



MEMBERSHIP
MOVES
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**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
Friday, June 7		
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.	<p>Scale versus quality: Systems and the physician leadership challenge</p> <p>James Orlikoff, President, Orlikoff & Associates</p> <p>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</p>	
11:15 – 11:30 a.m.	Break	
11:30 a.m. – 1:00 p.m.	<p>What's the future of Medicare quality measurement? CMS has a vision</p> <p>Michelle Schreiber, MD, CMS, Director, Quality Measurement and Value-Based Incentives Group</p> <p><i>Reaction panel:</i></p> <p>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</p>	

1:00 – 2:00 p.m.	Networking Luncheon	
2:00 – 3:00 p.m.	A new integrated primary care model for Medicare adults: Oak Street Health 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

ADDAMS
West Tower, Silver Level

AMERICAN CRAFT KITCHEN & BAR

ATLANTA
West Tower, Gold Level

BELL DESK
East Tower, Blue Level

BIG BAR
East Tower, Blue Level

BUCKINGHAM
West Tower, Bronze level

BURNHAM
West Tower, Silver Level

BUSINESS CENTER
East Tower, Purple Level

COLUMBIAN
West Tower, Bronze Level

COLUMBUS HALL (ROOMS A-L)
East Tower, Gold Level

COMISKEY
West Tower, Bronze Level

CONCIERGE
East Tower, Green Level

CRYSTAL BALLROOM
West Tower, Green Level

DADDY'S PUB & GAME ROOM

DUSABLE
West Tower, Silver Level

EAST TOWER MAIN ENTRANCE
East Tower, Green Level

EAST TOWER PARKING
East Tower, Gold Level

FIELD
West Tower, Silver Level

FITNESS CENTER
West Tower, Blue Level

FRONT DESK
East Tower, Blue Level

GIFT SHOP
East Tower, Bronze Level

GOLD COAST
West Tower, Bronze Level

GOLD PASSPORT
East Tower, Blue Level

GRAND BALLROOM
East Tower, Gold Level

GRAND BALLROOM REGISTRATION
East Tower, Gold Level

GRAND SUITES
East Tower, Gold Level

HAYMARKET
West Tower, Bronze level

HERTZ
East Tower, Green Level

HONG KONG
West Tower, Gold Level

HORNER
West Tower, Silver Level

LAKESHORE MEETING SUITES
East Tower, Bronze level

MARKET CHICAGO

MCCORMICK
West Tower, Silver Level

NEW ORLEANS
West Tower, Gold Level

OGDEN
West Tower, Silver Level

PACKAGE PICK-UP
East Tower, Purple Level

PICASSO
West Tower, Bronze Level

PLAZA BALLROOM
East Tower, Green Level

REGENCY BALLROOM
West Tower, Gold Level

RIVERSIDE CENTER
East Tower, Purple Level

SALES, CATERING & CONVENTION SERVICES
East Tower, Bronze Level

SAN FRANCISCO
West Tower, Gold Level

SANDBURG
West Tower, Silver Level

SKYWAY MEETING ROOMS
East Tower, Blue Level

SOLDIER FIELD
West Tower, Bronze Level

STETSON CONFERENCE CENTER
West Tower, Purple Level

STETSON MODERN STEAK + SUSHI

TORONTO
West Tower, Gold Level

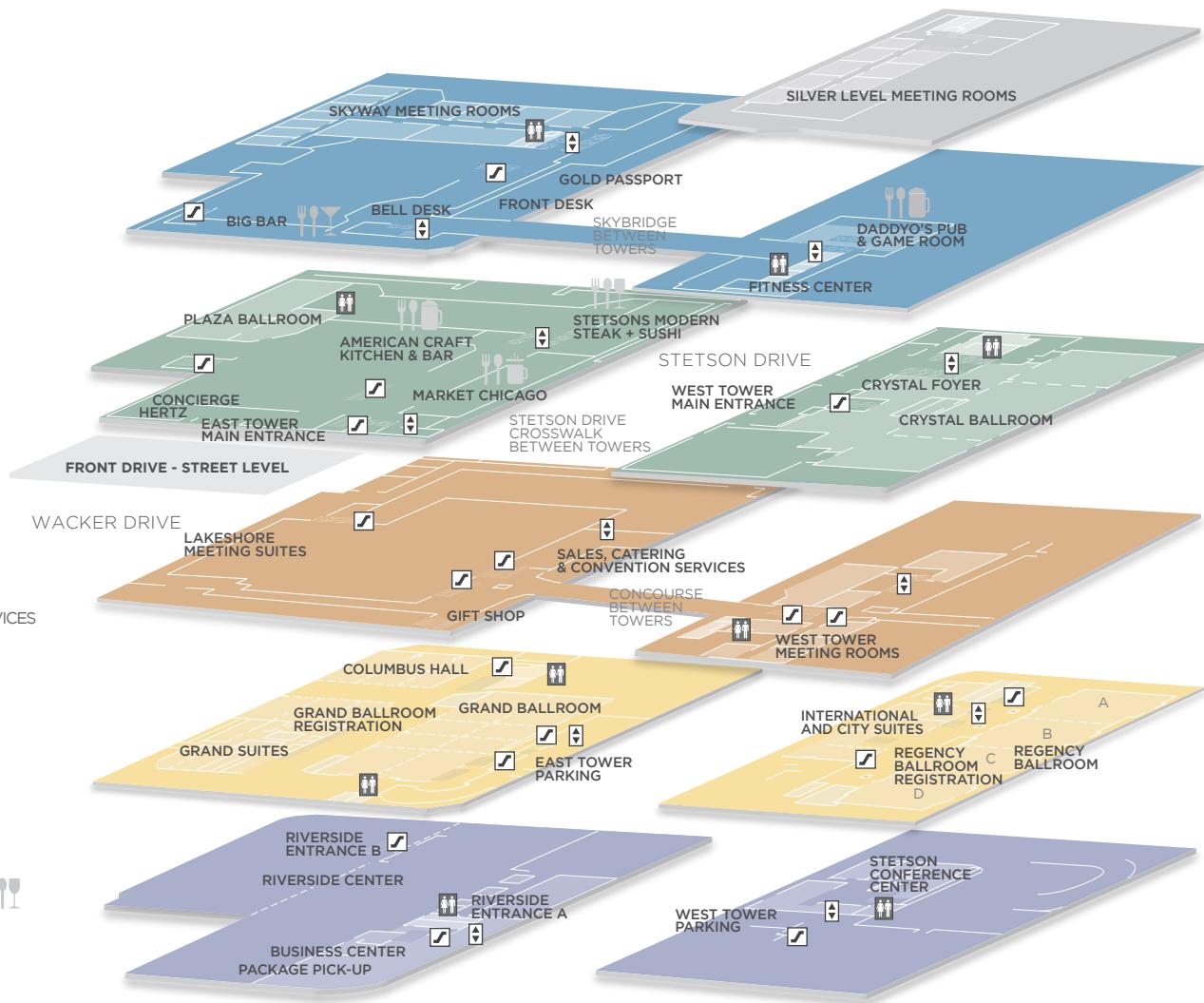
WATER TOWER
West Tower, Bronze Level

WEST TOWER PARKING
West Tower, Purple Level

WRIGHT
West Tower, Silver Level

WRIGLEY
West Tower, Bronze 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.



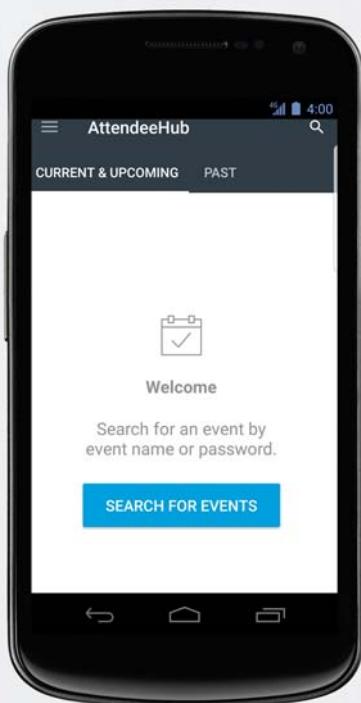
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<https://event.crowdcompass.com/amaannual2019>*

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



MEMBERSHIP
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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

1 Whereas, House of Delegates (HOD) reports generated by the AMA Councils and Board of
2 Trustees, produce important AMA policies which have potentially far-reaching impact in terms of
3 AMA initiatives and advocacy efforts; and
4
5 Whereas, The majority of AMA Council and Board reports originate from HOD resolutions that
6 are "referred" for report or decision; and
7
8 Whereas, Once an HOD resolution is referred, the Board of Trustees assigns the referred
9 resolution to one of the seven AMA Councils (Council on the Constitution & Bylaws; Council on
10 Ethical & Judicial Affairs; Council on Legislation; Council on Long Range Planning &
11 Development; Council on Medical Education; Council on Medical Service; and Council on
12 Science & Public Health) or to the AMA Board of Trustees; and
13
14 Whereas, The assigned entity (council or Board) works with AMA staff to thoroughly research
15 and prepare a comprehensive report for release to the HOD at a specified time, at which time
16 the report will be debated and either adopted, adopted as amended, not adopted, or referred;
17 and
18
19 Whereas, AMA policy G-615.030 states in part that "[AMA] Councils should actively seek
20 stakeholder input into all items of business. . . .and that councils make draft reports available
21 online for comment when time and circumstances permit"; and
22
23 Whereas, The AMA sections and representative societies in the HOD may be able to provide
24 important perspectives and expertise; and
25
26 Whereas, Some AMA councils proactively seek input from key stakeholders, others offer
27 transparency and a role for engagement at stakeholders' request, and others prefer a more
28 closed process and categorically do not share any draft reports; and
29
30 Whereas, There is no clear path for sections or other stakeholders represented in the HOD to
31 know what council or Board reports are under development or to offer input until the reports are
32 final and presented in the online forum, HOD handbook, reference committee or House floor at
33 which time meaningful input is difficult to consider, possibly resulting in referral and delay in
34 taking timely action on defining policy, therefore be it
35
36 RESOLVED, That our American Medical Association study and propose a process for
37 interested stakeholders represented in the House of Delegates to view an online list of AMA
38 Council and Board reports under development and a mechanism for stakeholder input on draft
39 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

1 IPPS Governing Council Report A identifies resolutions and reports relevant to integrated health
2 care delivery groups or systems that have been submitted for consideration by the AMA House of
3 Delegates (HOD) at the 2019 AMA Annual Meeting. This report is submitted to the Assembly for
4 further discussion and to facilitate the instruction of the IPPS Delegate and Alternate Delegate
5 regarding the positions they should take in representing the Section in the HOD.

6

7

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

10

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

12 Introduced by New Mexico

13

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

18

19

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

26

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

28

29

30

31 **REFERENCE COMMITTEE A (MEDICAL SERVICE)**

32

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

34 Introduced by Ohio

35

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

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

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

20 Introduced by Illinois
21

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

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

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

33 ***Recommendation: The Governing Council recommends that the AMA-IPPS Assembly discuss
34 Resolution 205.***

35 **REFERENCE COMMITTEE B (LEGISLATION)**

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

37 Introduced by Hawaii
38

39 RESOLVED, That our American Medical Association form a workgroup to outline the legal
40 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.*

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

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

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

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

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)

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)

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)

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)

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)

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

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

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

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.***

1 **REFERENCE COMMITTEE G (MEDICAL PRACTICE)**

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

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

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

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

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

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

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

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

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

47 9. That our AMA reaffirm Policy H-440.828 on community health workers (CHWs)
48 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)

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)

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

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

8 Whereas, In the 17-year period from 2001-2017, Medicare hospital payments increased roughly
9 50%, including average annual increases of 2.6% for inpatient services and 2.5% per year for
10 outpatient services (CMS Report 4, I-18); and

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

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

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

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

34 RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS to make
35 Medicare payments for the same service routinely and safely provided in multiple outpatient
36 settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate
37 data regarding the actual costs of providing the service in each setting. (Directive to Take
38 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)

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)

1 At the 2018 Interim Meeting, the House of Delegates referred Resolution 826, Developing
2 Sustainable Solutions to Discharge of Chronically-Homeless Patients, which was introduced by the
3 Resident and Fellow Section. Resolution 826 asked that our AMA “work with relevant
4 stakeholders in developing sustainable plans for the appropriate discharge of chronically-homeless
5 patients from hospitals.” The resolution further asked that our AMA reaffirm Policy H-270.962,
6 Unfunded Mandates, and Policy H-130.940, Emergency Department Boarding and Crowding.
7

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

12 BACKGROUND

13

14 Homeless individuals are more likely than the general population to experience behavioral health
15 disorders, acute and chronic conditions, and injuries resulting from assaults and accidents. This
16 increased prevalence, in concert with lack of insurance or access to a usual source of medical care,
17 leads homeless individuals to seek care at EDs at a high rate and increases their rates of
18 hospitalization. Indeed, as many as two-thirds of homeless individuals visit an ED each year, as
19 compared to just one-fifth of the general population, and the hospitalization rate for homeless
20 individuals is as much as four times higher than that for non-homeless individuals.¹⁻⁶
21

22 Not only are homeless patients more likely to visit an ED, but they are also more likely to re-visit
23 an ED. Indeed, an analysis of national ED utilization rates found that homeless patients were more
24 than three times as likely as non-homeless patients to have been evaluated in the same ED within
25 the previous three days, and were more than twice as likely to visit an ED within a week of
26 discharge from the hospital.⁷
27

28 ED utilization is not uniform across the homeless population, with one study representative of the
29 literature on the topic finding that a small proportion of frequent users (7.9%) account for an
30 outsized proportion of total use (54.5%).⁵ Anecdotal accounts, which are not uncommon, cite cases
31 of individual homeless patients with more than 100 ED visits in a year and total costs topping
32 \$1 million.^{8,9}
33

1 DISCUSSION

2

3 *Discharge planning and ED overuse*

4

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

13

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

21

22 *Hospital requirements for discharge planning*

23

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

28

29 (1) Identifying inpatients for whom discharge planning is necessary;*

30

31 (2) Providing a discharge plan evaluation to each identified patient, which “must include an
32 evaluation of the likelihood of a patient’s capacity for selfcare or of the possibility of the
33 patient being cared for in the environment from which he or she entered the hospital;”

34

35 (3) Developing and “[arranging] for the initial implementation of the patient’s discharge plan;”

36

37 (4) Transferring or referring the patient, “along with necessary medical information, to
38 appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary
39 care;” and

40

41 (5) Reassessing the discharge planning process “on an on-going basis;” which must include “a
42 review of discharge plans to ensure that they are responsive to discharge needs.”¹⁶

43

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

* 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.”

1 might consider utilizing, on a voluntary basis, an abbreviated post-hospital planning process for
2 certain categories of outpatients...and for certain categories of emergency department discharges.”¹⁷
3

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

9

- 10 • logging all discharges of homeless patients;
- 11 • providing a meal, clothing, medication, and transportation upon discharge;
- 12 • coordinating with social service agencies; and
- 13 • discharging homeless patients only during the daytime.^{19,20}

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

25

26 *Moving beyond discharge planning*

27

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

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

40

- 41 • neighborhood revitalization;
- 42 • home assessment and repair programs;
- 43 • medical care for the homeless;
- 44 • medical respite care; and
- 45 • transitional or permanent supportive housing.²²

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

1 and health systems.²⁴⁻²⁶ 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.²⁷ 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)

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)

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

4
5 That our American Medical Association (AMA): (1) study the impact of current advanced
6 Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable
7 populations; and (2) advocate legislatively that advanced APMs examine the evaluation of
8 quality performance (for bonus or incentive payment) of providers caring for vulnerable
9 populations in reference to peer group (similarities in SES status, disability, percentage of dual
10 eligible population).

11
12 This report provides an overview of vulnerable populations and the emergence of APMs, highlights
13 numerous APMs and value-based care initiatives incorporating social determinants of health into
14 their models, summarizes relevant AMA policy, provides a summary of AMA advocacy activities,
15 and recommends policy to encourage the development of APMs that serve vulnerable populations
16 while protecting physicians from being financially penalized.

17
18 **BACKGROUND**
19

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

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

12
13 However, APMs may inadvertently create incentives for physicians to avoid caring for vulnerable
14 patients who are at increased risk for high costs and poor outcomes that are beyond the physician's
15 control.³ In order to increase health equity and to fully realize the benefits of APMs, APMs must
16 contemplate and account for vulnerable populations.

17
18 *Impact of Vulnerable Population Status on Patient Outcomes*

19
20 Vulnerable populations in health care include the economically disadvantaged, racial and ethnic
21 minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ) groups; uninsured individuals;
22 rural individuals who may have trouble accessing care; and those with stigmatized chronic
23 conditions such as severe mental illness or human immunodeficiency virus (HIV).⁴ These
24 populations may be more likely to suffer from hunger and access to healthy food options, lack
25 social and economic support, have lower education levels, live in unsafe neighborhoods devoid of
26 parks and playgrounds, and often are subjected to discrimination.⁵

27
28 Vulnerable populations are less likely to have health coverage, struggle with health care access,
29 and often have little interaction or trust in the health care system. They are less likely to receive
30 preventive services and are more likely to go to the emergency department or hospital for a
31 condition that might have been treated in a lower cost facility.⁶ As a result, their medical
32 interventions generally come much later and at significantly higher cost than for other populations.
33 Moreover, lower income populations are twice as likely as those with higher incomes to have
34 behavioral health problems, three times as likely to be socially isolated, and 10 times more likely to
35 experience food insecurity.⁷ Additionally, there is considerable overlap in vulnerable populations.
36 For example, Black and Hispanic American minorities are significantly more likely than Whites to
37 be uninsured, live below the poverty line, and have higher rates of HIV or AIDS diagnosis and
38 death rates.⁸

39
40 Though access to health care is essential for well-being, it is not the greatest health determinant.⁹
41 Zip Code™ now is understood to be a stronger predictor of quality of health than even genetic
42 code. Research suggests that health-related behaviors such as smoking, diet, and exercise, are more
43 important determinants of early death than health care itself. Furthermore, there is a growing
44 consensus that non-medical factors shape an individual's ability to engage in health behaviors. For
45 example, children born to parents who have not completed high school are more likely to live in an
46 environment that poses barriers to health such as lack of safety, exposed garbage, and substandard
47 housing.¹⁰ Such environmental factors may have multi-generational impacts.

48
49 Generally, the current health care system is not built around the poorest and most vulnerable.
50 Exacerbating the ability to effectively care for these populations is the fact that many physicians
51 are not able to identify high-risk patients. Some of the current risk algorithms used by payers were

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

5

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

7

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

17

18 Accountable Health Communities

19

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

27

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

35

36 The Chinese Community ACO

37

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

46

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

49

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

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

11

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

13

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

23

24 AMA POLICY

25

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

37

38 Moreover, AMA policy is committed to promoting physician-led payment reform programs that
39 serve as models for others working to improve patient care and lower costs. Policy D-390.953
40 directs the AMA to advocate with CMS and Congress for alternative payment models developed in
41 concert with specialty and state medical organizations. Policy H-390.844 emphasizes the
42 importance of physician leadership and accountability to deliver high quality and value to patients
43 and directs the AMA to advocate for providing opportunities for physicians to determine payment
44 models that work best for their patients, their practices, and their regions. Policy H-450.961 states
45 that incentives should be intended to promote health care quality and patient safety and not
46 primarily be intended to contain costs, provide program flexibility that allows physicians to
47 accommodate the varying needs of individual patients, adjust performance measures by risk and
48 case-mix to avoid discouraging the treatment of high-risk individuals and populations, and support
49 access to care for all people and avoid selectively treating healthier patients. Additionally, Policy
50 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

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

5

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

13

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

17

18 DISCUSSION

19

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

31

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

46

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

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

7

8 RECOMMENDATIONS

9

10 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
11 712-A-18 and the remainder of the report be filed:

12

- 13 1. That our American Medical Association (AMA) support alternative payment models (APMs)
14 that link quality measures and payments to outcomes specific to vulnerable and high-risk
15 populations and reductions in health care disparities. (New HOD Policy)
- 16 2. That our AMA continue to encourage the development and implementation of physician-
17 focused APMs that provide services to improve the health of vulnerable and high-risk
18 populations. (New HOD Policy)
- 19 3. That our AMA continue to advocate for appropriate risk adjustment of performance results
20 based on clinical and social determinants of health to avoid penalizing physicians whose
21 performance and aggregated data are impacted by factors outside of the physician's control.
22 (New HOD Policy)
- 23 4. That our AMA reaffirm Policy H-385.913 stating that APMs should limit physician
24 accountability to aspects of spending and quality that they can reasonably influence; APMs
25 should understand their patient populations, including non-clinical factors; and support new
26 data sources that enable adequate analyses of clinical and non-clinical factors that contribute to
27 a patient's health and success of treatment. (Reaffirm HOD Policy)
- 28 5. That our AMA reaffirm Policy H-385.908 stating that the AMA should continue advocating for
29 APMs limiting the financial risk requirements to costs that physicians participating in an APM
30 have the ability to control or influence and work with stakeholders to design risk adjustment
31 systems that identify new data sources to enable adequate analyses of clinical and non-clinical
32 factors that contribute to a patient's health and success of treatment, such as severity of illness,
33 access to health care services, and socio-demographic factors. Moreover, Policy H-385.908
34 recognizes that technology should enable the care team and states that the AMA should work
35 with stakeholders to develop information technology (IT) systems that support and streamline
36 clinical participation and enable IT systems to support bi-directional data exchange. (Reaffirm
37 HOD Policy)
- 38 6. That our AMA reaffirm Policy H-350.974 recognizing that racial and ethnic health disparities
39 is a major public health problem, stating that the elimination of racial and ethnic disparities in
40 health care is an issue of highest priority for the AMA, and supporting education and training
41 on implicit bias, diversity, and inclusion. (Reaffirm HOD Policy)
- 42 7. That our AMA reaffirm Policy D-35.985 supporting physician-led, team-based care
43 recognizing that interdisciplinary physician-led care teams are well equipped to provide a
44 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.

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Speaker biographies

James E. Orlikoff

- Quality verus 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

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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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.

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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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.



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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."
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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.



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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-base 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.

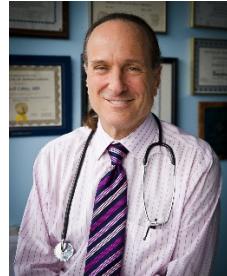


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IPPS Governing Council Elections

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.



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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.



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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.