalties, and events. In doing so, the Council recommends ways in which the health care system can do more to address non-medical factors that often go undetected and untreated among vulnerable populations within the context of a changing payment and delivery system.

The Council's recommendations build upon the AMA's current policy on value-based payment programs and social determinants of health. The Council recommends reaffirming existing AMA policies to highlight the need for health equity across populations and the corresponding need for APMs and risk adjustment methodologies to protect against financially penalizing the physicians who care for and serve populations who are overwhelmingly sicker and poorer. The Council is sensitive to concerns that APMs may have the impact of not only financially penalizing physicians caring for at-risk populations, but also causing adverse selection in patient treatment. The Council believes that it is critical that social determinants of health be meaningfully incorporated into APM quality measures to encourage and support physicians to care for these patients, and the Council recommends that APMs be designed with the flexibility needed to address the unique challenges of vulnerable populations.

The Council understands and agrees with the sponsor's concern that APMs may have adverse effects on vulnerable populations because current risk adjustment methodologies are not accurate enough to distinguish between suboptimal care and high-quality care provided to high-risk individuals. Accordingly, the Council believes that it is critical that the AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health.

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 10-A-19

Subject: Alternative Payment Models and Vulnerable Populations  
(Resolution 712-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G  
(Rodney Trytko, MD, Chair)

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At the 2018 Annual Meeting, the House of Delegates referred Resolution 712, which was introduced by the New England Delegation and assigned to the Council on Medical Service for study. Resolution 712-A-18 asked:

That our American Medical Association (AMA): (1) study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and (2) advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

This report provides an overview of vulnerable populations and the emergence of APMs, highlights numerous APMs and value-based care initiatives incorporating social determinants of health into their models, summarizes relevant AMA policy, provides a summary of AMA advocacy activities, and recommends policy to encourage the development of APMs that serve vulnerable populations while protecting physicians from being financially penalized.

### BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula and created new ways for the Medicare program to pay physicians for the care they provide to Medicare beneficiaries. Specifically, MACRA's physician payment program is the Quality Payment Program (QPP). The QPP has two tracks of participation: APMs and the Merit-based Incentive Payment System (MIPS). As part of the QPP's drive to value-based care, it creates incentives for physicians to participate in APMs, which aim to provide greater flexibility to manage the health of patient populations by aligning provider incentives with cost and quality goals. MACRA specifically encourages the development of Physician-Focused Payment Models (PFPs), which are APMs wherein Medicare is the payer, physician group practices or individual physicians are APM participants, and the focus is on the quality and cost of physician services. MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and assess PFP proposals submitted by stakeholders to the committee based on certain criteria defined in regulations. The PTAC is an 11-member independent federal advisory committee. Since its inception, the PTAC has received 31 proposals for consideration, a few of which have not been reviewed yet by PTAC. Of those proposals, PTAC has recommended 15 proposals to the Secretary of Health and Human Services (HHS) to test in various ways.

As the national push toward value-based payment and care delivery continues, many studies have demonstrated substantial evidence linking social circumstances to health and health outcomes.<sup>1</sup> It is now understood that non-medical factors, such as social determinants of health (SDH), account for about 60 percent of a person's health outcomes.<sup>2</sup> Together, the drive toward value and recognition of SDH impacts on health are fueling interest in the ways in which addressing SDH may be incorporated into new payment and delivery models like APMs. Within an APM, physicians often are financially rewarded for keeping patients healthy and out of the hospital and emergency departments. To achieve this goal, APMs often have the flexibility to support services that can significantly improve health outcomes. Therefore, physicians can respond to APM incentives by improving care coordination and integration, which may be particularly beneficial for vulnerable populations.

However, APMs may inadvertently create incentives for physicians to avoid caring for vulnerable patients who are at increased risk for high costs and poor outcomes that are beyond the physician's control.<sup>3</sup> In order to increase health equity and to fully realize the benefits of APMs, APMs must contemplate and account for vulnerable populations.

#### *Impact of Vulnerable Population Status on Patient Outcomes*

Vulnerable populations in health care include the economically disadvantaged, racial and ethnic minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ) groups; uninsured individuals; rural individuals who may have trouble accessing care; and those with stigmatized chronic conditions such as severe mental illness or human immunodeficiency virus (HIV).<sup>4</sup> These populations may be more likely to suffer from hunger and access to healthy food options, lack social and economic support, have lower education levels, live in unsafe neighborhoods devoid of parks and playgrounds, and often are subjected to discrimination.<sup>5</sup>

Vulnerable populations are less likely to have health coverage, struggle with health care access, and often have little interaction or trust in the health care system. They are less likely to receive preventive services and are more likely to go to the emergency department or hospital for a condition that might have been treated in a lower cost facility.<sup>6</sup> As a result, their medical interventions generally come much later and at significantly higher cost than for other populations. Moreover, lower income populations are twice as likely as those with higher incomes to have behavioral health problems, three times as likely to be socially isolated, and 10 times more likely to experience food insecurity.<sup>7</sup> Additionally, there is considerable overlap in vulnerable populations. For example, Black and Hispanic American minorities are significantly more likely than Whites to be uninsured, live below the poverty line, and have higher rates of HIV or AIDS diagnosis and death rates.<sup>8</sup>

Though access to health care is essential for well-being, it is not the greatest health determinant.<sup>9</sup> Zip Code™ now is understood to be a stronger predictor of quality of health than even genetic code. Research suggests that health-related behaviors such as smoking, diet, and exercise, are more important determinants of early death than health care itself. Furthermore, there is a growing consensus that non-medical factors shape an individual's ability to engage in health behaviors. For example, children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health such as lack of safety, exposed garbage, and substandard housing.<sup>10</sup> Such environmental factors may have multi-generational impacts.

Generally, the current health care system is not built around the poorest and most vulnerable. Exacerbating the ability to effectively care for these populations is the fact that many physicians are not able to identify high-risk patients. Some of the current risk algorithms used by payers were

originally developed without access to electronic medical record (EMR) data, so many current predictive risk tools have limited utility. The link between non-medical factors and poor health outcomes is well-documented, but few traditional payment and delivery models are equipped to address these non-medical factors that drive high health care costs and poor outcomes.

#### *Addressing the Unique Needs of Vulnerable Populations in Payment and Delivery*

There are a growing number of initiatives to address SDHs and challenges unique to vulnerable populations within and outside of the health care system. These include multi-payer federal and state initiatives, Medicaid initiatives led by states or health plans, and physician-level activities focused on identifying and addressing the social needs of their patients. APMs can provide opportunities to cover services that can help provide care and support that vulnerable or high-risk populations need but that are generally not available under traditional payment models. Examples of such initiatives are highlighted below and include: Accountable Health Communities, the Chinese Community Accountable Care Organization (ACO), the Acute Unscheduled Care Model, and the Patient-Centered Opioid Addiction Treatment (P-COAT) APM.

#### Accountable Health Communities

In 2016, the Center for Medicare and Medicaid Innovation (CMMI), which was established by the Affordable Care Act, announced the Accountable Health Communities model, which is focused on connecting Medicare and Medicaid beneficiaries with community services to address health-related social needs.<sup>11</sup> The model provides funding to examine whether systematically identifying and addressing social needs of beneficiaries through screening, referral, and community navigation services affects health costs and reduces health care utilization. In 2017, CMMI awarded grants to organizations to participate in the model over a five-year period.<sup>12</sup>

Twenty awardees will encourage partner alignment to ensure that community services are available and open to the needs of beneficiaries. To implement the alignment approach, bridge organizations will serve as “hubs” in their communities that will identify and partner with clinical delivery sites to conduct systematic screenings of beneficiary health-related social needs and make referrals to community services that may be able to address the recognized social needs; coordinate and connect beneficiaries to community service providers through community service navigation; and align model partners to optimize community capacity to address these social needs.

#### The Chinese Community ACO

The Chinese Community ACO (CCACO) is a community-based physician-owned ACO that serves about 12,000 Medicare fee-for-service (FFS) beneficiaries in the Chinese communities in New York City.<sup>13</sup> The aim of the model is to reduce overall health care costs and disparities by identifying high-risk individuals and undertaking proactive disease management. The CCACO establishes a network of organizations by partnering with hospitals, nursing homes, home health agencies, senior centers, and others to facilitate coordinated care. The model anticipates that, due to care coordination efforts, it will prevent emergency room visits and hospital readmissions in this population.

#### Acute Unscheduled Care Model (AUCM) Enhancing Appropriate Admissions from the American College of Emergency Physicians (ACEP)

The AUCM was developed by the ACEP. The particular payment model was submitted to the PTAC, and the PTAC subsequently recommended to the Secretary of HHS that the model be

implemented. It centers on incentivizing improved quality and decreased costs associated with the discharge decisions made by emergency department (ED) physicians.<sup>14</sup> The model proposes that it may reduce Medicare spending and improve quality care by reducing avoidable hospital inpatient admissions and observation days by giving ED physicians the ability to coordinate and manage post-discharge home services. The model is a bundled payment, and the episode of care begins with a qualifying ED visit and ends after 30 days or with the patient's death.<sup>15</sup> All of the Medicare services received within that 30-day window are included in the bundle. To assist in care transformation efforts, the model also uses several waivers in order to allow ED physicians to offer telehealth services, bill for transitional management codes, and permit clinical staff to offer home visits.

#### Patient-Centered Opioid Addiction Treatment (P-COAT) APM

The P-COAT model is a payment model created jointly by the American Society of Addiction Medicine (ASAM) and the AMA. The model proposes to manage opioid use disorder, a highly stigmatized condition, by increasing utilization of and access to medications for the treatment of opioid use disorder by providing the appropriate financial support to successfully treat patients and broaden the coordinated delivery of medical, psychological, and social supports.<sup>16</sup> The current payment system offers little support for the coordination of behavioral and social supports that patients being treated for opioid use disorder need. Therefore, under P-COAT, treatment teams are eligible to receive two new types of payments that would be expected to provide the necessary financial support to enable providers to deliver the appropriate opioid addiction treatment.<sup>17</sup>

#### AMA POLICY

The AMA has a wealth of policy on both APMs and SDH. Regarding APMs, Policy H-385.913 promulgates goals for physician-focused APMs, develops guidelines for medical societies and physicians to begin identifying and developing APMs, encourages the Centers for Medicare & Medicaid Services (CMS) and private payers to support assistance to physician practices working to implement APMs, and states that APMs should account for the patient populations, including non-clinical factors. Policy H-385.908 states that the AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to control or influence, will work with stakeholders to design risk adjustment systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage, access to health care services, and socio-demographic factors.

Moreover, AMA policy is committed to promoting physician-led payment reform programs that serve as models for others working to improve patient care and lower costs. Policy D-390.953 directs the AMA to advocate with CMS and Congress for alternative payment models developed in concert with specialty and state medical organizations. Policy H-390.844 emphasizes the importance of physician leadership and accountability to deliver high quality and value to patients and directs the AMA to advocate for providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions. Policy H-450.961 states that incentives should be intended to promote health care quality and patient safety and not primarily be intended to contain costs, provide program flexibility that allows physicians to accommodate the varying needs of individual patients, adjust performance measures by risk and case-mix to avoid discouraging the treatment of high-risk individuals and populations, and support access to care for all people and avoid selectively treating healthier patients. Additionally, Policy D-35.935 supports physician-led, team-based care delivery recognizing that the interdisciplinary care team is well equipped to provide a whole-person health care experience.

1 The AMA has myriad policies on health disparities, health inequities, and diversity, and the AMA  
2 continues to exercise leadership aimed at addressing disparities (Policies H-350.974, D-350.991,  
3 D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943,  
4 H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Policy H-350.974 affirms that the  
5 AMA maintains a zero-tolerance policy toward racially or culturally based disparities in care and  
6 states that the elimination of racial and ethnic disparities in health care are an issue of highest  
7 priority for the organization. The policy encourages the development of evidence-based  
8 performance measures that adequately identify socioeconomic and racial/ethnic disparities in  
9 quality. Furthermore, Policy H-350.974 supports the use of evidence-based guidelines to promote  
10 the consistency and equity of care for all persons. Moreover, the policy actively supports the  
11 development and implementation of training regarding implicit bias and cultural competency.  
12 Policy H-280.945 calls for better integration of health care and social services and supports while  
13 Policy H-160.896 calls to expand payment reform proposals that incentivize screening for social  
14 determinants of health and referral to community support systems. Additionally, Policy D-350.995  
15 promotes diversity within the health care workforce, which can help expand access to care for  
16 vulnerable and underserved populations.

17  
18 Recognizing that current risk adjustment and performance measure systems may disincentivize  
19 caring for the most vulnerable, Policy H-450.924 supports that hospital program assessments  
20 should account for social risk factors so that they do not have the unintended effect of financially  
21 penalizing hospitals, including safety net hospitals, and physicians that may exacerbate health care  
22 disparities.

#### 23 24 AMA ACTIVITY

25  
26 The AMA continues to work to aid physicians in the implementation of MACRA and by  
27 encouraging and enabling physician participation in APMs. The AMA has been active in  
28 educational activities including webinars and regional conferences for physicians and staff and will  
29 be continuing these activities. Recent AMA advocacy activity has called for improvements in the  
30 methodologies behind APMs. Such areas for improvement in methodology include performance  
31 targets, risk adjustment, and attribution. The AMA recognizes that proper methodologies enable  
32 more physicians to participate in APMs and promotes design of APMs in such a way that  
33 prioritizes the patient's need.

34  
35 The AMA continues to strive to ensure that all communities of Americans receive equal access to  
36 quality health care. The AMA is committed to working toward the goal of all Americans having  
37 access to affordable and meaningful health care. It is addressing this issue systemically by striving  
38 for health equity by mitigating disparity factors. For example, the AMA has developed numerous  
39 resources including a Health Disparities Toolkit that helps connect physicians and care teams to  
40 chronic disease prevention programs in the community. The AMA STEPSForward™ module  
41 entitled Addressing Social Determinants of Health describes how a practice can select and define a  
42 plan to address SDH issues. Additionally, steps toward health equality are being taken in the  
43 AMA's effort toward creating the medical school of the future. Within the AMA's Accelerating  
44 Change in Medical Education (ACE) initiative, some medical schools are incorporating education  
45 on disparities within their curricula while others are addressing diversity in the health care  
46 workforce by changing admissions and pipeline programs to ensure that our nation has the diverse  
47 workforce that it needs.

48  
49 Additionally, the AMA is integrating SDH into its Integrated Health Model Initiative (IHMI), a  
50 collaborative effort that supports a continuous learning environment to enable interoperative  
51 technology solutions and care models that evolve with real world use and feedback. IHMI's



collaborative platform is discussing SDH with the goal of identifying those factors that should be incorporated into the IHMI data model. Moreover, the IHMI team has delivered a module that incorporates two of the widely accepted SDH: the nine-digit Zip Code™ where one lives and those who are dually-eligible for Medicaid and Medicare.

Importantly, the AMA recognizes that health quality can only happen in concert with efforts to improve physician satisfaction and wellbeing. Therefore, the AMA is helping create an engaged workforce and mitigating burnout. To that end, the AMA has developed STEPSForward™ resources and Burnout Assessment Tools to allow physicians to assess their practices and find ways to leverage their entire care team to improve physician and patient experience and care. The AMA knows that advocating for physicians and patients is critical to achieve health equity. Patients and the public are partners in the quest for equitable access to quality health and health care.

Moreover, the AMA is establishing a new Health Equity Center with the goal of enabling optimal health for all with an eye on social justice. The Center will serve as a demonstration of the AMA's long-term and enduring commitment to health equity.

## DISCUSSION

Health care disparities often occur in the context of wider inequality. It has been shown that if patients' basic needs are not met, they are not likely to stay healthy regardless of the quality of health care received. Because APMs are typically designed to be flexible to compensate for care that is not traditionally reimbursed, they present an opportunity to better care for and serve vulnerable populations. However, several studies have demonstrated that value-based payment programs disproportionately penalize physicians serving the poorest and most vulnerable populations, possibly disincentivizing physicians from caring for them. Therefore, the Council offers a set of recommendations that it hopes mitigates these negative outcomes, penalties, and events. In doing so, the Council recommends ways in which the health care system can do more to address non-medical factors that often go undetected and untreated among vulnerable populations within the context of a changing payment and delivery system.

The Council's recommendations build upon the AMA's current policy on value-based payment programs and social determinants of health. The Council notes that reaffirming existing AMA policies helps to highlight the need for health equity across populations and the corresponding need for APMs and risk adjustment methodologies to protect against financially penalizing the physicians who care for and serve populations who are overwhelmingly sicker and poorer. The Council is sensitive to concerns that APMs may have the impact of not only financially penalizing physicians caring for at-risk populations, but also causing adverse selection in patient treatment. The Council believes that it is critical that social determinants of health be meaningfully incorporated into APM quality measures to encourage and support physicians to care for these patients. The current health care system was not built for vulnerable populations, and they remain woefully underserved. Therefore, the Council recommends that APMs be designed with the flexibility needed to address the unique challenges of vulnerable populations and believes that PFPs provide an excellent opportunity to transform care delivery to better meet the needs of underserved populations.

The Council understands and agrees with the sponsor's concern that APMs may have adverse effects on vulnerable populations because current risk adjustment methodologies are not accurate enough to distinguish between suboptimal care and high-quality care provided to high-risk individuals. Accordingly, the Council believes that it is critical that the AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of

health. The Council is steadfast in its belief that the structure and quality reporting of APMs must protect against penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. Furthermore, because of the Council's commitment to this principle, the Council believes that the topic of risk adjustment warrants revisiting and notes that at the 2019 Interim Meeting, it will present a report specifically addressing ways in which risk adjustment methodology and implementation can be improved.

## RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 712-A-18 and the remainder of the report be filed:

1. That our American Medical Association (AMA) support alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities. (New HOD Policy)
2. That our AMA continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations. (New HOD Policy)
3. That our AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. (New HOD Policy)
4. That our AMA reaffirm Policy H-385.913 stating that APMs should limit physician accountability to aspects of spending and quality that they can reasonably influence; APMs should understand their patient populations, including non-clinical factors; and support new data sources that enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-385.908 stating that the AMA should continue advocating for APMs limiting the financial risk requirements to costs that physicians participating in an APM have the ability to control or influence and work with stakeholders to design risk adjustment systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as severity of illness, access to health care services, and socio-demographic factors. Moreover, Policy H-385.908 recognizes that technology should enable the care team and states that the AMA should work with stakeholders to develop information technology (IT) systems that support and streamline clinical participation and enable IT systems to support bi-directional data exchange. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy H-350.974 recognizing that racial and ethnic health disparities is a major public health problem, stating that the elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA, and supporting education and training on implicit bias, diversity, and inclusion. (Reaffirm HOD Policy)
7. That our AMA reaffirm Policy D-35.985 supporting physician-led, team-based care recognizing that interdisciplinary physician-led care teams are well equipped to provide a whole-person health care experience. (Reaffirm HOD Policy)

- 1 8. That our AMA reaffirm Policy D-350.995 promoting diversity within the workforce as one  
2 means to reduce disparities in health care. (Reaffirm HOD Policy)  
3
- 4 9. That our AMA reaffirm Policy H-440.828 on community health workers (CHWs) recognizing  
5 that they play a critical role as bridgebuilders between underserved communities and the health  
6 care system and calling for sustainable funding mechanisms to financial CHW services.  
7 (Reaffirm HOD Policy)  
8
- 9 10. That our AMA reaffirm Policy H-450.924 supporting that hospital program assessments should  
10 account for social risk factors so that they do not have the unintended effect of financially  
11 penalizing safety net hospitals and physicians that exacerbate health care disparities. (Reaffirm  
12 HOD Policy)  
13
- 14 11. That our AMA reaffirm Policy H-280.945 supporting better integration of health care and  
15 social services and supports. (Reaffirm HOD Policy)  
16
- 17 12. That our AMA reaffirm Policy H-160.896 calling to expand payment reform proposals that  
18 incentivize screening for social determinants of health and referral to community support  
19 systems. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

## REFERENCES

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## Education Materials

Speaker Biographies
Speaker Slides

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## Speaker biographies

James E. Orlikoff

- Quality versus scale: Systems and the physician leadership challenge

Michelle Schreiber, MD

- What's the future of Medicare quality measurement? CMS has a vision

David Buchanan, MD, MS

- A new integrated primary care model for Medicare adults: Oak Street Health

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### James E. Orlikoff

James E. Orlikoff is president of **Orlikoff & Associates, Inc.**, a consulting firm specializing in health care governance and leadership, strategy, quality, organizational development, and risk management. He is the National Advisor on Governance and Leadership to the American Hospital Association and Health Forum. He was named one of the 100 most powerful people in healthcare in the inaugural list by Modern Healthcare magazine.

Mr. Orlikoff has been involved in leadership, quality, and strategy issues for over forty years. He has consulted with health systems and governments in twelve countries, and since 1985 has worked with physician group, hospital, and system governing boards to strengthen their overall effectiveness and their oversight of strategy and quality. He has worked extensively on developing effective governance and strategy for physician groups. He has written fifteen books and over 100 articles and has served on hospital, college, and civic boards. He currently is a member of the St. Charles Health System board in Bend, OR.

He was the vice-chair of the board of Virginia Mason Health System in Seattle, WA, and chaired their Governance Committee.

He is an author of the book Board Work: Governing Health Care Organizations, which won the ACHE James A. Hamilton Book of the Year award for 2000. He is the primary author of The Future of Health Care Governance: Redesigning Boards for a New Era; the primary author of the best selling book The Board's Role in Quality Care: A Practical

Guide For Hospital Trustees. He is the primary author of Malpractice Prevention and Liability Control for Hospitals Second edition. He is also the author of Quality from the Top: Working with Hospital Governing Boards to Assure Quality Care.

Mr. Orlikoff received his M.A. in social and organizational psychology from the University of Chicago, and his B.A. from Pitzer College in Claremont, CA.

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Chicago, IL 60615-2054

(773) 268-8009 phone      [j.orlikoff@att.net](mailto:j.orlikoff@att.net)

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**Michelle Schreiber, MD**

Dr. Schreiber is currently the Director of the Quality Measurement and Value-Based Incentives Group at CMS. Dr. Schreiber is a general internal medicine physician with over 25 years of health care experience. Most recently, she was the Senior Vice President and Chief Quality Officer of Henry Ford Health System (HFHS) in Detroit, Michigan. Prior roles at HFHS included the Division Head of General Internal Medicine, and the SVP of Clinical Transformation and IT Integration, where she was the clinical lead of the systemwide Epic implementation. The Epic implementation and use earned HFHS a Davies Award in 2018. She has also held senior leadership roles at the Detroit Medical Center, where she was the Chief Quality Officer, and with Trinity Health System where she was the national system Chief Medical Officer, and acting interim Chief Medical Information Officer.

In addition to her health system roles, Dr. Schreiber has served on numerous quality committees including Michigan Hospital Association statewide quality committee, and Board of Directors for the MHA Keystone Center and the Patient Safety Organization, the Board of Directors of MPRO (Michigan Peer Review Organization – the Michigan QIO), the Board of Directors of Health Alliance Plan insurance company, the National Quality Forum Patient Safety Metrics Committee, and the National Quality Partners. She has worked with the Institute for Healthcare Improvement (IHI) including as part of its Leadership Alliance, the Pursuing Equity initiative, and an initiative to enhance Board of Trustees engagement in quality through a partnership with IHI and National Patient Safety Foundation. Dr. Schreiber has also served as a member of the Epic Safety Forum, and the Cerner Academic Advisory Group.

Dr. Schreiber's interests are quality improvement, quality measures, and the intersection with electronic medical records to advance quality and quality measures.

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## **David Buchanan, MD, MS**

David Buchanan is a general internist and Oak Street Health's Chief Clinical Officer. He leads Oak Street Health's efforts to improve the health and well-being of its patients across over 40 centers. He is an Associate Professor of Clinical Medicine at Northwestern University where his academic work has focused on quality improvement in primary care and the health impact of housing. Prior to Oak Street, he held leadership positions at a community health center, an ACO and a public hospital health system.





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## Speaker slides

Speaker slides can be found on the IPPS meeting [website](#).

- *Scale versus quality: Systems and the physician leadership challenge*
- *What's the future of Medicare quality measurement? CMS has a vision*
- *A new integrated primary care model for Medicare adults: Oak Street Health*



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## Announcements

Our people

Committees

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IPPS newsletter

IPPS members in the news

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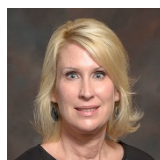
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## IPPS Governing Council



**Peter Rutherford, MD**  
**Chair**

Chief Executive Officer  
Confluence Health, WA



**Susan Pike, MD**  
**Member at-Large**

Director, Division of Plastic and  
Reconstructive Surgery, Baylor/Scott  
& White, TX



**Michael Glenn, MD**  
**Vice-Chair**

Chief Medical Officer  
Virginia Mason Medical Center, WA



**Barbara Spivak, MD**  
**Member at-Large**

President and Board Chair  
Mount Auburn Cambridge IPA, MA



**Russell Libby, MD**  
**Delegate**

Founder and President,  
HealthConnect IPA, VA



**Narayana Murali, MD**  
**Large group slotted seat**

EVP of Care Delivery and Chief  
Clinical Strategy Officer, Marshfield  
Clinic Health System, Executive  
Director of Marshfield Clinic



**Devdutta Sangvai, MD**  
**Alternate Delegate**

Executive Director, Duke  
Connected Care, Duke Health, NC



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## **Candidate Interview Committee**

- Albert Ray, MD
- Patrice Burgess, MD



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## **Volunteer opportunities**

### **IPPS Policy Development Committee**

Co-Chairs, Peter Rutherford, MD and Barbara Spivak, MD

The IPPS Policy Development Committee is charged with engaging Section members in the AMA's policy development process to advance the Section's influence and interests within the AMA, organized medicine, and healthcare.

If you have a special interest in health care policy, please consider becoming involved in this IPPS committee.

Contact Carrie Waller, [carrie.waller@ama-assn.org](mailto:carrie.waller@ama-assn.org).



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## Future IPPS meetings

Annual Meeting		Interim Meeting
2019	June 7, Hyatt Regency, Chicago, IL	Nov. 15, Manchester Grand Hyatt, San Diego, CA
2020	June 5, Hyatt Regency, Chicago, IL	Nov. 13, Manchester Grand Hyatt, San Diego, CA
2021	June 11, Hyatt Regency, Chicago, IL	Nov. 12, Walt Disney World Swan and Dolphin Resort, Orlando, FL
2022	June 10, Hyatt Regency, Chicago, IL	Nov. 10, Hilton Hawaiian Village, Honolulu, HI



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## Stay in the know with the IPPS newsletter

Get the latest news on integrated care by signing up for our monthly newsletter. Just follow these quick steps to get started:

1. [Sign in](#) to the preferences page (login required).
2. On the left navigation, click on "Subscriptions."
3. Click "Add New Subscriptions."
4. Click on "Member Interest Groups" (located in the middle of the page).
5. Scroll down to select "Integrated Practice Physicians."

[IPPS sample newsletter](#)

Questions? Contact Carrie Waller at [carrie.waller@ama-assn.org](mailto:carrie.waller@ama-assn.org).



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## **IPPS members in the news**

### **Congratulations to Virginia Mason Medical Center**

Virginia Mason Medical Center was recognized as one of forty-one hospitals to earn The Leapfrog Group's highest distinction for patient safety performance in every update since 2012.

### **Marshfield Clinic featured in AMA Moving Medicine Magazine**

Marshfield Clinic was featured in the inaugural edition of the AMA's new quarterly members-only magazine, AMA Moving Medicine. See, "In the rural Midwest, a telehealth community thrives" ([pages 11-14](#), login required).





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## Election materials

### Nominees for IPPS Governing Council

- Chair - Michael Glenn, MD
- Vice Chair - Devdutta Sangvai, MD
- Delegate - Russell Libby, MD
- Member at-Large - Adnan Munkarah, MD
- Member at-Large - Gregory Fuller, MD
- Large group slotted seat - Narayana Murali, MD
- Small/medium group slotted seat – Steven Farrell, MD

### Future elections

Elections for the IPPS Governing Council are held every two years. The next scheduled election is June 2021 at which time all seats will be open for election or re-election.

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## **IPPS Governing Council Elections**

*Candidate for chair*

**Michael Glenn, MD**  
**Virginia Mason Medical Center, WA**  
**Specialty: Otolaryngology**



### **Candidate's leadership experience in physician-led, integrated health care organizations:**

I have served in leadership roles at both an academic institution (University of Washington) and at a fully integrated physician practice (Virginia Mason Health System) over a 30+ year career in medicine.

Among other roles, I have served as Chief of Staff, Section Head of Otolaryngology, Chief of Cancer Care Services, Chief of Surgery, Medical Director of Clinics, Physician-in-Chief, and for the past several years, Chief Medical Officer of our system. I also developed and successfully grew a large regional referral clinical practice as a Head and Neck Cancer & Reconstructive Surgeon.

### **Why are you interested in serving in this elected position?**

I have committed several years to service on the Governance Council of the IPPS because I believe we are slowly, but successfully, shifting a decades-old paradigm of who, and what, the American Medical Association represents. This has somewhat lagged behind a significant shift in the model of how most US physicians practice - from smaller, usually single specialty, groups, to working in considerably larger and more complex integrated practice organizations.

I believe I understand the needs and goals of physicians in integrated practices and can successfully represent them. I have worked to be a curious and attentive listener in order to fully understand those preferences in my home organization, and will strive to effectively communicate similarly with IPPS members, in order to effectively represent them to the large and complex organization that is the AMA in 2019.

### **How will you bring diversity to the position for which you are applying**

By myself, I am not able to offer significant richness in terms of the demographic and other factors that immediately come to mind when discussing diversity; but I serve in a leadership role in an organization that values diversity highly, and is working actively to develop our workforce, our leadership team and our board to better reflect the diversity of the community that we serve. I hope to bring those values and that commitment to bear in this role, and would be a champion for diversity efforts within the IPPS, its leadership group and the AMA membership.



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## **IPPS Governing Council Elections**

*Candidate for vice chair*

**Devdutta Sangvai, M.D.**  
**Duke Health, NC**  
**Specialty: Family Medicine**



### **Candidate's leadership experience in physician-led, integrated health care organizations:**

For over ten years I have participated in physician-led activities at Duke Health. I currently lead Duke's population health management activities, including developing and implementing new models of care and new models of physician payment. My role also involves creating partnerships with physicians in the community as we transition to a value-based paradigm. I have helped launch provider-payer products, Medicare Advantage collaborations, and other insurance platforms, all the while taking into consideration the impact these will have on patients and physicians. I serve as executive director of a large clinically integrated network that includes an MSSP ACO. Prior to accepting this role I served on numerous initiatives at Duke, including bundled payment development, EHR rollout, physician satisfaction, infection control, and many others. I am presently chair of Family Medicine at Duke Regional Hospital (a community hospital) and have a solid understanding of what impacts physicians and how to partner with those that need or want to collaborate with integrated healthcare organizations.

### **Why are you interested in serving in this elected position?**

Over the last two years I have had the privilege of serving as your Alternate Delegate (AD). During this time, I have witnessed the importance of the IPPS at the individual member level and as a Section in our AMA. I believe the IPPS plays a critical role in the future of healthcare delivery in the US. Through Ref Coms and other activities, I see the issues of importance to IPPS members slowly becoming priorities for our AMA. It is with a deep respect for our members and their needs that I wish to serve as your Vice Chair. Prior to my service on the IPPS, I have served in a number of roles, including chair of the Young Physician Section, and more recently, AMA representative and vice chair to the Joint Commission Ambulatory Professional Technical Advisory Committee. These roles have given me a firm understanding of our organization, its members and its mission. Similarly, as a member of an academic physician organization in Durham, North Carolina, executive director of a large clinical integrated network (which includes faculty physicians and community-based physicians), and director of Duke Health's population health management office, I believe that I can represent the realities of today's practice environment. I

am particularly excited about this opportunity because it represents the forward thinking that exemplifies our organization. Creation of the IPPS validated the reality that physicians now practice in a complex healthcare environment, defined by new models of affiliation and employment. I firmly believe that the future of medicine compels the House of Delegates (HOD) to increasingly represent the changing nature of the practice of medicine. Despite all the change in medicine, one thing has remained – primacy of the patient doctor relationship; and I am committed to make that a guiding component of all that we do. I look forward to serving as your Vice Chair and will work tirelessly with members of the IPPS to ensure effective representation of the IPPS in the HOD and beyond.

**How will you bring diversity to the position for which you are applying?**

I am fortunate to have had several experiences that have given me the ability to grow as a broad-minded individual and apply this understanding in a genuine and fair manner in advocating for patients and physicians. Working as an HIV/AIDS educator for an Ohio Chapter of the Red Cross in 1992, I conducted worksite educational programs on how HIV is transmitted and the low risk of transmission in the workplace. While most in attendance at these sessions were thankful for the information, some were not. I was able to witness the early misunderstanding and prejudice related to HIV. I learned that data and education (and patience) are the most powerful tools to correct misunderstanding.

In 2003, I helped establish a free clinic at a residential program for individuals recovering from substance abuse. This clinic served as a primary care resource for patients in Durham, North Carolina, who would otherwise rely on charity care or the ED for healthcare. Individuals in this program are from different backgrounds, and setting up this clinic allowed me to appreciate that substance abuse does not discriminate against race, gender, education or financial status. It also reaffirmed that even basic healthcare services can make a difference, especially for those in recovery from substance abuse. In 2004, I received the AMA-Young Physicians Section Community Service Award for this program.

In 2005, I began to establish a clinical practice focused on the diagnosis and treatment of eating disorders where I often find myself taking care of some clinically complex individuals with mental health needs. From this practice, I have gained an appreciation for the importance of primary care and mental health services in the broader scope of healthcare. I have become a stronger advocate for mental health parity as it relates to insurance coverage. I believe these and other similar experiences will enable me to think more effectively as your Vice Chair as patient advocacy, whole-person treatment, and mental health are becoming increasingly important in our AMA.



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## **IPPS Governing Council Elections**

*Candidate for delegate*

**Russell Libby, MD**  
**Health Connect IPA**  
**Specialty: Pediatrics**



### **Candidate's leadership experience in physician-led, integrated health care organizations:**

Founder and Former President (2011-2016) of Health Connect IPA, a primary care IPA in Northern Virginia with IM, FP, and Pediatric physician members. Currently Board advisor. Former Board member and member of Quality Committee of Signature Partners, the CIN for Inova Health Systems in Northern Virginia (>1700 physician members).

### **Why are you interested in serving in this elected position?**

I have been at the AMA HOD for 10 years and have developed strong relationships with various delegations and AMA staff. I have served as the IPPS delegate for the past two years and have been able to elevate our section participation and influence on AMA policy. I would value the opportunity to continue to advocate for IPPS and its commitment to helping doctors adapt and evolve into the evolving clinical and operational paradigms of patient care and practice.

I am dedicated to helping move our profession into better models for improving the care of patients, improving the health of our communities, and enhancing the joy in practice. The evolution into CIN's and other vehicles for coordinating the care with the ability to perform in the marketplace is something that the AMA needs to help its member physicians achieve.

### **How will you bring diversity to the position for which you are applying?**

Diversity reflects experience and an open mind and I embody both. Whether that diversity reflects practice, academics, social activism, or cultural interests, I have a wide breadth of interests and experience.

## **IPPS Governing Council Elections**

*Candidate for member at-large*

**Adnan Munkarah, MD**  
**Henry Ford Health System, MD**  
**Specialty: Obstetrics and Gynecology**  
**Oncology**



### **Candidate's leadership experience in physician-led, integrated health care organizations:**

My leadership experience has been diverse and spans over 18 years. It started with leading the multidisciplinary program in gynecologic cancer at Karmanos Cancer Center as well as division of gynecologic oncology at Wayne State University. In past 10 years, I have served in many leadership positions at Henry Ford Health System (HFHS). These have included: Chairman of the department of Women's Health, Obstetrics and Gynecology; Chairman of the Board of Governors for the Henry Ford Medical Group (over 1500 multi-specialty providers and bioscientific staff); Chief Medical Officer of Henry Ford Hospital and Health Network. Currently I serve as Executive Vice President and Chief Clinical Officer for HFHS. In this role, I am responsible for quality and growth of all clinical programs across the health system, all clinical staff including our two employed medical groups (Henry Ford Medical Group and Allegiance Medical Group), our specialty service lines, our population health, our community health programs and our clinically integrated networks. Over the years I have had the chance to be engaged, serve as well as lead many committees with a diverse scope including: clinical quality, clinical integration, finance, salary management, clinical operations, education and research.

### **Why are you interested in serving in this elected position?**

The IPPS serves a great purpose by allowing physicians from integrated health systems to connect and share learnings. The section provides great forum for those physicians to think collectively on how to advance clinical integration with the goals to serve patients better, help physicians achieve their career goals and minimize burnout, and contribute to the healthcare transformation. This transformation is more critical now than ever before because of the multiple factors impacting the delivery, operations and finances of healthcare. Furthermore, the landscape is getting more complicated with the recent entry into the medical field of new non-medical players. Physician leaders from Henry Ford Health System have served before me in this role and helped advance the cause of patients and physicians in clinically integrated systems. I strive to follow in their footsteps and hope to be provided this opportunity. I believe that I am well prepared to serve on the council based on my leadership track and diverse professional experience.

**How will you bring diversity to the position for which you are applying?**

I believe that my training, my professional experience as well as my current position have prepared me to provide a well-diversified experience to this role. First, I have started my clinical training in internal medicine, subsequently moved to obstetrics and gynecology and then subspecialized in gynecologic oncology providing both clinical care and leadership in these areas. I have had the chance to look at clinical care through the eyes of a primary care provider as well as a subspecialist. When I was at Wayne State University, I had the chance to run the gynecologic oncology program at Oakwood Hospital, a large community hospital in the suburbs of Detroit. I had to balance the expectations, practices and concerns of an academic position as well as those of private practice. A three-year stint in the Middle East exposed me to healthcare outside of the US opening my eyes to many differences and opportunities. During the last decade, I have had the opportunity to serve in various roles that require an ability to look at things from different angles and learn to listen to understand. I have learned that there often many solutions to a problem- which solution is the best depends on the setting, the timing and the stakeholders. I apply to this position on the Governing Council with one goal- work with colleagues to help improve healthcare in our nation with patients at the center and physicians engaged, satisfied and supported to perform at their best.



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## **IPPS Governing Council Elections**

*Candidate for member at-large*

**Gregory M. Fuller, M.D.**  
**Catalyst Health Network**  
**Specialty: Family Medicine**



### **Candidate's leadership experience in physician-led, integrated health care organizations:**

Catalyst Health Network formed in 2015. I have been on the Board of Directors since 2015 and have been one of two Medical Directors since 2015.

### **Why are you interested in serving in this elected position?**

I have been a member of the Integrated Physician Practice Section since 2016. I have been a member of the AMA House of delegates since 2013. I would like to continue my participation in the IPPS, in a leadership role, by bringing my group's perspective as a clinically integrated group of independent primary care physicians. IPPS serves as a leading organization representing both independent and employed physicians and I would like to represent these physicians.

### **How will you bring diversity to the position for which you are applying?**

I am an independent Family Physician, in a small group, practicing full time. Being part of Catalyst Health Network, a certified clinically integrated group, has given independent primary care physicians in Dallas/Fort Worth a successful and viable option to remain in independent practice. Working as a large group of physicians, we have been able to improve quality, lower healthcare costs, provide care coordination, and develop chronic care platforms. Also, we have been improving the lives of our physicians with financial stability, increased collegiality, and engagement, I am active in the House of Delegates at our AMA, through the Texas delegation. I also participate with the Private Practice Physicians Congress.



## IPPS Governing Council Elections

*Candidate for large group slotted seat*

**Narayana Murali, MD**  
**Marshfield Clinic Health System**  
**Specialty: Nephrology**



### **Candidate's leadership experience in physician-led, integrated health care organizations:**

Presently, serve as the Executive Vice President of Care Delivery & Chief Clinical Strategy Officer of the Marshfield Clinic Health System, an integrated health system with an Operating Revenue of \$2.4 Billion. In 2015, I was elected by all my physician peers as their choice for the Marshfield Clinic's Physician Executive Director (ED). The Clinic physician ED, in coordination with the MCHS CEO, perform executive duties of the Clinic. This is a permanent position until retirement, resignation or is relieved of the duties by the System Board. In the above roles, I lead, manage and optimize the units below and thus fuel our mission to "Enrich lives, providing affordable, accessible and compassionate health care". Prior to this, I have served in various leadership capacities in the System.

Below are some of the areas that I oversee:

- 1250 clinicians and 7760 staff. Recently we have expanded to 5.5 Hospitals (soon to be 6.5). The 0.5 is a JV Critical Access Hospital.
- 4 Ambulatory Surgical Centers, 7 urgent cares, 17 pharmacies
- 60 clinical locations, 86 specialties
- 3 Skilled Nursing Facilities & CARES
- 33 Human & Veterinary Laboratories
- ACO 29,000 members, top 5% of MSSP and tied for the first place in MACRA
- Marshfield Clinic Research institute, the largest private medical research institute in Wisconsin, founded in 1959. Extramural funding in 2017 - \$17 Million
- Personalized Recovery Care - JV - our Hospital@Home Program
- Division of Education, which trains 77 Medical residents annually in addition to other training programs & partnerships – Nursing School, Pharmacy fellowship, Radiology etc.
- Family Health Center with 10 Dental Clinics

Cont'd on next page

**Why are you interested in serving in this elected position?**

Presently serve as a Physician Executive Member, Integrated Care Consortium, AMA. In that capacity I have worked with senior AMA Advocacy Staff, members of the IPPS Governing Council, some of the AMA Board of Trustees. My desire to serve on the IPPS Governing Council is to strengthen the AMA and the IPPS section by supporting them through value added, collaborative, synergistic insight of having been involved in running clinical care delivery, education and research of one of the largest physician led, multi-specialty, not for profit, rural Integrated Health Systems in the nation. Potential areas of value that I could add involve broad range of issues from how physicians are paid, capitation/risk, large employer based contracting, direct primary care, granular operational elements of clinical care delivery, processes, data driven analytics, guideline development, innovation, leadership, group problem solving, policymaking and educational content development for AMA. I have particular interest in the value equation, engagement, education, physician burnout and leadership development.

**How will you bring diversity to the position for which you are applying?**

I am a mission motivated, values-driven, physician executive that presently leads a high performing 102 year old care-delivery system drawing upon rich clinical, research, teaching, and administrative experience spanning almost 3 decades in 3 continents. I believe I have a deep understanding of and have great respect for physician/nursing needs, and their drivers – having demonstrated this through measurable success in engendering and relying on the collective wisdom, motivating and continually building stronger and more efficient care delivery teams committed to people, quality, outcomes, just culture and service excellence. In addition, I have been a participating content expert advisory member, panel speaker, or have served or serving on the Board of other large policy groups and involved in meeting federal and state legislators in terms of addressing policy issues.

## **IPPS Governing Council Elections**

*Candidate for small-medium group slotted seat*

**Steven E. Farrell, MD**  
**Hattiesburg Clinic, PA, MS**  
**Specialty: Internal Medicine**



### **Candidate's leadership experience in physician-led, integrated health care organizations:**

I joined Hattiesburg Clinic in 1996. In 2004 I was elected to the Board of Directors of this Physician owned, multispecialty clinic. I served as Secretary of the board in 2005 and Vice-President of the board from 2006 until 2010. In 2010 I was elected as Chairman of the Clinic Department of Medicine which holds a board and executive committee position. I have served in this capacity from 2010 to date. In 2009, I became the Chief Medical Officer of Forrest General Hospital which is the community not-for-profit hospital where Hattiesburg Clinic physicians practice inpatient care. The positions I hold in two separate organizations that must collaborate and function as an integrated system, have given me significant experience and the skills necessary to develop systems of care and operational efficiencies that benefit both organizations mutually. In 1997 I founded the first Hospitalist group in the state of Mississippi which has grown to be the largest in the state. Leading this group prepared me to facilitate goal directed care with a large number of physicians.

### **Why are you interested in serving in this elected position?**

I want to share the experience and successes I have achieved working with my clinic and hospital with other organizations that may be facing difficult and challenging opportunities as systems of care evolve to meet the needs of our patients. I also feel that participating on this council will give me additional insight and teach me the successes of the other organizations that are represented on the council. The strength of our profession lies in the individuals who comprise the membership and how their organized efforts produce results that guide the future of the care we will deliver. I want to be someone who helps membership face the future.

### **How will you bring diversity to the position for which you are applying**

My background and experience from years in the military and several positions in different states and different parts of the country have given me a broad view of the world we live in. I have worked within my organization to advance diversity and inclusion of all previously disenfranchised portions of our society, from our hiring practices, to our advancement of women in leadership roles, to our offer of benefits to same sex partners far in advance of the legalization of same sex marriage. As a leader in our clinic, I have been a strong supporter of LGBT physicians and their opportunities within the clinic and our

community. I have helped develop female leaders at our board level and in our large hospitalist program which is led by a female director and assistant director. It is often difficult to be viewed as a "diverse" individual when you are not a member of a minority or disenfranchised group within our society. What I can bring is my years of devout work to create equity and equality amongst all physicians and employees within our system.