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REPORT OF THE BOARD TRUSTEES

B of T Report 1, November 2020

Subject: 2019 Grants and Donations

Presented by: Russ Kridel, MD, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2019.

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2019
Amounts in thousands

Funding Institution	Project	Amount Received
Agency for Healthcare Research and Quality (subcontracted through Northwestern University)	Midwest Small Practice Care Transformation Research Alliance	$ 4
Agency for Healthcare Research and Quality (subcontracted through RAND Corporation)	Health Insurance Expansion and Physician Distribution	49
Centers for Disease Control and Prevention	Engaging Physicians to Strengthen the Public Health System and Improve the Nation's Public Health	18
Centers for Disease Control and Prevention (subcontracted through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	182
Centers for Disease Control and Prevention (subcontracted through National Association of Community Health Centers, Inc.)	Preventing Heart Attacks and Strokes in Primary Care	117
Centers for Medicare & Medicaid Services	Transforming Clinical Practices Initiative — Support and Alignment Networks	467
Government Funding		**837**
American Heart Association, Inc.	Target: Blood Pressure Initiative	111
Atrium Health	American Conference on Physician Health	12
The Physicians Foundation, Inc.	American Conference on Physician Health	20
The Physicians Foundation, Inc.	Practice Transformation Initiative: Solutions to Increase Joy in Medicine	55
UNC Health Care System	American Conference on Physician Health	15
Nonprofit Contributors		**213**
Contributions less than $5,000	International Medical Graduates Section Reception	5
Other Contributors		5
Total Grants and Donations		**$ 1,055**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2, November 2020

Subject: Update on Corporate Relationships

Presented by: Russ Kridel, MD, Chair

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2019. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

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

YEAR 2019 RESULTS

In 2019, 85 new activities were considered and approved through the Corporate Review process. Of the 85 projects recommended for approval, 47 were conferences or events, 10 were educational content or grants, 23 were collaborations or affiliations, two were member programs, one was an American Medical Association (AMA) Alliance activity and two were American Medical Association Foundation (AMAF) programs (Appendix B).

CONCLUSION

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

Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

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

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

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

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

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.

- AMA sponsorship of external events.

- Independent and company-sponsored foundation supported projects.

- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or CPT licensing.)

- Member programs such as new affinity or insurance programs and member benefits.

- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.

- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.

- Collaboration with academic institutions only if there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.

In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.

- Single-sponsor activities that do not meet ACCME Standards and Essentials.

- Activities involving risk of substantial financial penalties for cancellation.

- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees (BOT). The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

Appendix B

SUMMARY OF CORPORATE REVIEW
RECOMMENDATIONS FOR 2019

Project No.	Project Description	Corporations	Approval Date
CONFERENCES / EVENTS			
34034	**2019 E-Health Conference –** Updated sponsorship with AMA name and logo to establish CPT in Canadian healthcare market.	E-Health Annual Conference and Trade Show	3/21/2019
34535	**Annual Celebrate Leaders Benefit Sponsorship 2019 –** Sponsorship with AMA name and logo.	Leadership Greater Chicago	1/15/2019
34542	**Women Business Leaders (WBL) 18th Annual Summit Gold Sponsorship –** Sponsorship with AMA name and logo.	Women Business Leaders (WBL) Amgen, Inc. UnitedHealth Group Tivity Health, Inc.	1/16/2019
34602	**The Demystification of Coding and the Digital Health Implementation Playbook** – Speaking engagement including sponsorship with AMA name and logo.	Tennessee Chapter of Healthcare Information and Management Systems Society (HIMSS)	1/22/2019
34716	**13th Annual RISE Summit Silver Sponsor –** Sponsorship with AMA name and logo.	Rise Health, Inc Advantasure, Inc. Babel Health, Inc. Ankura Consulting Group, LLC	2/12/2019
34717	**America's Health Insurance Plans (AHIP) Institute & Expo 2019 –** Speaking engagement and member **s**ponsorship with AMA name and logo use.	America's Health Insurance Plans (AHIP)	3/18/2019
34810	**Arab Health 2020 Conference –** Sponsorship with AMA name and logo.	Arab Health (by Informa Markets)	2/25/2019
34835	**AMA sponsorship of The American Academy of Professional Coders (AAPC) Healthcon 2019** – Sponsorship with AMA name and logo.	American Academy of Professional Coders (AAPC) Optum360, LLC The Coding Network, LLC (TCN) Ultimate Medical Academy (UMA) Pinnacle Healthcare Consulting Wolters Kluwer N.V. HCTec	3/1/2019
34894	**Arizona Association of Medical Staff Services (AAMSS) and Michigan Association of Medical Staff Services (MAMSS) 2019 Annual Conferences** – AMA sponsorship with name and logo.	Arizona Association of Medical Staff Services (AAMSS)	3/7/2019

35036	**Association of Clinical Documentation Improvement Specialists (ACDIS) Clinical Documentation Integrity (CDI) Week Marketing Sponsorship** – Sponsorship with AMA name and logo.	Association of Clinical Documentation Improvement Specialists (ACDIS)	4/2/2019
35073	**National Minority Quality Forum Leadership Summit 2019 –** Sponsorship with AMA name and logo use.	The National Minority Quality Forum (NMQF)	4/3/2019
35169	**The Tenth Annual Patient Experience: Empathy & Innovation Summit –** AMA name and logo use to announce collaboration.	Cleveland Clinic Press Ganey Associates PricewaterhouseCoopers (PwC) Microsoft Corporation Sultan Bin Abdulaziz Humanitarian City International Business Machines Corporation (IBM) Siemens Healthineers, AG (Siemens Medical Solutions USA, Inc.) Wambi American Well Gozio Health (Gozio, Inc.) Verge Health (Verge Solutions, LLC) Baxter International, Inc. CEMOSoft Hill-Rom Services, Inc. Joint Accreditation Kyruus Medigate Oneview Healthcare The Continuous Ambient Relaxation Environment (C.A.R.E.) Channel Twistle, Inc. West – TeleVox Solutions Wolters Kluwer Financial Services, Inc.	4/29/2019
35186	**Rush University Medical Center - West Side Walks to Wellness –** Speaking engagement and sponsorship with AMA name and logo to encourage healthy physical activity and empower youth of color.	Rush University Medical Center	4/29/2019
35198	**American Health Information Management Association (AHIMA) World Congress Sponsorship** – Sponsorship with AMA name and logo.	American Health Information Management Association (AHIMA) World Congress (AWC)	5/3/2019
35268	**American Health Information Management Association (AHIMA) Clinical Coding Meeting –** Sponsorship of event dinner with AMA name and logo.	American Health Information Management Association (AHIMA) World Congress (AWC)	5/21/2019

35289	**Center for Healthcare Innovation Gold Level Sponsorship (2019) –** Sponsorship with AMA name and logo.	Center for Healthcare Innovation (CHI) AdvocateAuroraHealth Dunham Fund Otsuka Rush University Medical Center Cempa Community Care	5/24/2019
35344	**Celebrating Life Gala Sponsorship (2019)** – Sponsorship with AMA name and logo.	Metropolitan Chicago Breast Cancer Task Force	5/29/2019
35451	**Race, Bias, & Equity in Prenatal Care Beltway Briefing** – Sponsorship with AMA name and logo.	The Jennifer Bush-Lawson Foundation	6/8/2019
35453	**HLTH 2019** – Sponsorship with AMA name and logo.	HLTH, LLC	6/12/2019
35459	**Rock Health Summit 2019 –** Sponsorship with AMA name and logo use for summit on technologies transforming healthcare.	Rock Health	6/12/2019
35471	**National Association of Medical Staff Services (NAMSS) 2019 Sponsorship –** Sponsorship with AMA name and logo.	National Association of Medical Staff Services (NAMSS) MD-Staff (Applied Statistics & Management Inc.) Symplr Verity Health Intellisoft Group, LLC Verge Health (Verge Solutions, LLC) PreCheck, Inc. Hardenbergh Group, Inc. IntelliCentrics The Greeley Company	6/14/2019
35517	**Social Enterprise Alliance Summit 2019 –** Sponsorship with AMA name and logo for summit with national social enterprise leaders.	Social Enterprise Alliance (SEA) Airbnb, Inc. The Good Trade Wells Fargo & Company Catalyst Kitchens (FareStart) Classy Law Offices of Marc J. Lane The ICA (Industrial Cooperative Association) Group Catholic Charities USA Network for Good The Kresge Foundation UPS (United Parcel Service) BBVA (Banco Bilbao Vizcaya Argentaria) Compass (BBVA USA Bancshares, Inc. BBVA USA) Stanford Social Innovation Review (Stanford University) American Express Company Bank of America Corporation Northern Trust Corporation RSF Social Finance (Rudolf Steiner Foundation, Inc.) CiTTA Partnership, LLC Opendoor Advisors	6/27/2019

		Chicago Booth – Rustandy Center for Social Sector Innovation	
35575	**National Association of Black Journalists (NABJ) Annual Conference Sponsorship –** Sponsorship with AMA name and logo.	National Association of Black Journalists (NABJ)	7/5/2019
35620	**Institute of Electrical and Electronics Engineers (IEEE) Engineering in Medicine and Biology Society (EMBS) Conference 2019 –** Sponsorship with AMA name and logo of conference for physician, clinical and engineering innovation community.	Institute of Electrical and Electronics Engineers (IEEE) Engineering in Medicine and Biology Society (EMBS) National Institute of Health (NIH)	7/11/2019
35786	**Cardz for Kidz Event Sponsorship** – Sponsorship with AMA name and logo for event supporting hospitalized and traumatized children.	Cardz for Kidz!	8/8/2019
35800	**National Medical Fellowships' Champions of Health Awards (2019) –** Sponsorship with AMA name and logo.	National Medical Fellowships, Inc. Northwestern University Feinberg School of Medicine	9/4/2019
35838	**Stanford Medicine & National Academy of Medicine Artificial Intelligence (A.I.) Conference –** Sponsorship with AMA name and logo.	Gordon and Betty Moore Foundation National Academy of Medicine Regenstrief Institute, Inc. Stanford Presence Stanford Human-Centered AI Institute Vanderbilt University	8/5/2019
35928	**2019 Brady Action Awards –** Sponsorship with AMA name and logo.	The Brady Campaign to Prevent Gun Violence	8/8/2019
35936	**Genetic Health Information Network Summit (GHINS) sponsorship –** Sponsorship with AMA name and logo.	Genetic Health Information Network Summit (GHINS) Concert Genetics, Inc. Genome Medical, Inc.	8/28/2019
35945	**2019 Cook County Health Foundation Gala and Awards Event –** Sponsorship with AMA name and logo.	Cook County Health Foundation (CCHF)	9/3/2019
36014	**Congressional Black Caucus Foundation Annual Legislative Conference National Town Hall –** Sponsorship with AMA name and logo.	The Congressional Black Caucus The Procter and Gamble Company (P&G)	9/6/2019
36016	**Connected Health Conference (CHC19) –** Sponsorship with AMA name and logo.	The Connected Health Conference HIMSS (Healthcare Information and Management Systems Society) Teva Pharmaceuticals Industries Ltd. Conversa Health, Inc.	9/11/2019
36017	**Medical Organization for Latino Advancement (MOLA) Latino Health Symposium 2019 –** Sponsorship with AMA name and logo.	Medical Organization for Latino Advancement (MOLA)	9/6/2019

36022	**Systematized Nomenclature of Medicine (SNOMED) Clinical Terms Expo 2019 –** Sponsorship with AMA name and logo.	Systematized Nomenclature of Medicine (SNOMED) International TPP (The Phoenix Partnership) Goldblatt Systems, LLC CSIRO (Commonwealth Scientific and Industrial Research Organization)	9/4/2019
36048	**2019 Annual Hispanic Health Professional Student Scholarship Gala –** Sponsorship with AMA name and logo.	National Hispanic Medical Association National Hispanic Health Foundation United Health Foundation Davita, Inc. Fresenius Medical Care Amgen, Inc. Charles R. Drew University of Medicine and Science David Geffen School of Medicine at University of California, Los Angeles (UCLA) Adventist Health Southern California Huntington Memorial Hospital Montefiore Medical Center Latino Commission on AIDS Western University School of Pharmacy Children's Hospital of El Paso	9/9/2019
36094	**2019 Chicago United Bridge Awards Dinner –** Sponsorship with AMA name and logo.	Chicago United	9/19/2019
36156	**Special Olympics Illinois Sponsorship 2019 –** Sponsorship with AMA name and logo for Breakfast of Executive Champions to support inclusion and diversity.	Special Olympics Illinois	9/30/2019
36231	**Chicago Cares, Find Your Cause 2019 –** Sponsorship with AMA name and logo for social responsibility event.	Chicago Cares	10/8/2019
36280	**2020 National Rx Drug Abuse & Heroin Summit –** Sponsorship with AMA name and logo.	The National Rx Drug Abuse & Heroin Summit	10/9/2019
36281	**2019 National Addiction Treatment Week –** Sponsorship with AMA name and logo.	ASAM (American Society of Addiction Medicine) Advocates for Opioid Recovery Facing Addiction Faces and Voices of Recovery National Institute on Alcohol Abuse and Alcoholism (NIAAA) National Institute on Drug Abuse (NIDA) White Coats for Recovery National Association of Addiction Treatment Providers (NAATP) National Institute on Drug Abuse (NIDA) Bates Creative Group, LLC NACoA (National Association for Children of Addiction) Student Coalition on Addiction	10/9/2019

36290	**2019 Chicago Urban League, Annual Golden Fellowship Dinner –** Sponsorship with AMA name and logo.	Chicago Urban League	10/15/2019
36340	**International Association of Industrial Accident Boards and Commissions –** Sponsorship of breakfast meeting with AMA name and logo.	International Association of Industrial Accident Boards and Commissions (IAIABC)	10/9/2019
36384	**15th World Congress of Bioethics Conference Bags –** Sponsorship of conference bags with AMA name and logo.	2020 World Congress on Bioethics at Penn Penn State University	10/28/2019
36400	**2019 Juvenile Diabetes Research Foundation, 40th Annual One Dream Gala –** Sponsorship with AMA name and logo.	Juvenile Diabetes Research Foundation (JDRF) Illinois	10/28/2019
37016	**2020 International Conference on Physician Health –** Sponsorship with AMA name and logo.	The International Conference on Physician Health (ICPH) Canadian Medical Association (CMA) British Medical Association (BMA)	12/17/2019
37143	**American Academy of Professional Coders Healthcon 2020 –** Sponsorship with AMA name and logo.	American Academy of Professional Coders (AAPC) Optum360 Simplify Compliance PGC Software (Professional Graphics Controller) Alpha II Duva Sawko Ohana Coding RSM Coding Solutions, LLC UMA (Ultimate Medical Academy)	12/26/2019
	AMA sponsorship of the 2019 Alliance for Health Policy Dinner – Sponsorship of event dinner with AMA name and logo.	Alliance for Health Policy	8/26/2019
EDUCATIONAL CONTENT OR GRANTS			
30540	**AMA Ed Hub Gaples Institute Collaboration –** Gaples nutrition curriculum to be featured on the AMA Education Center with name and logo.	Gaples Institute	5/21/2019
34714	**Edge-U-Cate – Credentialing School Certification Study Sponsor –** Sponsorship with AMA name and logo listed on website as credentialing sponsor for education verification.	Edge-U-Cate, LLC American Board of Medical Specialties (ABMS) Solutions/CertiFACTS American Osteopathic Information Association (AOIA)	2/7/2019
34780	**What You Can Do Initiative –** AMA name and logo use on instructional video for health care workers to reduce firearm injury and death among high risk populations.	"What You Can Do to Stop Fire Violence" (WYCD) University of California (UC) Davis Heising-Simons Foundation California Wellness Foundation State of California American Academy of Pediatrics (AAP)	2/18/2019

		American College of Physicians (ACP) American Chemical Society (ACS)	
35571	**Becker's Healthcare Webinar Sponsorship 2019 –** Sponsorship with AMA name and logo for educational webinar on credentialing.	Becker's Healthcare Allscripts Healthcare, LLC Mercy Virtual Care Center Capella University Visitpay	7/5/2019
35585	**JAMA Network Content Licensing –** JAMA Network name and logo to be used in the educational section only of the Pfizer Pro website to identify JAMA content.	Pfizer, Inc.	7/9/2019
35745	**100&Change MacArthur Foundation Grant Application –** AMA submission to be a partial recipient of grant.	The MacArthur Foundation American Heart Association (AHA) World Hypertension League (WHL)	8/1/2019
36362	**Career Step Fulfillment Project –** AMA name and logo to be used with Career Step logo on limited use student book fulfillment form for AMA Current Procedural Terminology (CPT) Coding books.	Career Step, LLC Carrus	10/24/2019
36409	**PS2 Ambulatory Support Survey –** AMA name and logo use on collaborative survey including Amazon.com gift card.	Amazon.com Mayo Clinic (Mayo Foundation for Medical Education and Research) Stanford University	10/31/2019
36665	**Blood Pressure (BP) Measure Accurately Module Initiative –** Sponsorship with AMA and AHA names and logos for educational program on measuring blood pressure (BP) accurately.	American Heart Association (AHA)	11/14/2019
36666	**United States Pharmacopeia Convention (USP) Bicentennial Video –** AMA name and logo use on bicentennial video.	United States Pharmacopeia Convention (USP)	11/11/2019
COLLABORATIONS/AFFILIATIONS			
33627	**Health Care Organizations (HCOs) for the IHO Prevention Strategy Collaboration –** AMA name and logo will appear alongside these HCOs for the national diabetes prevention program.	Community Health Center of the New River Valley Louisiana Primary Care Association (LPCA) Start Corporation d/b/a/ Start Community Health Center Baystate Medical Practices Cook County Health Family Christian Health Center (FCHC) Mercy Health System Corp Valley Health Systems Bon Secours Hospital Care South Clinic	7/31/2019
34716	**America's Health Insurance Plans (AHIP) Sponsorship and Membership Agreement –** Repeat member **s**ponsorship with AMA name and logo use.	America's Health Insurance Plans (AHIP)	2/12/2019

34737	**Social Enterprise Alliance Membership –** Member **s**ponsorship with AMA name and logo use.	Social Enterprise Alliance (SEA)	2/12/2019
34849	**Healthcare Information and Management Systems Society (HIMSS) Interoperability Call to Action –** AMA name and logo to be listed on the webpage of pledge supporters.	Healthcare Information and Management Systems Society (HIMSS) Alliance for Nursing Informatics (ANI) National Association of County and City Health Officials (NACCHO) Riverside County Medical Association Bicgen Foundation, Inc. Integrating the Healthcare Enterprise (IHE) Institute for eHealth Policy Strategic Health Information Exchange Commission (SHIEC)	2/23/2019
34962	**2020 Census –** AMA name and logo with other supporters on the Census Bureau website.	The Census Bureau Uber Technologies, Inc. Major League Baseball United Way Worldwide National Domestic Workers Alliance Bird Rides, Inc. American Council on Education American Feed Industry Association No Kid Hungry (Share Our Strength) Children's Hospital Association League of Conservation Voters (LCV) Propel Water	3/18/2019
35034	**Building Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes Collaboration –** AMA name and logo use to support screening and referring high risk women to CDC – recognized Type Two diabetes prevention program.	Black Women's Health Imperative (BWHI) American College of Preventive Medicine (ACPM)	3/29/2019
35035	**AMA / Association of American Medical Colleges (AAMC) Residency Exploration Tool Collaboration –** AMA name and logo used in AAMC Residency Exploration Tool list of partners and collaborators.	Association of American Medical Colleges (AAMC)	4/2/2019
35111	**Omada – Chronic Disease Prevention Project –** Expansion of the AMA relationship with Omada for hypertension control.	Omada Health, Inc.	4/17/2019
35265	**Digital Bridge –** AMA name and logo use for Digital Bridge Membership.	Digital Bridge	5/16/2019
35318	**American Heart Association (AHA) and AMA – Measure Accurately Testing Organization –** AMA name and logo use with AHA to test e-learning module with healthcare organizations.	American Heart Association (AHA)	5/24/2019

35385	**IHMI Collaboration –** IHMI collaboration agreements with limited AMA name and logo use.	CloudDx United Healthcare (UHC) UnitedHealth Group Workgroup for Electronic Data Interchange (WEDI) Minnesota Mining and Manufacturing Company (3M) Carrot Health, Inc	5/31/2019
35406	**Chicago Area Public Affairs Group, Membership and Sponsorship (2019) –** Member sponsorship with AMA name and logo use.	Chicago Area Public Affairs Group (CAPAG)	6/6/2019
35719	**Validated Device Listing ("VDL") –** Independently developed criteria and program to provide physicians with a list of blood pressure devices demonstrating validation for clinical accuracy.	American Heart Association (AHA) National Opinion Research Center at University of Chicago (NORC) Association for the Advancement of Medical Instrumentation (AAMI) American Pharmacists Association Hypertension Canada Preventive Cardiovascular Nurses Association (PCNA) Food and Drug Administration	10/30/2019
35878	**Nuance IHMI Collaboration – Phase One –** IHMI collaboration agreement with limited AMA name and logo use for Phase One.	Nuance Communications, Inc.	9/4/2019
36018	**Physicians Foundation Practice Transformation Initiative –** AMA to receive grant with name and logo use.	The Physicians Foundation	9/11/2019
36020	**AMA Joy Recognition Program** – Sponsorship with AMA name and logo.	Southern California Permanente Medical Group Icahn School of Medicine at Mount Sinai University of Rochester Medical Center St. Vincent Medical Group/Ascension Medical Group Stanford University Medical Center Boston Medical Center Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center Wake Forest School of Medicine Ascension, Ascension Medical Group University of North Carolina Health Care	9/11/2019
36021	**The Collaborative for Healing and Renewal in Medicine (CHARM) –** The AMA name and logo to be associated with the Charter and the "CHARM" friends" on AMA and Arnold P. Gold Foundation websites.	Ada County Medical Society American College of Cardiology Bayhealth Medical Center California Pacific Medical Center (CPMC) Emory Healthcare Henry Ford Health System SurgeonMasters Nurturing MDs	9/11/2019

36049	**AMA Physician Innovation Network (PIN) Collaborators –** AMA Physician Innovation Network (PIN) collaboration agreements with limited AMA name and logo use.	Junto Health Hofstra University MassChallenge HealthTech Doctorpreneurs, Ltd. Savvy Cooperative HealthXL, LLC HealthTech Arkansas Programs, LLC The Medical Futurist (TMF) University of California San Francisco (UCSF) Health Hub	9/12/2019
36120	**AMA/Dubai Health Authority Joint Press Release –** Joint press release with AMA name and logo use to announce five-year agreement.	Dubai Health Authority (DHA)	9/12/2019
36383	**"Partnership" with Time's Up Healthcare –** AMA name and logo use to announce collaboration.	Time's Up Healthcare Time's Up Foundation	10/22/2019
36385	**Healthcare Information and Management Systems Society (HIMSS) 2020 Collaborator Agreement –** Sponsorship with AMA name and logo.	Healthcare Information and Management Systems Society (HIMSS)	10/24/2019
36397	**Health Level Seven International (HL7) Benefactor Membership –** AMA name and logo use with HL7 to empower health data interoperability.	Health Level Seven International (HL7)	10/28/2019
36511	**Dietary Supplement Quality Collaborative (DSQC) –** AMA name and logo use to advance AMA's policies on improvement of dietary supplement quality and safety.	Dietary Supplement Quality Collaborative (DSQC) The United States Pharmacopeia Convention (USP)	11/8/2019
MEMBER PROGRAMS			
31370	**Mirador Financial, Inc. –** AMA Affinity program for small practice lending services, Mirador acquired by Credit Union National Association (CUNA) Mutual Group.	Mirador Financial, Inc. Credit Union National Association (CUNA) Mutual Group	2/6/2019
32694	**Laurel Road Bank / KeyBank (KeyCorp) –** AMA Affinity program for student loan refinance. Updated ownership to Key Bank (KeyCorp).	Laurel Road Bank (f/k/a Darien Rowayton Bank "DRB") Credible Labs, Inc. KeyBank (KeyCorp).	3/22/2019
AMA ALLIANCE			
	America's Opioid Epidemic: Know the Facts – AMAA / PTA collaboration with AMAA name and logo use for opioid epidemic education program.	Parent Teachers Association (PTA)	2/27/2019

AMA FOUNDATION

American Medical Association Foundation (AMAF) Corporate Donors – Corporate donors for 2019.	AbbVie, Inc. Amgen, Inc. Boehringer Ingelheim Bristol-Myers Squibb Company Eli Lilly Co. Genentech, Inc. GlaxoSmithKline, PLC Merck & Co., Inc. Novartis Pharmaceutical Corp Pfizer, Inc. Pharmaceutical Research and Manufacturers of America (PhRMA) Sanofi, S.A.	10/8/2019
American Medical Association Foundation (AMAF) Richard Allen Williams Event – Sponsors for Richard Allen Williams event.	American Heart Association (AHA) American College of Cardiology Anthem Blue Cross Arbor Pharmaceuticals Blue Shield of California California Endowment DaVita, Inc. Global Blood Therapeutics McGraw-Hill University of California, Los Angeles (UCLA) Health	5/17/2019

REPORT OF THE BOARD OF TRUSTEES

B of T Report 3, November 2020

Subject: AMA Performance, Activities, and Status in 2019

Presented by: Russ Kridel, MD, Chair

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

INTRODUCTION

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

Removing obstacles that interfere with patient care

Insurer Practices

The AMA protected patients from unanticipated medical bills by working with state medical associations and national medical specialty societies to craft a common set of policies to guide advocacy efforts on surprise billing. The AMA also worked to ensure surprise billing legislation passed by Congress holds patients harmless for unanticipated medical bills and limited out-of-pocket expenses.

The AMA supported federal legislation to streamline prior authorization in Medicare Advantage plans and state legislation to improve the prior authorization process for patients and physicians in more than 15 states. Additionally, the AMA released new prior authorization physician survey data that highlighted the significant negative impact of this process on both patients and practices.

The AMA in partnership with state and specialty medical societies have helped remove prior authorization for medication assisted treatment for patients with opioid use disorder in the Medicaid and/or commercial markets in Arizona, Arkansas, Colorado, Delaware , the District of Columbia, Illinois, Iowa, Maine, Missouri, New Jersey, New York, Pennsylvania, Vermont, Virginia and Washington since the start of 2018.

Physician Payment

The AMA successfully urged CMS to adopt new physician payment models, including a set of primary care payment models and a model on emergency services, to help ease the transition to value-based care.

CMS implemented the Current Procedural Terminology (CPT®) framework to simplify documentation and coding of office visits—as well as other regulatory relief changes championed by the AMA—further reducing administrative burdens and needless paperwork.

The Current Procedural Terminology (CPT®) Editorial Panel and AMA-convened Digital Medicine Payment Advisory Group advanced coverage and payment for digital medicine services by establishing new codes for remote self-measure blood pressure monitoring e-visits between patients and physicians.

The AMA and CMS worked to reduce physician documentation. The newly adopted approach represents the first overhaul of Evaluation & Management (E/M) guidelines and codes in more than 25 years, which will reduce burden and provide physicians more time with patients.

International adoption of Current Procedural Terminology (CPT®) extended to Cyprus, Abu Dhabi, Dubai, and Bahrain as part of an effort to improve the quality, efficiency, and access of their healthcare systems. In addition, other countries and provinces have expressed interest as the rigorous approach of the terminology continues to attract international interest.

Practice Transformation

The AMA is working diligently so that practicing physicians are integral partners in the movement towards a thriving value-based health care system. AMA created over 12 resources and tools for physicians and practice leaders that provide strategic guidance and education, implementation and decision support, and practice financial forecasting, among others. The AMA along with ReachMD developed a value-based care podcast series called "Reaching the Potential of Value-Based Care" to help physicians better understand emerging topics on Medicare Advantage and behavioral health integration into clinical practice.

The AMA has committed to expanding the body of "practice science research" on solutions that increase joy in medicine. The goal of the "Practice Transformation Initiative" with health systems is to improve patient care and clinician satisfaction by implementing evidence-based workflow improvements. Through this new line of research, we look to move from studying prevalence, causes, and impacts of physician burnout to evaluating comprehensive evidence-based solutions. The AMA has engaged with 10 health systems across the country. The AMA also partnered with the Physicians Foundation to sponsor 20 practice sites from three state medical societies (Washington, North Carolina and New Jersey) who will participate as a cohort in this important initiative. All sites will collaborate with the AMA on measurement, interventions, reporting and dissemination of findings.

The AMA offers physicians and health systems cutting-edge tools, information and resources to help rekindle a joy in medicine, including:

- STEPS Forward™ - a collection of more than 50 award-winning online tools that help physicians and medical teams make transformative changes to their practices, including topics on managing stress, preventing burnout and improving practice workflow. Six new modules were released in 2019:
    1. Medical Student Well-Being: Minimize Burnout and Improve Mental Health Among Medical Students
    2. Team-Based Care in Resident Clinics: Engage Residents to Lead in Team-Based Care
    3. Medicare Annual Wellness Visit (AWV): Streamline Workflow to Perform a Thorough AWV
    4. Hospitalist Well-Being: Maximize Engagement and Minimize Burnout for Hospitalists
    5. Getting Rid of Stupid Stuff: Reduce Unnecessary Daily Burdens for Clinicians

6. Medication Management: Save Time by Simplifying Your Prescribing and Refill Process

- Institutional Assessments - the AMA assesses burnout levels within medical organizations to provide a baseline metric for implementing solutions and interventions that reduce system-level burnout rates and improve physician well-being. AMA has measured burnout in over 60 organizations.
- American Conference on Physician Health - the AMA, Mayo Clinic and Stanford Medicine hosted the second American Conference on Physician Health in Charlotte, N.C. to promote health and well-being in the ranks of U.S. physicians. ACPH brought together nearly 500 physicians, researchers and other interested parties from across the country.
- Debunking Regulatory Myths - the AMA provides regulatory clarifications to physicians and their care teams to aid in their day-to-day practice environment. New myths debunked included information on pain assessments, specifically if clinicians are required to ask patients about pain during every visit.

The AMA brought to a close the four-year, grant-funded Transforming Clinical Practice Initiative, which supported more than 140,000 clinician practices and resulted in 20 new AMA STEPS Forward™ modules to help practices implement evidence-based quality improvement strategies.

Leading the charge to prevent chronic disease and confront health crises

The AMA partnered with the American Heart Association on a new e-learning module on proper blood pressure measurement, following results of an AMA-American Heart Association survey highlighting the need for such additional education. In addition, we expanded our M.A.P. Blood Pressure program with 25 additional health care organizations and more than 100 pilot sites that provide care for nearly one million patients with hypertension.

The AMA was among the leading voices nationally calling for regulation of e-cigarettes and vaping devices by the U.S. Federal Drug Administration and urging physicians to make sure their patients were aware of the dangers posed by these new products, especially among youth.

As part of our national push for common-sense gun laws, the AMA urged Congress to earmark spending for gun violence research and prevention. Congress ultimately did so, dedicating $25 million for gun violence research for the first time in more than 20 years.

The AMA kept physicians and medical students informed on important issues, such as the Title X lawsuit and the E/M rule change through AMA Morning Rounds, AMA social media and email newsletters. The AMA also launched content leveraging several new channels, such as Apple News, podcasts, Alexa skill, and AMA Moving Medicine, our quarterly digital magazine focused on showing how the AMA and its members are impacting the practice of medicine.

The AMA established the AMA Center for Health Equity (CHE) as the operational home to build, drive and sustain health equity efforts across the organization and our health system. In less than one year, CHE has created a vision, mission, and strategic direction, begun building a CHE team, and provided racial equity training to the senior management team and across the organization. Externally, CHE has begun to cultivate important relationships that will be critical in enabling AMA's work to improve health outcomes, close disparities gaps, and advance equity.

The AMA has advocated directly to the Administration several times demanding oversight of southern border detention facilities and calling for proper health care and safety for migrating children and families.

The AMA launched an Enterprise Social Responsibility program to engage AMA employees in public service work aligned with the organization's values and goals. The mission of AMA ESR is to produce value for the AMA's strategic work in a way that also produces value for society. Employees logged nearly 2,400 volunteer hours in the program's first seven months, supporting more than 70 local charities in Chicago, Washington, D.C. and South Carolina.

Driving the future of medicine

JAMA

The JAMA Network continued to expand into new channels and content types, publishing more high-quality, innovative content in more digital formats in more accessible ways than ever before. *JAMA*, the flagship journal in our portfolio, increased its impact factor to 51.3, and the impact factors of all the specialty journals rank in the top three of their specialty. *JAMA Network Open*, our open access journal launched in 2018, published more than 800 papers in 2019, and debuted the translation of article titles and key points into Spanish and Mandarin—the only journal in the world to make every published article this accessible to non-English speakers.

In addition, the JAMA Network has increased multimedia content, including videos, podcasts, and visual abstracts, and downloads of podcasts exceed 3 million in 2019. Overall, across the JAMA Network, downloads of content exceeded 130 million.

AMA Ed Hub™

AMA's new education delivery platform is a powerful vehicle providing physicians and other health care providers the education they need to improve care. During the inaugural year of operations, AMA Ed Hub™ is achieving significant increases in learner discovery and engagement with the education portfolio. The online physician education platform has secured more than 43,000 users in its first full year of operations.

AMA Ed Hub™ successfully welcomed its first specialty society content partner, the American College of Radiology (ACR). An expanding set of ACR content is now available on AMA Ed Hub™. Collaborations with additional medical societies and academic institutions will be introduced in the coming year.

We expanded our certification and licensure offerings in AMA Ed Hub™ to automatically transmit completed CME activities from the American Board of Pediatrics, American Board of Otolaryngology, and select state medical boards.

Health and Science

AMA convened thought-leaders with diverse expertise for a discussion about surveillance and data sharing to inform targeted drug-related prevention, treatment, policymaking and harm-reduction strategies industrywide. This initiative was prompted by AMA policy and broad interest from physicians for a public health approach and strategy. A white paper detailing the day, outlining best practices, barriers, and tools for surveillance implementation which lead to treatment and prevention, is under development. The white paper will identify opportunities with the greatest need and highest potential impact to inform AMA's future efforts.

Med Ed

The AMA awarded the first 11 grants through our Reimaging Residency Initiative, a five-year, $15-million grant program that builds on our Accelerating Change in Medical Education program by supporting innovations that will provide meaningful and safe transitions from undergraduate to graduate medical education.

The AMA launched our Health Systems Science Learning Series and our Health Systems Science Scholars Program, ensuring future physicians are well-equipped to care for patients in the modern health system. The 9 modules of the learning series have been accessed by hundreds of pre-med students, along with many physicians, providing basic education in Health Systems Science.

The AMA hosted ChangeMedEd in September. This premier medical education innovation conference brought together more than 500 stakeholders in the physician education continuum to disseminate and grow ideas about medical education transformation.

The AMA invested in the physician leaders of tomorrow by bringing 400 medical students to Capitol Hill to meet with government leaders; by bringing together our Board of Trustee members with more than 450 medical students at 30 medical schools; and by adding 10 new leadership positions at the AMA and developing a new leadership certificate program.

The AMA contributed the Physician Masterfile to support the establishment of an Accelerating Change in Education data warehouse in conjunction with NYU School of Medicine Institute for Innovations in Medical Education. The data warehouse will be used to answer important educational and research questions around workforce, clinical exposure, and quality of care as they relate to education and training.

Journal of Ethics

AMA Journal of Ethics received more than 3 million annual web visits. Monthly theme issues introduced the journal's medical student and physician readership to timely and important clinical, scientific, and public health topics ranging from ethics of artificial intelligence and human genome editing to access to prescription medication and caring for undocumented patients.

Digital Health

The AMA expanded our reach in digital health, working to scale solutions that are validated, effective and trusted through focused research and practice resources, such as the AMA Digital Health Implementation Playbook.

The startup we co-founded, Xcertia, released and widely circulated industry standards for the privacy, security, operability, content and usability of digital health applications.

More than 500 digital health organizations across the country submitted their new technology for consideration for the inaugural University of California, San Francisco (UCSF) Digital Health Awards. Finalists were selected across 14 categories by a team of expert judges from the health care industry. When choosing finalists, judges referenced the mHealth App Guidelines from Xcertia. Submissions were open to qualified, mature health tech companies with in-market products that have been used by thousands of patients and have been verified in a validation study or clinical trial. Each digital health company was judged on how its technology can reduce the health care costs while improving health care. Ten finalists per category were chosen for the UCSF

Digital Health Awards in collaboration with the AMA Physician Innovation Network and other organizations.

Our online digital health collaborative, the Physician Innovation Network (PIN), grew to more than 10,000 users and 20 partner organization across the industry, leveraging physician experience and expertise in the design of new digital heal technologies.

The Office of the National Coordinator (ONC) for Health Information Technology recently updated their Health IT Playbook to include an AMA-developed implementation guide to help physicians adopt and use digital health technology in their practice. ONC's Health IT Playbook is an easy-to-navigate resource designed by and for physicians. AMA's Digital Health Implementation Playbook complemented ONC's efforts by offering key steps, best practices and resources to accelerate the adoption and scale of remote patient monitoring services.

IHMI

The AMA positioned the Integrated Health Model Initiative (IHMI) as a key stakeholder in data interoperability by receiving founding-member status in the Gravity Project, the leading collaborative responsible for developing Social Determinants of Health data standards under HL7. Those data standards are under development in 2020.

IHMI is scheduled to beta release its first Self Monitored Blood Pressure app designed to assist providers in earning incremental revenue while better managing their hypertensive patients via new DMPAG CPT codes effective in 2020. This represents IHMI's first SMART on FHIR app with integrated support for the IHMI SMBP data standard as well as the AMA Validated Device List for home blood pressure devices.

IHMI has been recognized and asked to advise several leading interoperability projects, including the HL7 Da Vinci Project, which is focused on prior auth automation, as well as the USCDI Task Force, which advises the ONC on data interoperability. The sum of these efforts has re-positioned IHMI and the AMA as significant influencers within the national data interoperability space.

Membership

Membership grew for the 9th consecutive year, with a 3% increase in dues paying members in 2019. Growth was fueled by an innovative and award-winning campaign, "Membership Moves Medicine™," which celebrates the powerful work of physician members and showcases how their individual efforts - along with the AMA - are moving medicine forward.

EVP Compensation

During 2019, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,144,978 in salary and $1,125,032 in incentive compensation, reduced by $3,164 in pre-tax deductions. Other taxable amounts per the contract are as follows: $14,478 imputed costs for life insurance, $7,620 imputed costs for executive life insurance, $2,500 paid for health club fees, $2,760 paid for parking and $3,500 paid for an executive physical. An $81,000 contribution to a deferred compensation account was also made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement.

For additional information about AMA activities and accomplishments, please see the "AMA 2019 Annual Report."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 4, November 2020

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2019 through February 2020

Presented by: Russ Kridel, MD, Chair

This report summarizes American Medical Association (AMA) activities and progress in tobacco control from March 2019 through February 2020 and is written pursuant to AMA Policy D-490.983, "Annual Tobacco Report."

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

According to the Centers for Disease Control and Prevention (CDC) tobacco use remains the leading preventable cause of disease and death in the United States with an estimated 480,000 premature deaths annually, including more than 41,000 deaths resulting from secondhand smoke exposure. These data translate to about one in five deaths related to tobacco use annually, or 1,300 deaths every day. Each year, the United States spends nearly $170 billion on medical care to treat smoking-related disease in adults. From March 2019 through February 2020, the CDC released 12 MMWRs related to tobacco use. These reports provide useful data that researchers, health departments, community organizations and others use to assess and develop ongoing evidence-based programs, policies and interventions to eliminate and/or prevent the economic and social costs of tobacco use.

2019: https://www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2019/index.htm
2020: https://www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2020/index.html

Youth Tobacco Use: Analysis of 2019 National Youth Tobacco Survey (NYTS)

The December 6, 2019 MMWR published an analysis of tobacco product use patterns and associated factors from the 2019 National Youth Tobacco Surveys (NYTS). The NYTS is an annual survey that has been conducted since 1999. According to the report approximately one in four youths (23.0%) had used a tobacco product during the past 30 days. By school level, this represented approximately three in 10 high school students (31.2%) and approximately one in eight middle school students (12.5%). Among current tobacco product users, 55.5% reported use of e-cigarettes only. Among students who reported current tobacco use of two or more products, e-cigarettes were the most commonly used product in combination with other tobacco products.

Approximately one in three current tobacco product users (33.9%) reported using multiple tobacco products; youths who use multiple tobacco products are at higher risk for developing nicotine dependence and might be more likely to continue using tobacco into adulthood. The authors noted some encouraging news. More than half of current youth tobacco product users reported seriously thinking about quitting all tobacco products. By school level, 57.7% of high school students and 57.9% of middle school students reported they were seriously thinking about quitting.

The authors' analysis of factors associated with tobacco product use included exposure to marketing and flavors, curiosity, perceptions about harms and cravings among current users. The percentage of students who reported that intermittent use of tobacco products causes "a lot of harm" was highest for cigarettes (54.9%), followed by smokeless tobacco products (52.5%), hookahs (44.9%), and e-cigarettes (32.3%). The percentage of students who reported that intermittent use causes "no or little harm" was highest for e-cigarettes (28.2%). The most commonly reported reason for usage among current exclusive e-cigarette users was curiosity (56.1%) followed by the fact that a friend or family member used them. Flavors such as mint, chocolate and candy were also reported by 23.9% as a reason for e-cigarette use and the ability to "do tricks" was reported by 12%.

Adult Smoking Rates

According to a study in the November 15, 2019 MMWR an estimated 13.7% of US adults were current cigarette smokers in 2018, the lowest prevalence recorded since 1965. However, no significant change in cigarette smoking prevalence occurred during 2017–2018. To assess recent national estimates of tobacco product use among US adults aged ≥18 years, the CDC, the Food and Drug Administration (FDA), and the National Institutes of Health's National Cancer Institute analyzed data from the 2018 National Health Interview Survey (NHIS). The NHIS is an annual, nationally representative in-person survey of the noninstitutionalized U.S. civilian population. The NHIS core questionnaire is administered to a randomly selected adult in the household (the sample adult).

According to the analysis, an estimated 49.1 million U.S. adults (19.7%) reported currently using any tobacco product, including cigarettes (13.7%), cigars (3.9%), e-cigarettes (3.2%), smokeless tobacco (2.4%), and pipes including water pipe or hookah (1.0%). Among current tobacco product users, 18.8% used 2 or more tobacco products.

Adults who use multiple tobacco product are also at increased risk for nicotine addiction and dependence. E-cigarettes were commonly used among multiple tobacco product users. Primary reasons for e-cigarette use among adults include curiosity, flavoring, cost, consideration of others, convenience, and simulation of cigarettes.

Medicaid enrollees have the highest rates of smoking compared to private insurance enrollees

The smoking prevalence for adults enrolled in Medicaid is 23.9% compared to 10.5% of privately insured adults, placing Medicaid enrollees at increased risk for smoking-related disease and death. The February 14, 2020 MMWR published American Lung Association's (ALA) surveillance data of Medicaid coverage for tobacco cessation and barriers to accessing treatment.

To monitor changes in state Medicaid cessation coverage for traditional Medicaid enrollees the ALA collected data on coverage of nine cessation treatments by state Medicaid programs during December 31, 2008–December 31, 2018: individual counseling, group counseling, and the seven FDA-approved cessation medications. As of December 31, 2018, 15 states covered all nine cessation treatments for all enrollees, up from six states as of December 31, 2008. Of these 15 states, Kentucky and Missouri were the only ones to have removed all seven barriers to accessing these cessation treatments. The barriers include co-payment, prior authorization, restrictions on prescribing medications, duration limits, stepped care therapy, and annual and lifetime limits.

Compared with smokers with private health insurance, smokers enrolled in Medicaid have been found to be more likely to have chronic diseases and to experience severe psychological distress.

The high smoking prevalence among Medicaid enrollees imposes a substantial health burden. State Medicaid programs can help reduce this health and financial burden by covering all evidence-based cessation treatments, removing coverage barriers, and promoting covered treatments to Medicaid enrollees and providers to increase their use.

TOBACCO CONTROL NEWS

States Take Action after Vaping Related Illnesses and Deaths

Public health officials and medical groups including the AMA have been concerned for years about the health consequences associated with the use of e-cigarettes especially by youth. As early as 2010, the AMA Council on Science and Public Health issued a report on e-cigarettes that outlined the known substances in the products and highlighted the lack of oversight of manufacturing and advertising.

In June 2019 state health officials noticed an increase in lung illnesses that seemed to be linked to e-cigarette use, many of them involving teens and young adults. The affected individuals have had symptoms including cough, shortness of breath and fatigue. Some also experienced vomiting and diarrhea. Symptoms worsened over a period of days or weeks before some required hospitalization. The first death from a vaping-related illness was reported August 23, 2019 in Illinois. National and state data from patient reports and product sample testing showed that vitamin E acetate and tetrahydrocannabinol (THC) were linked to this outbreak. CDC categorized these vaping-associated illnesses as E-cigarette, or Vaping, product use Associated Lung Injury or EVALI. In December, CDC attributed vitamin E acetate in black-market marijuana products as the strongest link to EVALI.

As of February 18, 2020, a total of 2,807 hospitalized EVALI cases or deaths have been reported to CDC from all 50 states, the District of Columbia, and two U.S. territories (Puerto Rico and U.S. Virgin Islands) with 69 deaths confirmed in 29 states. In response to the outbreak several states enacted policies to restrict access to e-cigarettes. Michigan became the first state to limit the sale of e-cigarettes followed by similar legislative actions in Massachusetts, New York, Washington and New Jersey. While no one e-cigarette manufacturer was identified as the cause of the outbreak, JUUL received wide-spread media attention for selling 1 million contaminated mint-flavored and outdated pods. Several states have filed suit against JUUL including Illinois, New York and California for deceptive marketing practices.

US House of Representatives Passes Comprehensive Bill to Address Youth Tobacco Use

On February 27, 2020, the US House of Representatives passed the Protecting American Lungs and Reversing the Youth Tobacco Epidemic Act of 2020. This bill would ban most flavored tobacco and vaping products, including mint and menthol, and imposes a tax on the nicotine in e-cigarettes. It also prohibits online sales of most tobacco products and requires the FDA to implement graphic warning labels on cigarette packs and advertising. This provision is required under the 2009 Tobacco Control Act but has been delayed due to lawsuits by the tobacco industry. The bill also includes funding to Community Health Centers to support tobacco cessation treatment and research to improve cessation treatments.

The bill isn’t an outright ban on sales of flavored e-cigarettes. It includes an opportunity for FDA to authorize sales if a company can show that the flavor is necessary to help adult smokers switch from traditional cigarettes and doesn’t have an adverse health impact or cause nonsmokers to take

up vaping. The sponsors acknowledge that it is unlikely that an e-cigarette manufacturer can meet this requirement.

AMA TOBACCO CONTROL ACTIVITIES

AMA Responds to Vaping Illnesses and Deaths from E-Cigarettes

As public health officials responded to the increase in vaping-related illnesses and death, the AMA moved quickly to urge the public to avoid the use of e-cigarette products. The AMA called on its physician members to make sure their patients are aware of the dangers of e-cigarettes, including toxins and carcinogens.

In a CNN interview, AMA President Dr. Patrice Harris reminded viewers that nicotine in any form should be avoided. She went on to specify that the AMA is very concerned around the increased use of e-cigarettes and vaping in teenagers. She reiterated the AMA's support for FDA's accelerated efforts to regulate e-cigarettes. There is no evidence that shows they are a safe alternative to combustible tobacco products.

AMA and Coalition of Public Health Organizations Believe FDA Needs to Take Stronger Efforts

In April 2019 the AMA joined with other physician groups and public health organizations including the American Academy of Family Physicians, American College of Physicians, American Heart Association and American Lung Association in responding to an FDA draft guidance on proposed modification to its compliance policy for certain deemed products.

The draft guidance outlined restrictions to youth access to flavored products but fell short of the forceful action needed. The AMA and others felt the guidance policies were an insufficient response to the current crisis of youth e-cigarette use, as well as to the continuing adverse public health consequences of youth cigar smoking. A particular area of concern was the FDA's reliance on the top five e-cigarette manufacturers to provide solutions to youth use of their products. The coalition believes the FDA must assert its own authority and not rely on voluntary action from manufacturers.

In 2009 the FDA was given the authority to regulate the manufacture, marketing, and distribution of cigarettes, cigarette tobacco, roll-your-own tobacco, and smokeless tobacco products. The Tobacco Control Act also gave FDA the authority to issue regulations deeming other products that meet the statutory definition of a tobacco product. These products include but are not limited to electronic nicotine delivery systems, cigars, pipe and waterpipe tobacco, nicotine gels and dissolvables.

AMA calls for total ban on all vaping products not approved by FDA

At the 2019 Interim Meeting, the House of Delegates adopted tobacco control policies in response to increasing harms associated with e-cigarettes and youth-focused marketing by JUUL. The AMA adopted policies supporting banning the sale and distribution of all e-cigarette and vaping products, with the exception of those approved by the FDA for tobacco cessation purposes and advocating for research funding to study the safety and effectiveness of e-cigarette and vaping products for tobacco cessation purposes. The House of Delegates also called for a thorough study of the use of pharmacologic and non-pharmacologic treatment strategies for tobacco use disorder and nicotine dependence resulting from the use of non-combustible and combustible tobacco products in populations under the age of 18.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 8, November 2020

Subject: White House Initiative on Asian Americans and Pacific Islanders

Presented by: Russ Kridel, MD, Chair

EXECUTIVE SUMMARY

This informational report is put forth in response to paragraph two of Policy H-350.954, "Disaggregation of Demographic Data Within Ethnic Groups", which directs that our AMA report back at the 2020 Annual Meeting on the issue of data disaggregation regarding Asian American and Pacific Islanders (AAPI) with regard to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine. This report lays out an historical overview of the politicizing of the AAPI community for the purpose of distributing federal resources based on need as determined by federal data collection efforts. This report also outlines what current federal, state, local, as well as private and non-government associated data efforts entail, and the limitations associated with current efforts. It links to existing AMA policies, emphasizing where there can be greater coherence between policies. Finally, this report re-emphasizes the need for continued surveillance of data collection initiatives, and greater granularity of data collection, pertaining to AAPI communities in the U.S. and its territories.

BACKGROUND

At the height of the Vietnam War in 1968, a young Japanese graduate student at the University of California at Berkeley, Yuji Ichioka, banded with other students in an attempt to shut down the university in collective protest against the conflict. The demonstration was not only successful for five months, but Ichioka and his fellow students also successfully initiated a self-determination campaign against the derogatory term, "Oriental," then reserved for all persons of Asian descent, birthing the distinction, "Asian American,"[1] which we use to this day.

The United States Census Bureau's "Asian" racial category refers to "a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent...," while "Native Hawaiian or other Pacific Islander" refers to "a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.[2]" Asian Americans and Pacific Islanders (AAPI) collectively comprise the largest and fastest growing racial group in the U.S. Having ancestry from over 20 countries, they emigrated to the U.S. for myriad life opportunity and/or geo-political reasons, which are outlined in greater detail in the following sections below. Their health experiences in the U.S. are as diverse as their backgrounds and socio-political statuses within the U.S, yet our data systems infrastructure do not fully illustrate the rich complexity of their different experiences.

Prior to the 1997 Clinton Administration, the White House Office of Management and Budget (OMB) operationalized all public data according to its long-standing "Standards for the Classification of Federal Data on Race and Ethnicity." After signing Executive Order (EO) 13125, which intended to "improve the quality of life for Asian Americans and Pacific Islanders through

increased participation in Federal programs where they may be underserved…"[3], President Clinton established the White House Initiative in June 1999. The grouping of AAPIs should therefore be understood as a socio-political construct, born from the Clinton White House Initiative in order to bring greater attention to the disparate life experiences that different Asian subgroups experience in the U.S.[4] The following year, the Clinton Administration revised the OMB standards, and declared:

> OMB is accepting the recommendations of the Interagency Committee for the Review of the Racial and Ethnic Standards with the following two modifications: (1) the Asian or Pacific Islander category will be separated into two categories – "Asian" and "Native Hawaiian or Other Pacific Islander," and (2) the term "Hispanic" will be changed to "Hispanic or Latino."
>
> The revised standards will have five minimum categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There will be two categories for data on ethnicity: "Hispanic or Latino" and "Not Hispanic or Latino."[5]

Since then, the Bush[6] and Obama[7] Administrations have also amended and/or extended the original EO, creating national statutes meant to recognize and redress the health and social inequities which AAPIs have historically experienced. President Trump re-established the White House Initiative on AAPIs in May 2019, during Asian Pacific American Heritage month[8].

Through these EOs, the previous Administrations also maintained a webpage, which featured AAPI health data, along with other considerable data points. The webpage operated under the purview of the Department of Education but has since come under the directorship of the Department of Commerce. On October 10, 2019, our AMA sent a letter to Secretary of Commerce, Wilbur Ross, advocating for the restoration of webpages on the Asian American and Pacific Islander initiative that specifically address disaggregation of health outcomes related to AAPI data, therefore successfully fulfilling that element of Policy H-350.954. On December 17, 2019, our AMA received notice from Secretary Ross's office indicating that they are working on web page restoration. At the completion of this report, however, the web page had not yet been restored to the Department of Commerce website.

The dearth of racially and ethnically disaggregated data reflecting the health of AAPI persons and families underlies the struggles of the physician community to fully attend to, and be attuned to, the unique needs of their AAPI patients. Beyond the clinical setting, given that federal designations and distinctions yield variances in terms of resource distribution (i.e., public health programs supports, public benefits, etc.), it is imperative to hasten all efforts that disaggregate Asian American and Pacific Islander health outcomes and overall social needs. Without such granularity, clinical providers and researchers risk misunderstanding the unique characteristics that impact AAPI health behaviors, beliefs, uses of medical spaces, and the components that lead to their distinct health outcomes. In accordance with paragraph 2d of Policy H-350.954, "Disaggregation of Demographic Data Within Ethnic Groups", the remainder of this report will focus on the current state of data disaggregation regarding AAPI health outcomes and representation in medicine.

ASIAN AMERICAN AND PACIFIC ISLANDERS (AAPIS) IN THE U.S.

Historical Considerations

The Asian and Pacific Islander presence, in the land that would become the United States, dates back to the 1850s. Life opportunity, economic promise, war, and/or colonialism and other cultural conflict, either pulled or pushed many individuals and families from their homelands to a new land.

The first groups to arrive were Chinese and Japanese men to work in California gold mines, or on the Transcontinental Railroad, or to cultivate new frontier lands. Over the course of almost a century, newly emigrated Asians in America faced severe economic hardship and social exclusion from mainstream society through racialized policies, including the Chinese Exclusion Act (1882), the Immigration Act (1917), the National Origins Act (1924), and the imprisonment of Japanese Americans at the start of World War II[9] (for which they received reparations in the form of restored property rights, $20,000, and a Presidential apology)[10]. Consequently, Asian communities were relegated to service industries-level occupations and de jure segregated ghettos. While Asians generally value work ethic and entrepreneurship, it was the seeds of social discrimination across generations that bred a practice of business ownership in America. This trend remains today: most major American cities with a large Asian-American population retain a Chinatown, an enclave of small, Asian-American owned restaurants, laundries, groceries, salons, and other such service-oriented businesses[11].

Current State of AAPI Community

Today, approximately 20 million Asian Americans hail from about 20 sovereign or American colonized countries across East Asia, South Asia, and Southeast Asia: more specifically, most are from China, India, or the Philippines[12]. Vietnamese, Korean, and Japanese descendants are also strongly represented in the U.S. To a lesser extent, there are American residents with ethnic roots to Pakistan, Cambodia, Thailand, Laos, Bangladesh, Burma, Nepal, Indonesia, Sri Lanka, Bhutan, Malaysia, and Mongolia. The Hmong people are technically country-less; many who are refugees (or mere generations removed) from the Laos region[13], also now call the U.S. home. Collectively, Asian Americans comprise the largest and fastest growing racial group in the U.S., burgeoning from 11.9 million to 20.4 million between 2000 and 2015[14]. They are slated to account for 11 percent of the U.S. population by 2050 [15] and "by 2065, the Asian American population alone is projected to almost triple to 62 million.[16]" Asian Americans make up almost 60% of the Hawaiian population. About half (45%) of the Asian American population in the U.S. live on the West Coast between California, Nevada, and Washington State. A quarter of Asian Americans live in the U.S. South, about the same proportion reside in the Northeast corridor, and about 12 percent live in the Midwest. Almost a third of Asians in America reside in multi-generational homes[17].

Altogether, the Asian American community represents well over 100 spoken languages, an aspect that lends astutely to the growing globalization rationale that all but necessitates that American-born citizens learn at least one Asian language, namely Mandarin Chinese[18]. About half of Asian American adults possess a bachelor's degree or higher, surpassing higher education rates of White Americans, and most are gainfully employed. More recent immigrants from South Asia are doctors and nurses, engineers, and financiers with greater means to come to the US[19]. Such high performance along socioeconomic indicators perpetuate the Asian "minority model" myth, where ostensibly, unlike other minoritized groups, Asians are lauded for having improved their collective status and social standing through hard work and exceptional educational performance, without asking for special considerations, or without reliance on public benefits[20]. This trope erringly gives the impression that AAPIs do not have needs to which governments, researchers, and physician bodies must pay especial attention. In fact, Asian Americans experience the highest language barriers compared to other racial and ethnic groups with Limited English Proficiency (LEP), and more than a third reside in linguistically isolated homes. Among a number of Asian American communities, Limited English Proficiency is highly correlated with medication non-compliance[21] and inconsistent engagement with Western health systems. Islamophobia, and other experiences of discrimination against non-Christian practicing Asians (many of whom practice Buddhism, Hinduism, Sikhism, Taoism, animism, or other religions) are harmful to the health of AAPIs. Furthermore, racial profiling of AAPIs—especially since 9/11—is associated with poorer health

outcomes[22]. Subsets of the Asian community have been hit hard by anti-immigrant rhetoric and U.S. Immigration and Customs Enforcement (ICE) raids in their communities, creating fear and isolation. Understanding their health and engendering their trust is critical for our public health. More recent xenophobia against Asians, spurred by the coronavirus outbreak and misinformation on the pandemic, only exacerbate these stressors.

Moreover, while they are collectively economically strong, existing data suppresses the wide education, economic, and overall health outcomes, in between ethnically Asian subgroups. For instance, Indian Americans, on average, have more education, and enjoy higher salaries[23] on account of attaining more lucrative occupations as physicians and scientists, compared to Laotian or Cambodian Americans, who historically work within service industries.

Clearly, due to wide sub-ethnic group representation, Asian America is by no means monolithic and is in fact comprised of the most diverse of minoritized populations.[24] This rich diversity is attributable to myriad languages spoken, religions practiced, and other cultural distinctions that set Indonesians apart from Indians, who are very different from Japanese and Koreans, and so on. Consequently, their health behaviors, beliefs, and challenges deserve distinct attention. Given the unique social positions they occupy—spanning from the "model minority" to the war-trauma refugee—documenting differences among such highly segmented communities is an essential starting point for implementing a wide array of policies and interventions to give credence to the potentially vastly different interventions needed to improve overall Asian American health.

AAPI Health Status & Public Health Implications

Before the implementation of the Patient Protection and Affordable Care Act (ACA) tenets mandating insurance coverage for all, and especially the protections afforded special populations under Section 1557[25], AAPI health research already cited the deep healthcare access barriers AAPIs faced[26], but existing data are limited for the reasons outlined below.

AAPIs experience tremendous health disparities among Asian and Pacific Islander groups and inequities compared to the non-AAPI or non-Hispanic White population. AAPIs are the sole group in which cancer—especially of the stomach and the liver[27]—is still the leading cause of death[28], and where rates of tuberculosis and Hepatitis B[29] are still exceedingly high (almost 30 times higher than non-Hispanic Whites). AAPIs experience higher rates of diabetes and obesity, as well as cardiovascular diseases compared to non-Hispanic Whites. Health screening (for HIV/AIDS, for example) and preventive health-seeking behaviors are also lower among AAPIs compared to non-Hispanic Whites.[30]

Under the auspices of the ACA, all federally funded health surveys must collect data disaggregated by seven Asian American categories: Chinese, Indian, Filipino, Vietnamese, Korean, Japanese, and 'other Asian'[31]. This 'other Asian' delineation collapses a more complex story. On the other hand, since the ACA, there has been an increase of insurance coverage among AAPIs; their insurance coverage rates are now similar to those of White Americans[32]. Yet, overall, AAPIs still experience difficulties with Medicaid enrollment due to language inaccessibility, although there is very little research that demonstrates the extent of this. The ACA has done much to advance data disaggregation efforts of the AAPI health experience, but more needs to be done. Extended and disaggregated data collection of these challenges would lend well toward creating a fuller and more accurate story and interventions to correct these issues.

EXISTING COLLECTION EFFORTS OF AAPI RACE & ETHNICITY DATA: STRENGTHS & LIMITATIONS

Data Collection: Existing Federal Efforts

Much of what we know about the health of the U.S. population comes from national surveys conducted by the federal government, such as the National Health and Nutrition Examination Survey (NHANES) and the National Health Interview Survey (NHIS). The significant role these scientific data repositories play in determining how national funds are appropriated in support of one program, often at the behest of another, or sets of others, cannot be overstated. Each year, Members of Congress on the Appropriations Committee assign monies to critical programs through a more or less objective process wherein they depend on existing data to rank programmatic, and thus, population need, for programs. The greater the severity of the issue that impacts a community, and/or the larger the community itself, the greater the odds that programming or resources supporting that issue and/or community's needs will be funded and funded well. Gone are the days of Congressional earmarking—Members no longer have the power to set aside specific monies for their constituent communities that may be in the direst of need. For these reasons, it is even more necessary that national data with respect to the health and social progress of Asian Americans and Pacific Islanders be distinguished and narratives clearly demonstrate the great inter-disparities between ethnic groups.

With Census 2020 upon us, reaching AAPI communities at the disaggregated level is crucial not only for determining accurate counts, but also for demonstrating the social strengths and, perhaps most importantly, the social vulnerabilities AAPI communities face and will face in this new decade. Without deriving adequately representative data of such special communities, it is likely that smaller AAPI communities will be counted out and their medical needs, unaccounted. For those most marginalized and socially isolated, the lack of data is also a lack of control, which often hinders communities from developing their narratives, health or otherwise, for which they can contend in current social structures, including both the right to have and analyze collected data.

Each national source provides a baseline sense of specific AAPI populations' health status. For instance, *Healthy People 2010* and *Healthy People 2020* both highlight the unique needs of Asian Americans by establishing baseline health outcomes data for AAPIs in infant mortality, cancer, heart diseases, HIV/AIDS, diabetes, and immunization rates[33]. However, neither fully encapsulates and conveys the heterogeneity of AAPIs, thus suppressing fundamental cultural differences between communities, as well as the health behaviors, beliefs, and outcomes differences that arise as a consequence of these inherent variances.[34] In processes of determining distribution of limited and critical monies for programs and policies that support health of highly diverse communities, there is limited utility associated with high-overview data.

Essentially, there are major limitations to the use of existing survey data, particularly for studying small populations such as AAPI subcommunities. In addition to the problems associated with smaller sample sizes, there are other weaknesses associated with federal race and ethnicity data. Federal data tend to be cross-sectional and do not capture more temporal sensitive phenomena that bear on health outcomes, such as stress associated with racial or ethnic discrimination. Federal data are dependent upon self-report, which may not always be corroborated with more objective methods, such as health records, and the like. There is also a lack of consistent race/ethnicity categories used in data collection.

The greatest of these data threats stem from the size of AAPI population segments relative to the total Asian population; there is a small likelihood that the data sets will adequately capture or

achieve robust representation of unique life experiences across the AAPI community. Apart from highly specialized studies, surveys generally obtain data from too few people to break out separate results for small populations. Even when these data are available, other unique characteristics, such as immigration status, confound outcomes and those groups need to be weighed comparably to U.S. born AAPIs. As a result, even valid inferences drawn about the population (or major segments thereof) based on well-designed survey samples may not apply to small populations. Challenges exist in obtaining sufficient sample sizes to conduct powerful analysis of Asian Americans overall, and even more for subpopulations. Researchers often attempt to correct for this by oversampling certain communities, but often, these segments are difficult to identify, hard-to-reach, and therefore hard-to-count, or may outright be less likely to participate in federal survey research for myriad reasons, including mistrust of American government and fear of retaliation from authority figures[35].

Data Collection: Existing State & Local Efforts

It is not surprising that the states and locales comprised of the largest AAPI populations are leading the force in disaggregated data collection. For this, we can look at efforts in California (at the state level), New York City, and Chicago.

The State of California is, by far, the most advanced state in disaggregated collection of data pertinent to the Asian American experience, delineated by AAPI ethnic community. Dating back to the mid-1990s, the state has required its agencies, boards and commissions to collect and disaggregate its public-facing data by race and ethnicity, specifically for AAPIs. More recently, under the auspices of 2016 state Assembly Bill No. 1726 (AB-1726), the decree is extended beyond the earlier law. It will take full effect in 2022, and will track major disease and mortality trends, pregnancy rates, and housing-related phenomena. More specifically,

> Existing law **requires any state agency, board, or commission that directly or by contract collects demographic data as to the ancestry or ethnic origin of Californians to use separate collection categories and tabulations for specified Asian groups and Pacific Islander groups**, and requires a state agency, board, or commission to include data on specified collection categories and tabulations in every demographic report on ancestry or ethnic origins of California residents that it publishes or releases. Existing law requires specified agencies to use additional separate collection categories and other tabulations for major Asian groups and Native Hawaiian and other Pacific Islander groups, and also requires those agencies to take additional actions, including, among other things, posting, and annually updating, the demographic data collected on their Internet Web sites, and updating the reporting categories to reflect these Asian and Pacific Islander groups as they are reported for the 2020 decennial census.[36]

However, even this measure is funding-dependent. So, while the edict is authorized, its lack of appropriated funds threatens the potential scope of the effort.

In March 2018, the New York City Department of Health and Mental Hygiene put forth a comprehensive data brief on the state of "Health Disparities Among Asian New Yorkers"[37]. Using Community Health Survey (CHS) data, the report highlighted health behaviors, health conditions, and healthcare utilization rates of the city's Chinese, Indian, Filipino, and Korean residents. It provides a sharp view of challenges the city is and will face without pointed public health interventions by racial/ethnic subgroup. So, it is disconcerting to also report that, in December 2019, New York Governor Andrew Cuomo vetoed a State Assembly Bill 677, citing budgetary constraints and implementation impediments as threats to the bill's longevity. Designed in a spirit

similar to California's Assembly Bill No. 1726, the New York equivalent, "would have required state agencies to collect demographic data for a wide number of Asian American ethnicities".[38]

Outside of formal data collection, local forums and community-based organizations have a major role to play with respect to supporting data collection of AAPI community residents. Due to the rapport and trust they have inculcated with AAPI communities over time, these organizations tend to have greater accessibility and entree into more esoteric or sacred spaces occupied by AAPIs than do government representatives. They often head up health-oriented interventionist programs. In Chicago, for example, the organization Cook County CARES (Cancer Alliance to Reignite and Enhance Screening), works with community-based organizations and with hospitals, and other health systems, to increase colorectal screening rates among low income residents, including Asian men aged 50 and older. In other cities throughout the U.S., the Asian Pacific Islander American Health Forum, the Association of Asian Pacific Community Health Organizations, and the National Asian Women's Health Organization are all examples of organizations pulling hefty weight to spread critical health messages to AAPI constituents, indirectly, yet substantially supporting the very purpose that disaggregated data sets out to achieve: telling a fuller story.

Data Collection: Academia & Private Institutional Initiatives

Countless researchers have shed light on the distinctions between AAPI communities and have used their research to call for granularity in data in order to identify medically underserved AAPI communities (MUACs)[39]. In 2009, the Institute of Medicine (IOM) released a report, titled "Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement"[40], which called for standardization for health care quality improvements, centered around training health care providers and implementing best practices for assessing patient race, ethnicity, and language proficiencies. Private grant-conferring institutions also rely on national data to help determine their grantee applications. Private philanthropy often relies on national data trends to determine funding allocations, and also uses data to prioritize and qualify applications. Applications that rely on AAPI data are arguably, then, at a disadvantage if they cannot demonstrate health phenomena at the subgroup level.

Data Collection: Our AMA Masterfile

To date, our AMA's efforts to eliminate health inequities and close existing health disparities gaps, through policy, education, and advocacy initiatives, have been firm steps forward. Our AMA has developed a *Working Together to End Racial and Ethnic Disparities: One Physician at a Time* toolkit for physicians that includes material used to improve awareness and skills in addressing the inequities in care that racial and ethnic minority patients receive. Even more so with the initiation of the Center for Health Equity, our AMA is well-positioned to internally guide our Business Units through processes of deeply embedding a health equity lens throughout all of our work and perpetuate greater leadership in the national health equity space.

Our AMA HOD policies around race and ethnicity data collection are broad in nature. For example, D-350.982, "Racial and Ethnic Identity Demographic Collection by the AMA", says:

> Our AMA will develop a plan with input from the Minority Affairs Section and the Chief Health Equity Officer to improve consistency and reliability in the collection of racial and ethnic minority demographic information for physicians and medical students.

Yet, our current internal system does not yet collect these data at all. Under the Division of Health Solutions and Data Management (HSDM), our AMA maintains the Physician Masterfile ("the

Masterfile"). Initially built in 1906, the Masterfile contains current and historical training and professional certification data for approximately 1.4 million physicians (MD and DO), residents, and medical students throughout the U.S., and the American territories, including Guam, the Northern Mariana Islands, and the American Samoa, all within the Pacific Islands. These records are maintained into perpetuity. Medical schools and other physician organizations, federal agencies, and research institutions rely on the Masterfile as a valid and reliable source of information about our nation's physician workforce and their competencies. However, beyond date of birth, mailing address, specialty area, and level of training, the Masterfile does not provide comprehensive demographic breakdown of our nation's physicians, the languages they speak, the patient communities to whom they deliver care, or other considerations from which entities can derive a cultural context that bears on the differential health needs of patients across diverse American communities. Moreover, other physician-oriented institutions, including the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME), all utilize different racial and ethnic data sources, which presents standardization of data problems.

AAPI REPRESENTATION IN MEDICAL PATHWAYS PROGRAMMING & LEADERSHIP

The desire and/or inspiration to pursue a pathway to medical service and leadership often begins early in life. Yet the pathways are often uneven for minoritized populations for reasons outside of their individual control. In their 2001 study, Luzzo and McWhirter astutely noted, "for many ethnic minority adolescents, career decisions are not based on personal choice and interests but are instead bound to socioeconomic needs and cultural obligations."[41] Other historical issues, such as de facto segregation, and inequitable school resource distribution renders medical education unattainable for many minoritized students who would otherwise strive to become physicians[42]. AAPI students, who tend to value and are reared in households where interdependence and family obligations are paramount over self-aspirations[43], are underrepresented in medicine. This is particularly the case for lower-income AAPI adolescents, such as Laotians and Cambodians, compared to adolescents of higher socioeconomic standing, such as those of Japanese or Indian descent. Between 2002-2012, there was a surge of Asian applicants to American medical schools, but the data do not distinguish by subgroup[44], and in fact creates the impression that Asians as a bloc are overrepresented in medicine, where in fact the lack of data disaggregation contort the picture that certain Asian groups are more represented than others, who are not highly represented at all.

One current pathway for Asian physicians seeking to secure permanent residency or citizenship in the U.S., as well as guaranteed job placement, is through the Conrad 30 J-1 Visa Waiver Program. Conrad 30 "allows J-1 medical doctors to apply for a waiver for the 2-year residence requirement upon completion of the J-1 exchange visitor program.[45]" To qualify for the waiver, these physicians must deliver care in health professional shortage areas (HPSAs), or among patient populations that are deemed a part of a medically underserved populations (MUP). The implications of maintaining this program are significant: given the U.S. is already experiencing a physician shortage, especially in rural and underserved areas, these physicians cover crucial care delivery gaps. The program has yet to be extended, although several U.S. Senators have presented Congressional legislation—the Conrad State 30 and Physician Access Reauthorization Act[46]—to extend the program through 2021. Our AMA supports this legislation.

Research has shown that "demographic representation…improves health care access for underserved populations, improves the cultural effectiveness of the physician workforce as a whole, and improves medical research and innovation for all populations.[47]" As the racial and ethnic demographics of our nation shift, there is greater need for pathways and workforce opportunity programming that encourages a more representative physician workforce.

CONCLUSION

Beyond data disaggregation, our AMA will actively review existing AMA policy on disaggregated racial and ethnic data collection, and better coordinate existing efforts to standardize data production on the state of AAPI medical leadership and by ethnic community health outcomes. This will be a cross-enterprise effort between several AMA Business Units with expertise and experience in data collection, public health, and medical education. Undoubtedly, there is great need for both national as well as community-level disaggregated AAPI health data collection delineated by race and ethnicity, and also offered in languages native to the AAPI community. What is measured is what is valued; what is undercounted tends to be counted out. Precise investigative research disaggregated by ethnic subgroups is needed to yield accurate health outcomes trends for Asian Americans and Pacific Islanders. Current efforts are not robust enough to close the lid on this case. Surely, quantitative research will help researchers to visualize trends, but qualitative reports will add a density to the data that is currently missing. Without individual groups information, the physician community stands mired in serious knowledge gaps and may risk unintentionally perpetuating harms.

Moving forward, intentional efforts to support collection and evaluation of AAPI data as a whole and by subgroup will be a part of our AMA mission. The effort underscores each of our AMA Strategic Arc purviews in that supporting disaggregated AAPI data will (1) help create a clearer picture of medical education and ongoing training needs of AAPI student-physicians, current physicians, and aspiring doctors; (2) shed light on the prevalence of chronic conditions from which certain AAPI sub-populations suffer compared to others; and, (3) provide insight on how physicians may tailor their practices to better serve their AAPI patients from a culturally competent standpoint.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 11, November 2020

Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Russ Kridel, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165. 938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. Board of Trustees Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT

Our AMA continues to engage policymakers and advocate for meaningful, affordable health care for all Americans to improve the health of our nation. Our AMA remains committed to the goal of universal coverage, which includes protecting coverage for the 20 million Americans who acquired it through the ACA. Our AMA has been working to fix the current system by advancing solutions that make coverage more affordable and expanding the system's reach to Americans who fall within its gaps. Our AMA also remains committed to improving health care access so that patients receive timely, high quality care, preventive services, medications and other necessary treatments.

Our AMA continues to advocate for policies that would allow patients and physicians to be able to choose from a range of public and private coverage options with the goal of providing coverage to all Americans. Specifically, our AMA has been working with Congress, the Administration, and states to advance our plan to cover the uninsured and improve affordability as included in the "2020 and Beyond: AMA's Plan to Cover the Uninsured." The current COVID-19 pandemic has led to many people losing their employer-based health insurance. This has only increased the need for significant improvements to the Affordable Care Act. We also continue to examine the pros and cons of a broad array of approaches to achieve universal coverage as the policy debate evolves.

Our AMA has been advocating for the following policy provisions:

<u>Cover Uninsured Eligible for ACA's Premium Tax Credits</u>

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible individuals and families with incomes between 100 and 400 percent federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges.
- Our AMA has been advocating for enhanced premium tax credits to young adults. In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium

tax credits could be provided with "enhanced" premium tax credits — such as an additional $50 per month — while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio.

- Our AMA has been advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

Cover Uninsured Eligible for Medicaid or Children Health Insurance Program

In 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or Children Health Insurance Program (CHIP). Reasons for this population remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and enrollment.
- Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals' health and well-being.

Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits

In 2018, 5.7 million of the nonelderly uninsured were ineligible for financial assistance under the ACA, either due to their income, or because they have an offer of "affordable" employer-sponsored health insurance coverage. Without the assistance provided by ACA's premium tax credits, this population can continue to face unaffordable premiums and remain uninsured.

- Our AMA has been advocating for eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL.
- Our AMA has been advocating for the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage. Section 1332 waivers have also been approved to provide funding for state reinsurance programs.
- Our AMA has been advocating for lowering the threshold that determines whether an employee's premium contribution is "affordable," allowing more employees to become eligible for premium tax credits to purchase marketplace coverage.

EXPAND MEDICAID TO COVER MORE PEOPLE

In 2018, 2.3 million of the nonelderly uninsured found themselves in the coverage gap – not eligible for Medicaid, and not eligible for tax credits because they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals do not have a pathway to affordable coverage.

- Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

TEXAS VS. AZAR SUPREME COURT CASE

The Supreme Court agreed on March 2, 2020 to address the constitutionality of the ACA for the third time, granting the petitions for certiorari from Democratic Attorneys General and the House of Representatives. Oral arguments will likely take place in the fall with a decision to follow before June 2021. The decision to hear the case now will avoid several years of delay while the case worked its way through the lower courts. Granting the petition also puts the ACA front and center in the presidential election. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

The Trump Administration filed a brief with the Court, asking the justices to overturn the ACA in its entirety. The Administration clarified that the Court could choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal experts point out, the entire ACA would be struck down if the Court rules that the law is inseparable from the individual mandate—meaning that there would be no provisions left to selectively enforce.

MERIT-BASED INCENTIVE PAYMENT SYSTEM AND ALTERNATIVE PAYMENT MODELS

The Medicare Access and CHIP Reauthorization Act (MACRA) represents an improvement over the flawed and now repealed sustainable growth rate payment methodology and legacy quality and cost reporting programs. The implementation of MACRA, though, has been a significant undertaking for the Centers for Medicare & Medicaid Services (CMS) and physicians. Our AMA continues to work closely with both Congress and CMS to promote a smooth implementation of the Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs).

The Bipartisan Budget Act of 2018 included improvements to MACRA that allowed for a more gradual transition into the program and helped many physician practices avoid penalties they likely would have otherwise incurred under the MIPS program. However, further refinements are needed to improve the program and ensure physicians can be successful going forward.

As physician practice expense payments fall increasingly below costs, patient access issues are expected to arise. Currently under MACRA, physicians are scheduled to receive a 0 percent payment update for 2020-2025. According to data from the Medicare trustees, Medicare physician pay has barely changed over the last decade and a half, increasing just seven percent from 2001 to 2019, or just 0.4 percent per year on average. In comparison:

- The cost of running a medical practice has increased 34 percent between 2001 and 2019, or 1.6 percent per year. Inflation in the cost of running a medical practice, including increases in physician office rent, employee wages and professional liability insurance premiums, is measured by the Medicare Economic Index or MEI.
- Economy-wide inflation, as measured by the Consumer Price Index, has increased 45 percent over this time period (or 2.1 percent per year, on average).

As a result, Medicare physician payment rates are insufficient. Adjusted for inflation in practice costs, Medicare physician pay has declined 20 percent from 2001 to 2019, or by 1.3 percent per year on average. Therefore, our AMA has been strongly urging Congress to replace the physician payment freeze with positive updates that allow physicians to sustain their practices and provide a margin to invest in practice improvements needed to transition to more efficient models of care delivery and better serve Medicare patients.

Extend the advanced APM incentive payments

One goal of MACRA was to provide physicians with a glide path to transition into more innovative payment models but changing the way physicians deliver care requires significant investment in new technologies, workflow systems, personnel and training.

To help physicians implement these changes, MACRA provided a 5 percent incentive payment for the first six years of the program for those who participate in advanced APMs, intended to create a margin for investing in care delivery improvements. However, the dearth of advanced APMs available for physicians limited their ability to take advantage of the APM incentive that Congress provided.

Therefore, our AMA has been strongly urging Congress to extend the advanced APM payments for an additional six years to provide physicians with an onramp to move to APMs once they become available as intended in the original legislation.

Implement Technical Improvements

Our AMA has also been very engaged with Congress and the Administration urging them to make additional technical changes to MACRA to reduce the burden of MIPS and make reporting more clinically meaningful for physicians.

Specifically, our AMA has been advocating for the following issues to be addressed including harmonizing the four MIPS reporting categories, setting multiple performance thresholds to even the playing field for practices of all sizes and locations, and aligning MIPS and Physician Compare measures, among others.

The primary goal should be to allow physicians to spend less time on reporting and more time with patients and on improving care, and to create a more sustainable MIPS program. Changes should also promote participation in APMs by adjusting the multi-payer thresholds and clarifying the role and responsibilities of the Physician-focused Payment Model Technical Advisory Committee.

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165.938 and other directives of the House of Delegates.

REPORT 12 OF THE BOARD OF TRUSTEES (November 2020)
2020 AMA Advocacy Efforts
(Informational)

EXECUTIVE SUMMARY

Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: It was prepared in August based on approval deadlines and may be updated if legislative, regulatory, or judicial developments warrant.)

At the start of 2020, the AMA advocacy agenda focused on a wide range of health care issues with a major focus on removing obstacles to the provision of optimal patient care. Targeted issues included but were not limited to surprise billing, regulatory relief, excessive prior authorization, access to health care, health disparities, scope of practice, and public health issues such as gun violence, vaping, and drug overdose and death. Quickly though, the AMA had to pivot to address the COVID-19 pandemic which created not only a public health crisis, but an economic crisis as well. A few months later, the tragic deaths of George Floyd and several other Black Americans due to unnecessary police violence caused a national outrage. Both the COVID-19 pandemic and policing issues placed equity issues at the forefront of federal and state legislative debates. The AMA has relied on its policy to guide its legislative and regulatory efforts and has made significant progress on many of these issues in 2020.

On the COVID-19 front, the AMA successfully sought billions in emergency funding to help physician practices stay viable and keep providing needed care through the Coronavirus Aid, Relief, and Economic Security (CARES) Act and subsequent emergency supplemental legislation. At the AMA's urging, federal and state officials approved broad telehealth expansions to increase access to care and provide patients with a safer way to receive COVID-19 and non-COVID-19 care. The AMA has called for greater access to personal protective equipment (PPE) for physicians and other health care providers. The AMA has also urged policymakers to follow science and evidence in response to the pandemic. A more comprehensive list of AMA efforts is included in this report.

The AMA continued to call for health insurers to modify policies that inhibit optimal health care for patients. This included advocating for reform of the prior authorization process. The AMA has also had to fend off surprise billing legislation that creates unfair negotiating leverage for insurers and harms physician practices.

The AMA has urged federal lawmakers to work together to enact legislation on unnecessary police violence issues specifically asking them to support research into the public health consequences of violent police interactions with the public and to support a ban on the use of choke-holds among other recommendations.

The AMA will continue to work on these priority issues heading into the remaining months of 2020.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12, November 2020

Subject: 2020 AMA Advocacy Efforts

Presented by: Russ Kridel, MD, Chair

BACKGROUND

Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: The report was prepared in August based on approval deadlines and may be updated if legislative, regulatory, or judicial developments warrant.)

DISCUSSION OF 2020 ADVOCACY EFFORTS

At the start of 2020, the AMA advocacy agenda focused on a wide range of health care issues with a major focus on removing obstacles to the provision of optimal patient care. Targeted issues included but were not limited to surprise billing, regulatory relief, excessive prior authorization, access to health care, health disparities, scope of practice, and public health issues such as gun violence, vaping, and drug overdose and death. Quickly though, the AMA had to pivot to address the COVID-19 pandemic which created not only a public health crisis, but an economic crisis as well. A few months later, the tragic deaths of George Floyd and several other Black Americans due to unnecessary police violence caused a national outrage. Both the COVID-19 pandemic and policing issues placed equity issues at the forefront of federal and state legislative debates. The AMA has relied on its policy to guide its legislative and regulatory efforts and has made significant progress. However, much more work needs to be done on many of these issues. The following is a summary of the AMA's 2020 advocacy work to date.

COVID-19 Response

As the COVID-19 pandemic manifested in several regions of the country in early 2020, the AMA immediately turned its legislative and regulatory lobbying efforts to address this public health emergency as well as the financial fallout for physician practices stemming from it. With millions of infections and thousands of deaths nationwide, COVID-19 has been a public health nightmare, and the AMA thanks and applauds the physicians, nurses and other health care professionals on the frontlines taking care of America's COVID-19 patients. The AMA is also acutely aware of the effect that the suspension of elective procedures and other COVID-19-imposed restrictions have had on physician practices and is working extensively with federal and state leaders to mitigate the negative impact as much as possible. Key AMA efforts include:

- Successfully sought billions in emergency funding to help physician practices stay viable and keep providing needed care through the Coronavirus Aid, Relief, and Economic Security

(CARES) Act and subsequent emergency supplemental legislation. Many practices qualified for loan-to-grant programs, advance payments and emergency payments;

- Sought and secured broad telehealth expansion at the federal and state levels to increase access to care and provide patients with a safer way to receive COVID-19 and non-COVID-19 care;
- Obtained changes to federal payment rules to allow for parity in payment for telehealth services whether provided by audio/video means or audio-only;
- Called for a "Manhattan Project" to provide Personal Protective Equipment (PPE) and other needed resources to frontline responders as the magnitude of this pandemic rapidly emerged;
- Urged the federal government to improve and expand testing and allow increased U.S. Food and Drug Administration (FDA) Emergency Use Authorizations to speed the process and lead to more informed policy decisions;
- Convinced FDA and the Centers for Disease Control and Prevention (CDC) to review and revise antibody tests and guidelines based on validity concerns, reflecting guidelines issued by the AMA to help ensure physicians and the public are aware of the limitations and potential uses of serological testing/antibody testing;
- Successfully sought temporary expansion of Medicaid eligibility to uninsured individuals for COVID-19 testing;
- Urged states to eliminate Medicaid cost-sharing for COVID-19 related care, simplify Medicaid enrollment and renewal processes, and eliminate barriers to Medicaid coverage such as work requirements;
- Called on the administration to collect and release demographic data to help address any potential race, sex and age disparities during the pandemic;
- Advocated for added liability protections for physicians in federal legislation, state executive orders and state legislation to provide safe harbors for physicians when faced with suboptimal treatment arrangements, guidelines and protocols, patient surges and postponement of elective procedures;
- Called on federal and state policymakers, and private payers, to ease extraneous administrative burdens for physicians, such as prior authorization, audits, data requests and quality reporting, and persuaded the Centers for Medicare & Medicaid Services (CMS) not to penalize physicians for failing to complete MIPS reporting this spring;
- Created three new Current Procedural Terminology (CPT®) codes for COVID-19 testing and antibody testing;
- Successfully urged the administration to open visa processing for international physicians during the pandemic; and
- Conducted a nationwide survey on the financial impact of the COVID-19 pandemic on physician practices.

As the COVID-19 pandemic continues to spread and infections rise, the AMA's work to mitigate its impact is far from over. The following are front burner issues that the AMA is actively advocating on at the federal and state levels.

- Advising Congress on the true scope of physician practice financial loss during the pandemic and ways to aid physician practices in the upcoming COVID-response legislative packages;
- Pressing for the continuation of temporary telehealth provisions that enable better patient care, greater alignment of telehealth coverage, payment and coding policies across all payers, and the continued suspension of further regulatory hurdles;
- Urging Congress to protect and expand high quality, affordable health care coverage during this unemployment crisis, including additional funding for Medicaid;
- Continuing to work with private insurers to mirror new Medicare telehealth flexibilities in the commercial markets and call on employers with self-funded plans to do the same;

- Urging the reduction of limitations for international medical graduates and those with Deferred Action for Childhood Arrival status to remain in the country and provide urgently needed care as appropriate;
- Calling on states to adopt, in-full, Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) increased flexibility in prescribing and treatment requirements for opioid use disorder and for patients with pain;
- Emphasizing the importance of prescribing naloxone to patients at risk of opioid-related overdose and urging states to increase availability of sterile needle and syringe services programs to help prevent spread of blood-borne infectious diseases;
- Calling on federal and state leaders to rely on science when considering reopening businesses, schools, and other institutions as well as potentially relaxing/reissuing stay-at-home orders;
- Collecting expenditure and practice data to help address the financial impact of COVID-19 and barriers to reopening practices; and
- In conjunction with the American Heart Association (AHA) urging CMS to take immediate action to cover validated home blood pressure monitors for use at home with self-measured blood pressure (SMBP) monitoring through Medicare and Medicaid which is imperative during the COVID-19 public health emergency.

A full compilation of AMA COVID-19 response efforts can be found at the AMA COVID-19 Resource Center. Lastly, proof of the AMA's strong efforts on the COVID-19 pandemic came when a research firm that focuses on federal advocacy efforts reached out to the AMA and stated that the AMA tied for first with one other association when senior federal policymakers were queried about which organizations were doing good work on the COVID-19 crisis. This information affirmed the ongoing work that the AMA's Advocacy, Health & Science, Enterprise Communications, Center for Health Equity, Marketing & Member Experience, and several other AMA units have accomplished to support patients and physicians during this public health emergency.

Scope of Practice

In 2006, the AMA created the Scope of Practice Partnership (SOPP), a collaborative effort staffed by the AMA and comprised of every state medical association, 34 state osteopathic medical associations and 14 national medical specialty societies. Since 2007, the SOPP has awarded over $2 million in grants to medical societies. In 2019 and 2020 alone, the SOPP awarded grants to 10 state medical and osteopathic associations to help with state advocacy efforts. Detailed information on all grants is available through the AMA's Advocacy Resource Center.

Since 2019, the AMA, in strong collaboration with state and national medical specialty societies defeated more than 70 scope of practice bills across the country, including defeating bills that would have expanded the scope of practice of nurse practitioners in more than 14 states. In March 2020 AMA focus quickly shifted to COVID-19. Scope of practice remained a top priority as the AMA sought to push back against attempts by non-physician groups who seized upon concerns over workforce capacity during the pandemic to expand their scope of practice, including nurse practitioners, physician assistants, pharmacists and podiatrists. In response, the AMA sought ways to expand the physician workforce by expanding telehealth, encouraging retired or inactive physicians to return to the workforce as appropriate, fighting prohibitive immigration restrictions, and supporting civil immunity protections. The AMA also implored state and federal lawmakers that now is not the time for broad scope expansions. Any measures to relax existing scopes of practice must be temporary and narrowly tailored to caring for COVID patients.

Although generally a state issue, scope of practice concerns have also arisen on the federal level. Waivers and additional flexibility for COVID-19 testing and other health care services have led to renewed calls for the federal government to adopt permanent policies allowing non-physician health professionals to "practice to the top of their license." The AMA organized a Federation letter cosigned by over 100 state and national physician organizations urging that scope of practice waivers be sunset when the public health emergency concludes.

A letter cosigned by 78 Federation groups was also sent to the Department of Veterans Affairs (VA) asking the department to rescind a directive and memorandum allowing non-physician health care professionals in 32 specialties to operate "within the full scope of their license, registration, or certification" as it relates to encouraging all VA medical facilities to allow CRNAs to practice without physician oversight during the national health emergency.

Insurer Practices

Prior Authorization

Two years ago, the AMA reached a consensus statement with insurers and other stakeholders to reform the arduous prior authorization (PA) process. Since then, insurers have lagged in implementing the principles, and this has led to continuing obstacles for patients and physicians. According to an AMA survey on this issue, physicians say prior authorization interferes with patient care and can lead to adverse clinical consequences—with 16% of physicians reporting that the process has led to a patient's hospitalization. Moreover, surveyed physicians see little, if any, progress toward easing agreed-upon burdensome barriers to patient care, highlighting the need for legislative action to address a problem affecting patients across the country.

In response at the federal level, the AMA is supporting the Improving Seniors' Timely Access to Care Act, H.R. 3107, which would require Medicare Advantage plans to abide by many of the PA reforms outlined in the consensus statement. The bill's sponsors include Representatives Suzan DelBene (D-WA), Mike Kelly (R-PA), Roger Marshall, MD (R-KS), and Ami Bera, MD (D-CA), and the bill has now gained support from a bipartisan majority of the House of Representatives. The AMA's FixPriorAuth grassroots campaign continues to garner social media attention and traction, including an "Echo Back Video" urging support for H.R. 3107. The AMA and state medical associations have made good progress on this issue in recent years in state legislatures. In 2020, state efforts focused on minimizing burdens related to COVID-19 care. To date, 14 states have eased administrative barriers (e.g., prior authorization and step therapy for COVID-19 care) and dozens of states have removed prior authorization for testing.

Surprise Billing

As federal lawmakers continue to debate surprise billing proposals, states are moving ahead with legislation. While over a dozen bills were introduced this past year/session, four major pieces of legislation have been enacted in Indiana, Maine, Virginia and Georgia. The new Indiana statute places a ban on surprise billing without establishing a complete or fair payment mechanism for physicians, and therefore was largely opposed by provider groups. However, the other states' statutes, while not perfectly in line with Federation principles or AMA policy, come much closer to comprehensive solutions that promote good-faith contracting while protecting patients. In fact, all three incorporate some form of baseball-style arbitration to be made available to physicians (under certain circumstances) when the rates paid by the health insurers are insufficient. As learned from other states' experiences, continued vigilance will be needed to ensure these statutes and subsequent regulations are implemented fairly and as intended.

On the federal level, the AMA and its Federation partners have so far been successful in blocking passage of harmful surprise billing proposals that would give unfair advantage to insurers in network contract negotiations and drive down in-network payment rates. Political pressure from employers, patient groups, the White House, and Members of Congress from both political parties have caused the issue to resurface several times during the year, most recently in the context of the COVID-19 4.0 relief proposal being drafted over the summer.

Insurer Accountability Campaign

In January and February of this year, the AMA targeted voters in early 2020 Democratic Presidential Primary/Caucus states (Iowa, New Hampshire, Nevada, and South Carolina) as well as key national and inside the beltway audiences in order to generate general awareness around negative health insurance practices. Through an integrated social media and digital online campaign the AMA reached over 61 million people and had an unmistakable impact as evidenced by:

- The social media conversation with a negative sentiment surrounding health insurance practices grew throughout the campaign;
- Other organizations increased ad spends in primary states following the AMA's campaign launch. Drafting off AMA core messaging points, these ads focused on problems with health insurance practices like coverage gaps and narrow networks that lead to surprise billing; and
- AMA campaign messaging helped contribute to presidential campaign messaging shifts.

Drug Overuse and Death

In 2014, the AMA established the Opioid Task Force with the Federation to provide concrete recommendations for physicians to stem the opioid overuse and death epidemic facing the U.S. The work of this Task Force, including additional policy recommendations issued in 2019, has contributed to AMA advocacy wins, including:

- More than 20 new state laws to reduce barriers to evidence-based treatment for opioid use disorder;
- At least a dozen new state laws and regulatory developments to help enforce mental health and substance use disorder parity; and
- All 50 states now having laws that increase access to naloxone and nearly every state having a law that allows for standing orders for persons to obtain naloxone without a patient-specific prescription.

In addition, physician efforts continue, as evidenced by the recently released Opioid Task Force 2020 Progress Report: https://end-overdose-epidemic.org/wp-content/uploads/2020/07/AMA-Opioid-Task-Force-2020-Progress-Report.pdf

- There has been a marked decrease in opioid prescriptions from 244.5 million in 2014 to 153.7 million in 2019;
- There were over 1 million naloxone prescriptions in 2019—up from only 6,588 in 2015;
- There has been a 64.4% increase in the use of state prescription drug monitoring programs —to 739M queries in 2019;
- Hundreds of thousands of physicians accessing continuing medical education and other courses on substance use disorders, treating and managing pain, and more; and
- 85,000+ physicians and health care professionals certified to prescribe buprenorphine in-office—an increase of nearly 50,000 since 2017.

While these are positive trends, the nation's continuing increase in illicit drug overdoses and deaths is fueling the evolution of a more dangerous and complicated epidemic. Illicitly manufactured fentanyl and fentanyl analogues and stimulants are now killing more Americans than ever with the CDC reporting over 70,000 deaths in 2019. The use of these illicit drugs has surged and their overdose rate increased by 10.1% and 10.8%, respectively. The COVID-19 stay-at-home period appears to have worsened this situation as well. Patients with pain continue to suffer from arbitrary restrictions on opioid therapy as well as limited access to non-opioid pain care.

The AMA's 2019 policy roadmap with Manatt health (https://end-overdose-epidemic.org/wp-content/uploads/2020/05/AMA-Manatt-National-Roadmap-September-2019-FINAL.pdf), and the newly-enhanced drug overdose microsite—www.end-overdose-epidemic.org—will help the AMA more comprehensively advance efforts by the AMA Opioid Task Force, the AMA Pain Care Task Force and place increased emphasis on the need for ensuring public health data collection and surveillance efforts implement systems to accurately track overdose and mortality trends to provide equitable public health interventions that include comprehensive, disaggregated, racial and ethnic data collection related to testing, hospitalization and mortality associated with opioids and other substances.

Medicare/MIPS

AMA advocacy has focused on numerous important Medicare issues in 2020:

- Replacing the multiyear Medicare payment freeze in the Medicare Access and CHIP Reauthorization Act (MACRA) with positive annual payment updates;
- Securing improvements in Medicare payments for office visits consistent with the recommendations of the AMA/Specialty Society RVS Update Committee (RUC);
- Waiving the budget neutrality adjustment for the office visit payment increases;
- Getting the office visit increases included in the global surgical packages;
- Extending the five percent incentive payment for physicians participating in Advanced Alternative Payment Models (APMs) for an additional six years;
- Improving Medicare APMs by implementing physician-focused models;
- Simplifying the scoring of the Merit-based Incentive Payment System (MIPS) and creating more clinically meaningful and less burdensome voluntary MIPS options for physician participants;
- Expanding MIPS exceptions and flexibilities during the COVID-19 pandemic; and
- Initiating a Practice Expense Pilot Project involving 32 specialty practices to evaluate the feasibility of a revised practice expense data collection methodology.

MACRA provided positive Medicare payment updates from 2015-2019 and for 2026 and beyond, but left a gap from 2020-2025 with no payment updates. The AMA is continuing to advocate for Congress to address this gap. In addition, MACRA limited the incentive payment for Advanced APM participants to the first six years of the program. As there have been so few Advanced APM opportunities available for physicians, the AMA is asking Congress to extend the incentive payment for an additional six years.

CMS adopted the significant changes in office visit coding definitions and guidelines made by the CPT Editorial Panel, as well as the RUC-recommended relative value recommendations for implementation in 2021. These coding changes and payment increases are a very substantial improvement. Unfortunately, under current law the payment increases must be implemented in a budget neutral manner which will lead to steep negative adjustments for many physicians and other health care professionals who report relatively few office visit codes. As physicians are already

facing severe economic hardship due to COVID-19, the AMA is urging Congress to waive the budget neutrality adjustment for the office visit increases. In addition, the AMA has advocated for CMS to fully adopt the RUC recommendations for the office visit codes by including the payment increases in the global surgical packages.

The AMA has also been advocating for new voluntary options within MIPS that would allow physicians to focus on a specific episode of care, clinical condition, or public health priority instead of fragmented and unrelated measures in four different categories. In its 2020 rulemaking process, CMS outlined a new approach called MIPS Value Pathways that is a step in this direction. The AMA is advocating for a number of improvements to the MIPS Value Pathways approach to make it less burdensome and more relevant to clinical practice. The AMA also has been working with CMS to address the need for MIPS flexibilities and hardship exemptions for 2019 and 2020 MIPS reporting due to COVID-19.

On August 3, CMS issued a proposed rule that includes updates to payment policies, payment rates and quality provisions for services furnished under the Medicare Physician Payment Schedule effective on or after January 1. The proposed CY 2021 PFS conversion factor is $32.26, almost 11% lower than in 2020. This is necessitated by proposed additional spending of $10.2 billion partly due to changes in coding and payment for evaluation and management (E/M) services provided in the office setting, as well as other changes made by CMS. The agency also proposed to permanently keep several codes that were temporarily added to the Medicare telehealth list during the COVID-19 Public Health Emergency (PHE), including the prolonged office or outpatient E/M visit codes and certain home visit services. The AMA will submit comprehensive formal comments on the proposal.

Telemedicine

During the COVID-19 pandemic, the need for patients, physicians, and practice staff to avoid all but essential travel and to practice social distancing as much as possible, combined with an acute shortage of personal protective equipment (PPE), made it necessary for many physician practices to temporarily close. Through AMA advocacy with Congress and federal officials in multiple agencies, waivers and other policy changes were secured to facilitate replacement of these in-person services with telehealth and telephone services. Adoption of telehealth by physicians increased exponentially and extremely rapidly. For Medicare patients, instead of telehealth being confined only to rural areas, it became available everywhere in the country, and instead of needing to go to a facility to obtain telehealth services provided by clinicians in a distant site, patients were able to obtain telehealth services in their own homes, often provided by physicians from their own homes. The DEA provided new flexibilities to allow Schedule II controlled substances and medications for treatment of opioid use disorder to be prescribed based on telehealth visits.

Following this rapid and widespread adoption of telehealth, the challenge is to preserve these new policies beyond the COVID-19 pandemic. To that end, the AMA has been engaged in advocacy with CMS and with Congress. The AMA is working to secure legislation that will prevent the geographic and originating site restrictions on Medicare telehealth services to be permanently removed, and to secure CMS support for retaining the coverage of audio-only services and retaining the many services, such as emergency department and critical care visits, that were newly added to the Medicare telehealth list. The AMA is also working to preserve changes made that allowed patients to use their smart phones for telehealth services while also ensuring that HIPAA requirements will be deployed to protect the privacy of patients' health information when they obtain telehealth services. Finally, whereas the AMA is working to preserve physicians' ability to provide supervision via telehealth as has been permitted during the public health emergency, the

AMA is opposed to permanently eliminating requirements for supervision of nonphysician health professionals as has been done by Medicare on a temporary basis during the pandemic.

The AMA has had a model state telehealth bill since 2017 and has worked with many states on telehealth legislation over the past three years; however, COVID-19 has prioritized the need to update telehealth laws to further expand access, coverage and payment by state regulated plans and Medicaid programs. Shortly after the pandemic hit, the AMA created COVID-19 policy recommendations to provide guidance to state lawmakers, regulators and other policymakers on many issues, including telehealth. The AMA also tracked and summarized changes to state telehealth laws through gubernatorial executive orders, insurance directives, legislation, and Medicaid bulletins. The AMA sent letters to National Governors Association (NGA), National Association of Insurance Commissioners (NAIC), and National Council of Insurance Legislators (NCOIL) outlining its position on telehealth. Finally, the AMA participated in multiple webinars and workgroups related to telehealth with leading state policymaking organizations, including NGA, NAIC, National Association of Attorneys General (NAAG), and the Uniform Laws Commission. These collective efforts have secured AMA's place at the table to make sure the physician's voice is part of these ongoing discussions.

In response to COVID-19, all 50 states took some action related to telehealth. For example, at least 45 states expanded coverage of telehealth for Medicaid patients by eliminating originating site restrictions or other restrictions on the type of care that can be provided via telehealth. While 30 states already had coverage parity for telehealth by state regulated payors, many states took additional steps to further expand coverage of telehealth. About a dozen states required insurers and/or Medicaid plans to pay for telehealth services at the same rate as in-person services. This was instrumental in making sure physicians were able to continue providing care to their patients during this pandemic.

Police Violence

After the deaths of George Floyd and several other African Americans due to unnecessary police violence, the AMA's then-Chair Jesse M. Ehrenfeld, MD, MPH, and then-President Patrice A. Harris, MD, MA, issued a statement calling on police brutality to stop. The statement further indicated "What's often not highlighted are the harmful health impacts that result, such as the connection between excessive police activity and health. Research demonstrates that racially marginalized communities are disproportionally subject to police force, and there is a correlation between policing and adverse health outcomes." Further, the AMA wrote to Congress detailing physician support for the following changes, among others:

- Research into the public health consequences of violent police interactions;
- States requiring the reporting of legal-intervention deaths and law-enforcement officer homicides to public health agencies;
- Banning the use of choke-holds;
- For appropriate stakeholders, including law enforcement and public health communities, to define "serious injuries" for the purpose of systematically collecting data on law enforcement-related nonfatal injuries among civilians and officers;
- Law-enforcement departments and agencies having in place specific guidelines, rigorous training and an accountability system for the use of conducted electrical devices, often called Tasers;
- Research into the health impacts of conducted electrical device use and development of a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to these devices;

- Increased use of body-worn cameras by law enforcement officers, as well as funding for the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies;
- Training for law enforcement at all levels on implicit or unconscious bias and structural racism;
- School discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion or the referral of students to the juvenile or criminal justice system;
- More research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system; and
- Reauthorizing federal programs for juvenile justice and delinquency prevention, which should include incentives for community-based alternatives for youth who pose little risk to public safety, reentry and aftercare services to prevent recidivism and policies that promote justice to reduce disparities.

LGBTQ

The AMA opposes so-called "conversion therapy" and in 2020 two additional states—Utah and Virginia—banned the practice. The total number of states that have banned conversion therapy is now up to 20. The AMA has provided direct and indirect support for these laws. In addition, following a directive from the House of Delegates, the AMA has drafted model legislation banning conversion therapy. No additional activity related to conversion therapy is expected in 2020, but in 2021 the AMA will continue to work with state medical associations to pass laws in the remaining 30 states.

In close coordination with the South Dakota State Medical Association, the AMA worked to defeat harmful legislation that would have criminalized the provision of medically necessary care for transgender minors. The AMA opposed the bill as harmful to the health of transgender minors as well as a dangerous legislative intrusion into the practice of medicine. Similar bills were introduced in a handful of other states, but none advanced. The AMA will continue to monitor state activity and work with state medical associations if additional bills of this kind emerge.

Privacy

The AMA has been active on a variety of fronts related to privacy in 2020. Most notably, the organization developed and released to the public a set of Privacy Principles. The Principles were developed by AMA staff in tandem with the Council on Legislation and were approved by the Board of Trustees in April. They are derived primarily from AMA policy, and provide clarification in areas where AMA policy may be implied but not specific. They address (1) individual rights; (2) equity; (3) entity responsibility; (4) applicability; and (5) enforcement. The Principles will guide AMA advocacy efforts in light of ongoing discussions among Congress, the Administration, and stakeholders to address the growing concerns regarding patient privacy. The AMA has received favorable reaction to the Principles from Congressional offices and others in the health care and the privacy stakeholder community, and looks forward to continuing efforts to promote the importance of privacy in preserving trust between physicians and their patients.

The AMA has also been actively involved in multiple workgroups related to privacy including a steering committee that is seeking to develop a self-regulatory framework to protect patient health information not protected by HIPAA (e.g., health information created by wearables, stored and shared via smartphone apps, etc.) as a bridge until federal privacy legislation is passed by Congress. The AMA is also a lead participant in a workgroup seeking to protect privacy while

promoting interoperability, focused on data labeling and segmentation. This is an important strategy to encourage information sharing, while assisting physicians in using technology to support compliance with state and federal privacy laws. The workgroup recently proposed adopting a number of the AMA's Privacy Principles as foundational to the workgroup's mission. Additionally, the AMA is active within the standards development body Health Level 7 (HL7), and is incorporating AMA policy and the Privacy Principles in feedback on proposed implementation guides, particularly guides aimed at implementing the newly published regulations from the Office of the National Coordinator for Health Information Technology (ONC) and CMS on patient access, interoperability, and information blocking.

The AMA has also been active on privacy as related to COVID-19. For example, the AMA has provided behind-the-scenes technical assistance to multiple Congressional offices on bills seeking to address privacy concerns related to contact tracing technologies (e.g., smartphone apps). The AMA also partnered with the American Hospital Association (AHA) to develop a document for physicians working from home early in the pandemic to help them with proper privacy and security settings for their home networks and telemedicine platforms. Additionally, the AMA has shared information with the Federation about the federal government's notice of enforcement discretion related to HIPAA, including suggestions about the types of functionalities physicians should use to help protect the confidentiality of their patient information. Finally, the AMA is in the process of developing a second resource with the AHA to help educate physicians on technology considerations as they reopen their practices and prepare for a "second wave" of COVID in the coming months. This resource will include suggestions for how to prepare for the end of the government's HIPAA enforcement discretion.

International Medical Graduates

The AMA took several actions on behalf of International Medical Graduates (IMGs) to assist with various hurdles that arose in 2020. The AMA sent a letter to the Department of State (DoS) and the Department of Homeland Security (DHS) requesting that they open visa processing at embassies and consulates for physicians seeking to enter the U.S. to join residency programs on July 1. As a result of AMA advocacy, in concert with the Educational Commission for Foreign Medical Graduates (ECFMG), the DoS agreed to begin processing visa applications for foreign-born medical professionals and announced that J-1 physicians may consult with their program sponsor, to extend their programs in the U.S., and confirmed that J-1 physicians can engage in revised clinical training rotations/assignments in keeping with the Accreditation Council for Graduate Medical Education (ACGME) "Response to Pandemic Crisis."

On June 22, the President of the United States issued a second Presidential Proclamation. In response, on June 26, the AMA sent a letter urging the Administration to consider J-1 and H-1B International Medical Graduates (IMGs) and their families' entry into the U.S. to be in the national interest of the country. Moreover, the AMA spear-headed a sign-on letter for specialty societies. The letter urges DoS and DHS to issue clarifying guidance pertaining to the Proclamation by directing Consular Affairs to advise embassies and consulates that H-1B physicians and their dependent family members' entry into the U.S. is in the national interest of the country.

On July 6, the Student and Exchange Visitor Program (SEVP) announced that nonimmigrant F-1 and M-1 students attending schools operating entirely online could not take a full online course load and enter or remain in the U.S. In response, on July 9, the AMA sent a letter urging the Administration to withdraw its modifications to the temporary exemptions for nonimmigrant students taking online classes due to the pandemic for the fall 2020 semester, so that medical students seeking to study in the U.S. on an F-1 visa could enter or remain in the country. In part

due to the advocacy efforts of the AMA, on July 14, the Trump Administration rescinded the directive.

The AMA also created an IMG resource guide entitled "FAQs: Guidance for international medical graduates during COVID-19." This guide answers some of the questions that IMGs have surrounding their ability to practice, their visas, and available resources.

Immigration

The AMA was also very active on the immigration front in 2020. On July 14, the AMA submitted a comment letter to DHS and USCIS urging the Administration to withdraw Proposed Rule RIN 1125-AA94 which would change multiple aspects of the asylum immigration system and make it harder for worthy asylum seekers to find refuge in the U.S.

On June 18, the Supreme Court of the United States ruled in opposition of the U.S. Department of Homeland Security's attempt to rescind the Deferred Action for Childhood Arrivals (DACA) Program in a landmark decision. This decision aligns with the amicus brief that the AMA helped to write in conjunction with other leading health organizations, the letter the AMA signed onto urging regulatory or legislative action to retain DACA during the COVID-19 national emergency, and the AMA's advocacy supporting the American Dream and Promise Act of 2019 (H.R.6) and the Dream Act of 2019 (S.874).

CONCLUSION

The AMA has made significant progress on a challenging group of advocacy issues so far in 2020 and will continue to advocate powerfully for physicians and patients in the second half of the year. The situation is fluid with the COVID-19 pandemic worsening at the time of this report and protests over police violence occurring in many parts of the country. The November elections will be a major factor as well as many elected officials transition from legislating to campaigning. But the AMA will continue to press to advance AMA policy on these issues and others that arise.

REPORT 15 OF THE BOARD OF TRUSTEES (November 2020)
Plan for Continued Progress Toward Health Equity
(Center for Health Equity Annual Report)
(Informational)

EXECUTIVE SUMMARY

In accordance with Policy D-180.981, this informational report outlines the equity activities of our AMA from 2nd Quarter 2019 through the 3rd Quarter of 2020, with some projections into the 4th Quarter of 2020.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15, November 2020

Subject: Plan for Continued Progress Toward Health Equity (Center for Health Equity Annual Report)

Presented by: Russ Kridel, MD, Chair

BACKGROUND

This report is submitted for information to the House of Delegates. In June 2018, the House of Delegates adopted Policy D-180.981, "Plan for Continued Progress Toward Health Equity," directing our AMA to develop "an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities." Subsequently, in April 2019, our AMA hired its inaugural Chief Health Equity Officer and Group Vice President, Dr. Aletha Maybank, and established the Center for Health Equity ("the CHE", "the Center"). Under the auspices of the Center for Health Equity, our AMA has outlined an internal equity strategy to be leveraged across each business unit toward overall elevation of our AMA Strategic Arcs, and an external equity strategy to maximize and normalize the embeddedness of equity in policy development and in health care delivery, altogether toward the betterment of public health. Policy D-180.981 also states "the Board will provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." As it is just over a year since the inception of the CHE, and the first full annual report of this nature, this document will expound on endeavors that were in development in the mid and latter parts of 2019, and are now in full-fledge operation or complete.

DISCUSSION

Stating the Case for Strategic Equity

Based on the premise of advancing optimal health for all, strategic equity is the re-aligning objective for health systems, whether under normal operating procedure or in the midst of public health crises, such as that which our world faces in 2020 with coronavirus SARS-CoV-2, COVID-19. Especially in the face of pandemic, the CHE considers equity the accelerant that focuses and prioritizes health practitioners' practice-wide goals to deliver high-level, comprehensive, equitable care to all, with thoughtful consideration of myriad lived experiences of patients. Equity considerations ought not fall by the wayside under grim conditions. This is where such principles are needed the most.

Center for Health Equity Quarter Successes and Milestones

2nd Quarter, 2019

(1) Hired in April 2019, Dr. Aletha Maybank leads the CHE as Chief Health Equity Officer, as well as AMA Group Vice President (initially Vice President). Having an extensive background at the intersection of public health, medicine, government, and equity enterprise establishment, Dr. Maybank brings with her a deep reservoir of know-how regarding embedding equity across a multi-tiered organization such as our AMA. Prior to

joining the AMA, Dr. Maybank served as the Founding Deputy Commissioner for the Center for Health Equity at the NYC Department of Health and Mental Hygiene (2014). She was instrumental in infusing equity at the neighborhood level and advancing the Department's place-based approach to addressing health inequities. She also set precedence with groundbreaking work at the Office of Minority Health in the Suffolk County Department of Health Services (2006) while serving as the Founding Director. Dr. Maybank has taught medical and public health students on topics related to health inequities, public health leadership and management, physician advocacy, and community organizing in health. In 2012, along with a group of Black woman physician leaders, Dr. Maybank co-founded "We Are Doc McStuffins", a movement inspired by the Disney Junior character Doc McStuffins serving to shine light on the critical importance of diversity in medicine.

(2) Most of the time in the first quarter was spent learning AMA's culture and engagement with external partners. There was initial reach out and engagement with minoritized physician associations such as NMA and NHMA to start relationship building. Dr. Maybank provided in-depth AMA presence at NMA National Conference via participation in several panels. Also due to critical demand by business units (BU) across AMA, she began discussions BU by BU to share what she had learned in the past regarding institutional culture change as it related to equity as a way to start laying the foundation. She clearly articulated that AMA's approach needed to be an 'inside – outside' strategy in which the culture, practice, and policy within the management and membership was as equally critical to evolve as out external engagement in order to advance equity.

<u>3rd Quarter, 2019</u>

(1) By August 2019, Dr. Maybank hired Diana N. Derige, DrPH, as the CHE's Director of Health Equity Strategy and Development to focus on strategic planning, strengthen external partnerships such as West Side United, and identify external funding opportunities. In September 2019, Dr. Maybank hired Mia Keeys, MA, DrPH(c), as Director of Health Equity Policy and Advocacy to directly engage and support AMA Advocacy to center equity since advocacy is one of AMA's greatest assets. The Center is administratively supported by Executive Assistant Nish Wise, also hired within the 3rd quarter of 2019.

(2) Over the course of the 2019 3rd and 4th quarters, the CHE staff, with the guidance of an equity-in-practice consultant, developed strategic approaches, a vision, and a mission to guide the Center's work, which included embedding equity across the AMA enterprise. Internally, the CHE submitted its Strategic Roadmap for comment to AMA Management Team leadership at the end of 2019, listed below:

> CHE's vision is a nation where all people live in thriving communities where resources work well, systems are equitable and create no harm, and everyone has the power to achieve optimal health; and all physicians are equipped with the consciousness, tools, and resources to confront inequities as well as embed and advance equity within and across all aspects of the health care system.
>
> CHE's mission is to strengthen, amplify, and sustain the AMA's work to eliminate health inequities – improving health outcomes and closing disparities gaps – which are rooted in historical and contemporary injustices and discrimination.

Over the course of its development, the Center set about refining the Strategic Roadmap, informed by both internal and external stakeholder feedback, and have arrived at the tenets described in detail in a separate document, but, summarily, the CHE Strategies Approaches are:

- Embed health equity in practice, process, action, innovation and organizational performance and outcomes
- Build alliances and share power via meaningful engagement
- Ensure equitable opportunities and conditions in innovation for marginalized and minoritized people and communities
- Push upstream to address all determinants of health
- Create pathways for truth, reconciliation, and healing

(3) Also, in late 2019, CHE firmly established the Health Equity Workgroup building upon already exiting efforts with the AMA Management Team co- lead by Rodrigo Sierra and Michael Tutty. The Health Equity Workgroup ("HEW") is a conglomerate of AMA business unit representatives who are collectively tasked with building a community of equity learning and practice; supporting local and enterprise-wide accountability to equity principles; ensuring equity is explicit and infused during goal and objective setting; and better aligning and accounting for enterprise-wide health equity work. The HEW is a merger between AMA's Diversity and Inclusion and former Health Equity Workgroup. The CHE manages the Workgroup and coordinates its Steering Committee, which consists of leaders and members who are involved in planning, development, and implementation of Health Equity Workgroup and Business Action Team activities. Two persons per business unit have been appointed to work with their respective business units to create equity explicit metrics and goals. Following each HEW convening, those business unit representatives convey issues and decisions to supervisors, colleagues, and staff; appropriately escalate concerns; actively seek out, listen to, and incorporate other ideas and perspectives. They are heralded as accessible and open to discussing sensitive matters, and for bringing forth messages about health, race, gender, and social equity into communications with staff and stakeholders as it relates to their work.

Staff in these roles are voluntarily contributing significant time and talent to the development and implementation of health equity work and vision, at the behest of the enterprise-wide equity imperative. The HEW promotes inclusion of diverse voices (by gender/sexual identity, race, age), opportunity to build expertise around equity issues, and the implementation of an equity lens. The HEW gatherings and trainings are designed to focus on workforce equity, particularly at the leadership level, as well as to center equity in policy, practice, and programming.

(4) Since 2019, the Center has organized ongoing racial equity training for senior leadership and staff. Hosted by staff of the Racial Equity Institute (REI)—an organization dedicated to developing the equity capacity of organizations and its leaders—the training is a two-day immersive experience that features lessons tailored to organizational needs with respect to understanding, appreciating, and embedding racial equity across all goals and processes. For AMA, these trainings have included a deep review of organizational membership (by race), policies, and practices across its 175+ years existence. It has also included team-building and small-group discussions related to race, power, and how these constructs manifest within the context of our AMA. With the support of CEO Jim Madara, to date, 90% of Senior Management Group (SMG) have received REI training, and 17% of non-SMG staff have taken the REI training. Before the shelter-in-place and stay-at-home

orders went into effect, the Center had planned to hold additional trainings. The CHE plans to resume REI virtual trainings in the 4th Quarter of 2020, and in-person trainings in 2021 in accordance to AMA guidelines on in-person gatherings. The goal is to achieve 100% staff and SMG training by 2025.

1st Quarter, 2020

(1) In March 2020, the CHE hired and onboarded Hannah Seoh, Director of Health Equity Performance and Operations, and Diana Lemos, PhD, Senior Health Equity Program Manager.

(2) The Center for Health Equity is building sustainable and collaborative relationships with leading organizations likewise committed to an equity imperative. CHE has played a significant role in broadening the AMA's engagement with elected officials, with leaders throughout the fields of health care and public health, and also with non-traditional partners that have historically held rapport with marginalized and minoritized communities. Consequently, there is mounting evidence of the external environments' understanding and appreciation of AMA's Center for Health Equity, and for broader appreciation of the AMA's burgeoning practice of applying a strategic equity lens in relationship and alliance-building efforts. Table 1 in the Appendix further demonstrates identified cross-enterprise and external partners to date, and through 2025, thus far.

(3) Under the leadership of CHE, AMA is heavily investing in a nationwide effort to spread health equity messaging and community health resources across Black communities through *Essence*—the nation's leading lifestyle magazine brand for Black women—most notably through its internationally acclaimed annual July festival, and through its inaugural Wellness Houses in various cities with substantially large communities of Black women and their families. Immediate Past President, Dr. Patrice Harris, has participated in the *Essence Wellness House*, both in-person in Atlanta, GA, and, on March 31, 2020, virtually through the first broadcast of the *Essence Wellness House Live* during a session titled "Essence of the Matter: COVID-19's Impact on Black America".

The *Essence* partnership represents AMA's commitment to going to where trusted physician voices are needed and to building community trust through an established and time-honored brand. The Center's efforts also support the Improving Health Outcomes (IHO) business unit, build the AMA brand in health equity in the Black community, and demonstrate true partnership with the National Medical Association (NMA), the Association of Black Cardiologists (ABC), and the American Heart Association (AHA) to support community well-being.

(4) In February 2020, under the leadership of CHE, AMA partnered with notable hospitals, community health centers, and social organizations in Chicago in a $6 million collaborative social impact investment pact called West Side United (WSU). The investment in the collaborative is an investment in upstream improvements targeted at tackling social determinants of health (SDoH) and is a solid step forward toward closing the life expectancy gap between the loop and Chicago's westside neighborhoods through invigorating economic growth and improving educational outcomes.

For the first time, AMA is investing financially in our own backyard. In the first year, AMA is investing $2 million along with other health care institutions. This effort encourages investment in upstream work wherein health care institutions help to reduce burdens associated with SDoH. It also speaks to the awareness that health care institutions

and their leaders have a role in building community wealth and its impact on health. The WSU investment is a stellar example of how AMA can support upstream work, through social impact investing and a multi-tiered approach to planning, programming and assessment, while bringing together and leveraging the expertise of many AMA business units, including IHO (chronic disease management); Enterprise Communications—EC—(social responsibility); Finance (social impact investing) and coordinating human and financial resources to leverage impact.

2nd Quarter, 2020

(1) In May 2020, CHE also hired and onboarded Fernando De Maio, PhD, Director of Health Equity Strategic Data Use and Research, who brings experience in quantitative data analysis, social epidemiology and sociology. Dr. De Maio's role is a joint appointment with DePaul University, where he remains a tenured professor in the Department of Sociology. In May 2020, CHE also hired Alice Jones**,** Program Manager of Health Equity Performance and Operations. In June 2020, Aziza Jones and Joaquin Baca, MSPH**,** also joined the team as Marketing Manager and Senior Health Equity Policy Analyst, respectively. Formerly with the Environmental Intelligence and Strategic Analytics business unit, Chelsea Hanson also joined CHE as Director of Health Equity Innovation. Consequently, within a year of onboarding its first staff of four, the CHE has nearly tripled in size (see Figure 1 in the Appendix) with plans to hire a Director of Equitable Health Systems Integration by end of 3rd Quarter 2020.

(2) The CHE, in partnership with Enterprise Communications, drafted an online guide, titled Health Equity: A Guide on Concepts, Language and Narrative, which offers a selected glossary and analysis of key equity language and concepts. Its purpose is to enable readers to recognize, describe, think critically, and effectively engage in dialogue related to inequities and equity. It supports the value of ongoing dialogue as a method for advancing strategies for eliminating health inequities that undermine or diminish health. It is slated for full release at the beginning of the 3rd Quarter 2020.

(3) Early in 2020, the CHE launched the internal AMA Today site for staff, which includes learning modules on equity for staff edification; a reading list consisting of classic and contemporary texts and articles on various equity-related subjects; and videos/documentaries to aid self and business unit study of equity issues. At the onset of COVID-19, the equity in COVID-19 resource webpage for physician-members and staff was launched.

(4) On April 7, 2020, the *New York Times* published an article written by Dr. Maybank on the significance of race and ethnicity data in combating COVID-19. It contributed greatly to the national conversation and actions, received widespread attention on the issue, and elevated the role and growing importance and relevancy of the AMA Center for Health Equity. Demand from internal and external stakeholders for CHE's time, attention, and advice increased tremendously after this time.

(5) On Tuesday, April 14, 2020, via Apple TV+, Dr Maybank sat down (virtually), with international syndicate host Oprah Winfrey, during a special presentation, "Oprah Talks COVID-19 - The Deadly Impact On Black America". During this in-depth conversation, Dr. Maybank discussed the detrimental impact the COVID-19 pandemic is having on Blacks across the country. This too increased the demand for time and attention from CHE. It, like no other platform can do, elevated AMA as a serious contender in the fight for injustice in health.

3rd Quarter, 2020

(1) In just over a year, CHE has represented our AMA and its equity commitment in over 75 speaking engagements across the country. Table 2 in the Appendix describes speaking engagements at which CHE staff have represented the AMA since Interim 2019 to June 2020.

In addition to the physical and virtual speaking engagements, the CHE has solidified its online presence. In April 2020, the CHE, in collaboration with the Marketing and Member Experience (MMX) business unit, launched a YouTube-based conversation platform called **"**Prioritizing Health Equity**."** This series of conversation focuses on the experiences of marginalized and minoritized physicians, public health leaders, and medical students during the COVID-19 pandemic. The views have exceeded 50,000. Table 3 in the Appendix maps out the initiative to date.

(2) COVID-19 has shifted how CHE engages with AMA business units and with outside partners. At the time this report was written, CHE was in the process of refining the CHE Strategic Roadmap, informed both by internal and external feedback. In many ways, COVID-19 has enhanced engagement with external partners, and hastened output and collaboration across all AMA BUs while also looking to create both short-term, as well as sustainable endeavors to address the pandemic's impact on the AMA physician membership body, their patients, and on the greater public health environment.

The Center leads the AMA collection of emerging practices on Health Equity/Racial Equity COVID-19 strategic programs/policies. The collection and dissemination of the practices is meant to support best practice dissemination, innovation, and network development all in support of health equity. The Center will serve as repository of this information and will make the information available on the AMA website. Post COVID-19, the CHE will use the information to inform "after-action" conversations for planning and policy development.

Developed in response to the COVID-19 threat, this Equity COVID-19 Resource Page consists of articles, commentaries, resource lists, etc., produced by world health and public health leaders, as it relates to the pandemic. Not only are our AMA utilization analytics demonstrating its usefulness for physician-members—this is also a tool from which the general public is gaining utility. The Health Equity Resource Center for COVID-19 serves as a clearinghouse of sorts to ensure that communications from AMA have an equity framing and consideration of structural issues that contribute to, and could exacerbate, already existing inequities.

(3) In consultation with the National Council of Asian Pacific Islander Physicians, during Asian American Pacific Islander Heritage Month (May 2020), AMA released a public statement denouncing racism and xenophobia, particularly as it impacts Asian Americans and Asian-presenting persons in America. This document also publicly leverages a fuller report arguing for the discrete data disaggregation of Asian American and Pacific Islander health outcomes, which CHE also produced and release to the Board of Trustees in March 2020. A public version of the report is also available on the AMA website.

(4) One of the CHE's critical concerns related to COVID-19 is the dearth of publicly available granular data on the number of positive cases, hospitalizations, and mortality by race and ethnicity. Without these data, it is difficult to make sound decisions on resource allocation and to glean an overall understanding of how the virus has been impacting various

communities. Therefore, on April 3, 2020, in coordination with Advocacy business unit, the CHE submitted a letter to the Department of Health and Human Services (HHS) urging policymakers to require equitable demographic data collection and urging health systems/practices to collect data. The following physician and public health organizations signed onto this letter: the National Medical Association, the National Hispanic Medical Association, the National Council on Asian Pacific Islander Physicians, the Association of American Indian Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American College of Gynecologists.

(5) On April 2, 2020, CHE, in coordination with the Advocacy business unit, submitted legislative language on equity considerations for inclusion consideration for a forthcoming COVID-19 legislative package. The bill, HR 6585, called the Equitable Data Collection and Disclosure Act, was introduced as a stand-alone bill by Representatives Kelly (D-IL), Pressley (D-MA), Bass (D-CA), and Lee (D-CA). Its Senate companion was introduced by Senators Booker (D-NJ), Harris (D-CA), Markey (D-MA), Merkley (D-OR), and Warren (D-MA).

The following are the provisions of the bill, which CHE submitted:

- Require HHS to use all available surveillance systems to post daily updates on the CDC website showing the testing, hospitalizations, treatment data disaggregated by race, ethnicity, sex, age, socioeconomic status, disability status, county, and other demographic information, including patients' preferred written and spoken language;
- Require HHS to take all necessary steps to protect privacy in releasing this data;
- Require HHS to provide a summary of the final statistics and a report to Congress within 60 days after the end of the public health emergency;
- Create a Commission on Ensuring Health Equity during the COVID-19 Public Health Emergency, including federal, state, local, and tribal officials along with independent experts, to provide guidance on how to better collect, develop and analyze racial and other demographic data in responding to future waves of the coronavirus;
- Authorize $50 million in emergency supplemental funding to the CDC, state public health agencies, the Indian Health Service, and other agencies to conduct or support data collection on racial, ethnic, and other demographic implications of COVID-19.

Not long after the bill had been introduced, the Centers for Disease Control and Prevention (CDC) announced it would adopt several the bill's provisions.

(6) Following the initial success of the equitable data bill, the Center convened a series of intimate virtual meetings with leading and representative minds in equity and ethics in public health, policy, and health care, throughout the months of April and May 2020. The purpose of these meetings was to gather additional ideas for legislative action to address inequities related to COVID-19. The following is a list of our contributive partners:

America's Essential Hospitals	Illinois Coalition for Immigrant & Refugee Rights
American Public Health Association	National Birth Equity Collaborative
Association of American Indian Physicians	National Council of Asian Pacific Islander Physicians
Civic Health Partners	National Hispanic Medical Association
CommonSpirit Health	National Medical Association
Commonwealth Fund	Trust for America's Health
Families USA	Unidos US

(7) At the behest of the United States Breastfeeding Committee, CHE serves as a leading organizational representative on the Infant and Young Child Feeding Constellation. This body is prompted to review and put forth guidance on the impact and related advantages and/or challenges associated with breastfeeding as the world uncovers additional information about the novel coronavirus, COVID-19.

(8) At the onset of COVID-19, the City of Chicago witnessed high numbers of positive cases, hospitalizations, and deaths due to complications of the virus. An overwhelming number of these cases were among marginalized and minoritized communities. In a valiant effort to quell the rapid spreading of the disease, Mayor Lori Lightfoot instituted a comprehensive, city-wide plan, which included a new mandatory race and ethnicity reporting requirement for all COVID-19 cases reported under the auspices of one of the nation's first Racial Equity Rapid Response efforts. In May 2020, CHE joined this effort, with the goal of (1) supporting data analysis to understand the burden of COVID-19 in Chicago and how that burden varies across the city by race/ethnicity, and (2) leveraging AMA's national reach to elevate this work and learn lessons from efforts in other cities. The WSU collaboration is also a critical component of Chicago Mayor Lori Lightfoot's Racial Equity Rapid Response Team.

4th Quarter 2020 and early 2021 Projections

(1) The COVID-19 pandemic demonstrates that the case for addressing patients' health-related social needs by integrating social care into health care delivery has never been stronger. Pandemics like COVID-19 highlight both the existing challenges in the current health system, lack of coordinated preparedness, and also the fragile state of the safety net health system that supports children, the elderly, people of color, Limited English Proficient persons, geographically challenged persons, people who identify as LGBTQ+, religious minorities, persons with disabilities, and individuals of low socioeconomic status. These communities are even more vulnerable to the uncertainty of the preparation, response, and events surrounding public health crises. This trend is playing out repeatedly—it is a trend that is becoming the clamoring, cacophonous tenor of the American health care system. These experiences expose the need for an evidence-based social determinants approach to maximize the public health of the nation, and the efficacy of this nation's physicians and other health care professionals.

However, health practitioners lack adequate support and training to lead this transformation into an equity-driven system, particularly as they are overwhelmed by the onslaught of COVID-19. As a simultaneous response to this dearth of strategic equity guidance, and in anticipation of the evolved needs of the nation's patient population in the wake of COVID-19, the Center for Health Equity has developed the first ever Centering Equity in Emergency Preparedness and Response: A Health care Institutions' Guide. In addition to the COVID-19 Equity Resource page, the Guide serves as an iterative, living document meant as a guide during public health crises, and also as health systems' transformative guide based on the tenets of applying an equity lens throughout all of a health systems' efforts to embed equity. CHE developed this guidance for physicians as they:

- Renew and refine practice's internal strategic equity preparedness for COVID-19 related care and for future health crises;
- Consider innovative integration of social determinant approaches across communities they service;

- Leverage the suggested resources to bolster the health of physicians, co-workers, and families;
- Access guides and resources that aid physicians in helping patient communities to recover from impacts of COVID-19.

This document has also been reviewed by other institutional partners and is slated for release in 4th Quarter 2020.

(2) In partnership with the Satcher Health Leadership Institute at Morehouse School of Medicine, the Health Equity Advocacy and Leadership (HEAL) Fellowship proposes to close the ever-widening health gap by training physicians who are best positioned to elevate health equity for communities in need. This fellowship—slated for initiation in 2021—will mobilize and engage AMA members in health equity-focused advocacy leadership to use their power and privilege to create positive changes that will address the structural determinants affecting health and implement health projects that will eliminate health disparities. The program will create a common platform for in-depth engagement in exploring a panoply of topics that will give participants concrete tools to enable effective engagement of multidisciplinary sectors and resources required to improve health and community well-being. The Health Equity Advocacy Leadership (HEAL) Fellowship will actualize health equity that is inclusive of the political determinants of health framework developed by the Morehouse School of Medicine's Satcher Health Leadership Institute.

APPENDIX

Figure 1: Current CHE Staff (As of 6/22/20)

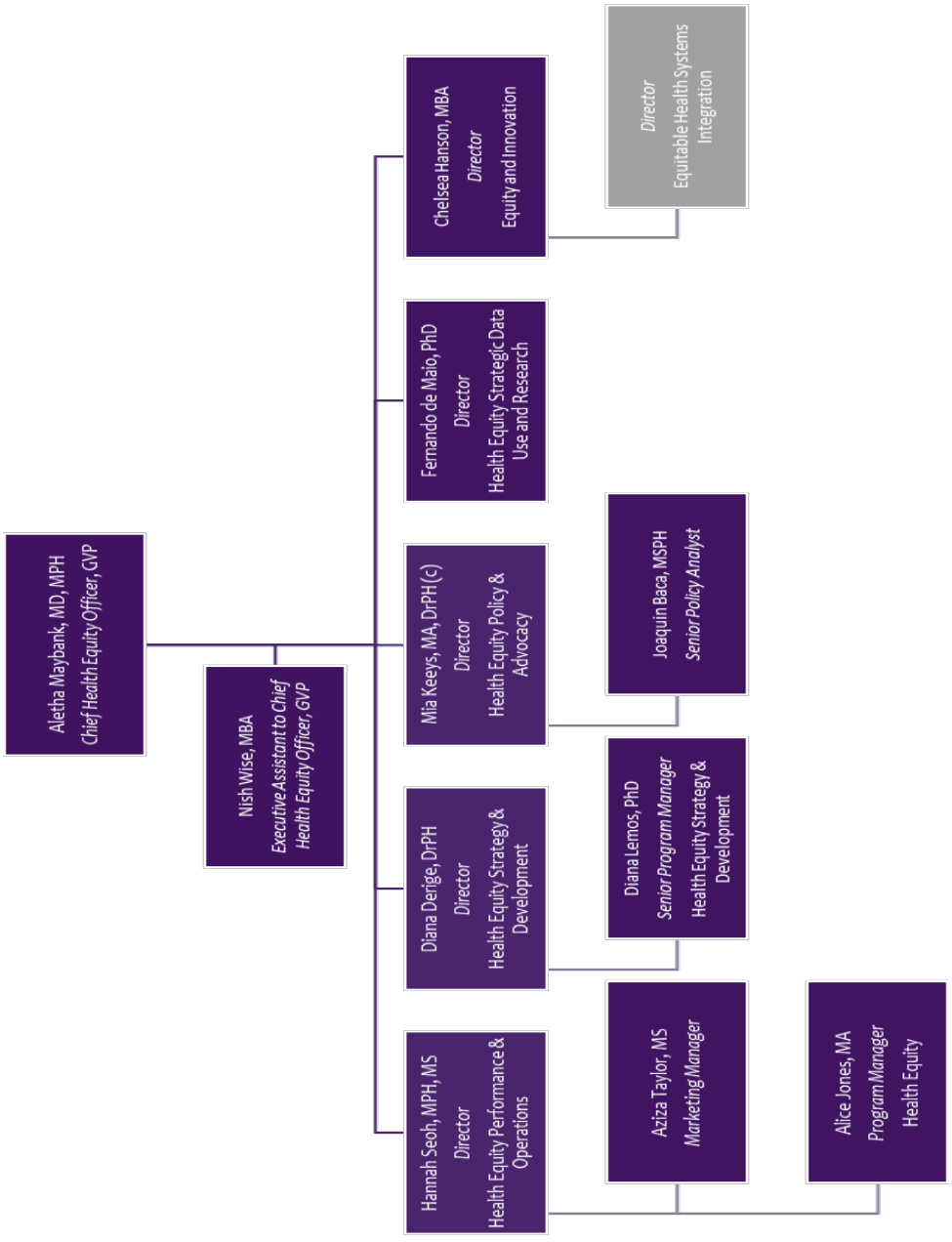


Table 1: AMA Center for Health Equity Supports & Partners (2020-2025)

	Identified Supports and Partners 2020-2025				
	Embed Equity	**Build Alliances & Share Power**	**Push Upstream**	**Ensure Equity in Innovation**	**Create Pathways for Healing**
Cross-Enterprise Partnerships	• All AMA management business units BUs co-creating opportunities and products • Human Resources • Enterprise Communications • EISAMR • Health Solutions • Advocacy • Publishing (Ed/Hub) • Marketing and Membership Experience (MMX) • AMA House of Delegates and Sections/Councils	• MMX (Ambassador Program, MAS (Minority Affairs Section), LGBTQ Advisory Committee, Womens Physicians Section (WPS)) • Advocacy [AMA PAC] • IHO (Improved Health Outcomes) • EISAMR • American Medical Association Foundation • AMA Federation	• IHMI • EISAMR • Health and Science • Med Ed • PS2 • Ed Hub • MMX	• EISAMR • PS2 • Health Solutions • Health & Science • IHMI • Health 2047	• AMA Archives • Health & Science [Ethics] • MMX
External Partnerships		• West Side United • Alliance for Health Equity • National Medical Association • National Hispanic Medical Association • Association of American Indian Physicians • National Council of Asian Pacific Islander Physicians • Congressional Black Caucus • Congressional Hispanic Caucus • Congressional Asian Pacific American Caucus • ESSENCE (Sponsorship) • REACH Media (Sponsorship) • Landmark Ventures (Sponsorship)	• West Side United • MEDICC • APHA (American Public Health Association) • American College of Preventive Medicine (ACPM) • NAACP • Academy of Nutrition & Dietetics	• AfroTech – Blavity • Landmark Ventures (Sponsorship) • HealthTech 4 Medicaid	• National Medical Association • National Hispanic Medical Association • Association of American Indian Physicians • National Council of Asian Pacific Islander Physicians • Harriet Washington – Author of American Apartheid • Meharry Medical College & Morehouse SoM
Consultants (paid)	• Race Forward • Morten Group • Racial Equity Institute • Interaction Institute for Social Change • OnBoard Health • Brandstage		• Health Begins • Advancing Health Equity (Uche Blackstock) • Jonathan Metzl (Vanderbilt)	• Onboard Health	• Kirwan Institute for the Study of Race and Ethnicity

Table 2: AMA Center for Health Equity National Speaking Engagements (November 2019- June 2020)

Table 2: American Medical Association Center for Health Equity National Speaking Engagements (Nov 2019-Present)				
EVENT	**DATE**	**LOCATION**	**PRESENTATION STYLE**	**AUDIENCE REACH**
Exponential	November 7, 2019	San Diego, CA		
Stanford University Artificial Intelligence in Health care: The Hope, The Hype, The Promise, The Peril	November 8, 2019	Stanford, CA	Solo	400
AMA I-19	November 12, 2019	San Diego, CA	Solo	NA
NHHF National Hispanic Health	November 21, 2019	Los Angeles, CA		NA
Brigham's Site Visit	December 12, 2019	Boston, MA		NA
Health Disparities Lecture at Rush	January 9, 2020	Chicago, IL	Solo	NA
MSS Standing Committee	January 12, 2020			NA
Chicago HS for AG Sciences	February 6, 2020	Chicago, IL	Solo	NA
Cook County	February 19, 2020	Chicago, IL	Panel	NA
Sojourner Truth Lecture	February 20, 2020	Claremont, CA	Solo	NA
University of Wisconsin–Madison's La Follette School of Public Affairs Inaugural Health Policy Conference	March 2, 2020	Madison, WI	Keynote Speaker	400+
Women's March/Moms Rising: Talking to Your Kids about Coronavirus	March 17, 2020	Zoom	Panel	1,129
AMA COVID-19 Update	March 25, 2020	Online	Panel	1,977
AMA COVID-19 Update	March 31, 2020	Online	Panel	582
AMA COVID-19 Update	April 2, 2020	Online	Panel	NA
ABA WEBINAR: Implications of the COVID-19 pandemic on African Americans	April 2, 2020	Zoom	Panel	NA
Prioritizing Equity: Physicians of Color and COVID-19	April 2, 2020	Online	Moderator	4,494
National Minority Quality Forum Webinar: (Every Friday since April 2020 to Present)	April 3, 2020 - Ongoing	RingCentral	Moderator	2,000+
AMA COVID-19 Update	April 6, 2020		Panel	550
COVID-19: MA's National Physician Townhall	April 9, 2020	Online	Panel	2,346

Oprah Talks COVID-19: The Deadly Impact of Black America	April 14, 2020		Solo	40,755
Cook County Commissioner Donna Miller's Virtual Town Hall - Our fight against COVID-19 in the southland focus on health equity	April 16, 2020	streamyard.com	Panel	2,900
University of N. Carolina Chapel Hill Class Lecture: Advocacy, Public Policy, & Health Reform: Improving Access to Quality Health Care	April 16, 2020	Zoom	Solo	25
Virtual - AMEC 2020 Speaker Invite	April 18, 2020	app.hopin.to	Solo	1,542
Birthright AFRICA Deep Dive Session	April 19, 2020	app.hopin.to	Panel	2,252
AMA COVID-19 Update	April 21, 2020		Panel	1,045
EPIDEMIC podcast Season 1 Episode 13: A Black Plague	April 21, 2020	Zoom	Solo	NA
AMA Moving Medicine Podcast - US Census 101 for Physicians, Part I	April 21, 2020		Panel	NA
Racial Disparities in the Pandemic, and what they mean for the Future of Medicine	April 23, 2020	Zoom	Solo	NA
Prioritizing Equity: Strengthening the Public Health Infrastructure to Battle Crises	April 23, 2020	Zoom	Moderator	558
COVID-19: The Battle to Save African American Lives Virtual Town Hall	April 30, 2020	Zoom	Panel	1200
National Minority Quality Forum Webinar (Every Friday since May 2020 to Present)	May 1, 2020	RingCentral	Moderator	1600+ to date
Black AZ COVID-19 Task Force	May 8, 2020	WebEX	Solo	100+
NewsOne Panel on COVID-19	May 13, 2020	Online	Panel	3,900
#ListenUpMBC Confab on Young Women's Metastatic Breast Cancer Disparities	May 29-30, 2020	Zoom	Keynote speaker & Moderator	100+
Northern CA Black Physicians Forum	June 12, 2020	TBD	Keynote speaker	NA

Table 3: AMA Center for Health Equity "Prioritizing Equity" YouTube Series (April – August 2020)

Date	Time	Title "Prioritizing Equity:…"	Panelists
4/2/2020	7 PM EDT/6 PM CDT	"Physicians of Color and COVID-19"	Dr. Patrice Harris Dr. Brian Thompson Dr. Elena Rios Dr. Winston F. Wong Dr. Siobhan Wescott
4/23/2020	7 PM EDT/6 PM CDT	"Strengthening the Public Health Infrastructure to Battle Crises"	Dr. Georges Benjamin Dr. J. Nadine Gracia Lori Tremmel Freeman
5/7/2020	7 PM EDT/6 PM CDT	"COVID-19 and the Experiences of Medical Students"	Alec Calac Alex Lindqwister Osose Oboh Sarah Mae Smith Yingfei Wu
5/14/2020	6 PM EDT/5 PM CDT	"COVID-19 and Latinx Voices in the Field"	Dr. Luis Seija Dr. Ricardo Correa Dr. Erica Flores Uribe Dr. Joaquín Estrada
5/21/2020	7 PM EDT/6 PM CDT	"COVID-19 and Native Voices in the Field"	Dr. Mary Owen Dr. Shannon Zullo Dr. Don Warren
5/28/2020	7 PM EDT/6 PM CDT	"The Root Cause"	Dr. Zinzi Bailey Dr. Joia Crear-Perry Dr. Camara Jones Dr. Jonathan Metzl Dr. Whitney Pirtle Dr. Brian Smedley
6/4/2020	1 PM EDT/12 PM CDT	"Police Brutality & COVID-19"	Dr. Rupa Marya Edwin G. Lindo Dr. Atheendar Venkataramani Dr. Mitchel Roger Jr. Dr. Rhea Boyd,
6/11/2020	1 PM EDT/12 PM CDT	"The Root Causes and Considerations for Healthcare Professionals"	LaShyra Nolen Dr. Michael Mensah Dr. Kamini Doobay Dr. Emily Cleveland Manchanda Dr. Brian Williams Dr. David Ansell
6/18/2020	2 PM EDT/1 PM CDT	"LGBTQ+ Health & COVID-19"	Dr. Jesse Ehrenfeld Dr. Blackstock Dr. Shilpen Patel Dr. Asa Radix Dr. David Malebranche
7/2/2020	1 PM EDT/12 PM CDT	"Moving Upstream"	Rishi Manchanda Lauren Powell David Zuckerman Sandra Hernandez
7/16/2020	1 PM EDT/12 PM CDT	COVID-19 & Asian American and Pacific Islander Voices	Dr. Julie Morita Dr. Raynald Samoa Dr. Jay Bhatt Dr. Manisha Sharma Ignatius Bau Dr. Ryan Huerto
8/6/2020	1 PM EDT/12 PM CDT	"Mental Health and COVID-19"	Dr. Patrice Harris Dr. Damon Tweedy
8/20/2020	1 PM EDT/12 PM CDT	"Political Determinants of Health"	Daniel Dawes Rep. Robin L. Kelly

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1, November 2020

Subject: Physician Competence, Self-Assessment and Self-Awareness

Presented by: Monique A. Spillman, MD, Chair

INTRODUCTION

At the 2019 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-I-19, "Competence, Self-Assessment and Self-Awareness." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-8.1.3 – Physician Competence, Self-Assessment and Self-Awareness

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians' technical knowledge and skills.

However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:

(a) Cultivate continuous self-awareness and self-observation.

(b) Recognize that different points of transition in professional life can make different demands on competence.

(c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

(d) Seek feedback from peers and others.

(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest.

(f) Maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness.

(g) Intervene in a timely, appropriate, and compassionate manner when a colleague's ability to practice safely is compromised by impairment, in keeping with ethics guidance on physician responsibilities to impaired colleagues.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment. (I, VII, VIII)

REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (November 2020)
Preparedness for Pandemics Across the Medical Education Continuum
(Informational)

EXECUTIVE SUMMARY

As the coronavirus (COVID-19) spread throughout the United States, the nation's medical education community was forced to prepare for a variety of issues across the medical education continuum. While the 2017 Department of Health and Human Services Pandemic Influenza Plan offered guidance on how to respond to a pandemic, education, including medical education at all levels, was not included as a distinct domain that needed to be supported with planning. At the March 15, 2020, meeting of the Council of Medical Education, members decided to develop an informational report on preparedness for pandemics across the medical education continuum in the context of COVID-19 for the November 2020 House of Delegates meeting. This informational report provides a framework for preparedness for pandemics and other large-scale public health emergencies across medical education based on lessons learned from the COVID-19 pandemic.

This report provides an overview of COVID-19 in the United States and discusses the following:

- The impact of COVID-19 on U.S. undergraduate medical education (UME),
- The impact of COVID-19 on U.S. graduate medical education (GME),
- The impact on international medical graduates entering GME programs in the U.S.,
- The impact of COVID-19 on continuing medical education (CME) in the U.S.,
- The impact of COVID-19 on mental health of students, residents, and physicians, and
- Efforts by key stakeholders to address issues in medical education, training, licensure, and credentialing.

The Council on Medical Education is committed to best equipping individuals for success at various points in their medical career while ensuring patient safety. As such, the Council on Medical Education anticipates there will be evolving issues related to COVID-19 and will continue to monitor the evolution of these issues.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4, November 2020

Subject: Preparedness for Pandemics Across the Medical Education Continuum

Presented by: Liana Puscas, MD, MHS, Chair

INTRODUCTION

The first confirmed coronavirus (COVID-19) case in the United States was reported on January 21, 2020. As COVID-19 increasingly spread throughout the United States, the nation's medical education community was forced to prepare for a variety of issues across the medical education continuum, including, but not limited to:

- Conscientious oversight of the deployment of medical students;
- Recommended trajectory for medical students transitioning from graduation to residency;
- Student and trainee movement across geographic areas for interviews and clinical rotations;
- Field promotion of fellows to attending roles;
- Access to, and instruction in, the use of adequate personal protective equipment;
- Accreditation, licensure, examination, and certification requirements;
- Flexibility in graduate medical education reimbursements;
- Guidelines for volunteer clinical work;
- Maintaining standards for credentialing and competencies during this time of emergency;
- Continuing education offerings for practicing physicians.

Based on lessons learned from the COVID-19 pandemic, the Council on Medical Education offers this informational report to provide a framework for preparedness for pandemics and other large-scale public health emergencies across the medical education continuum.

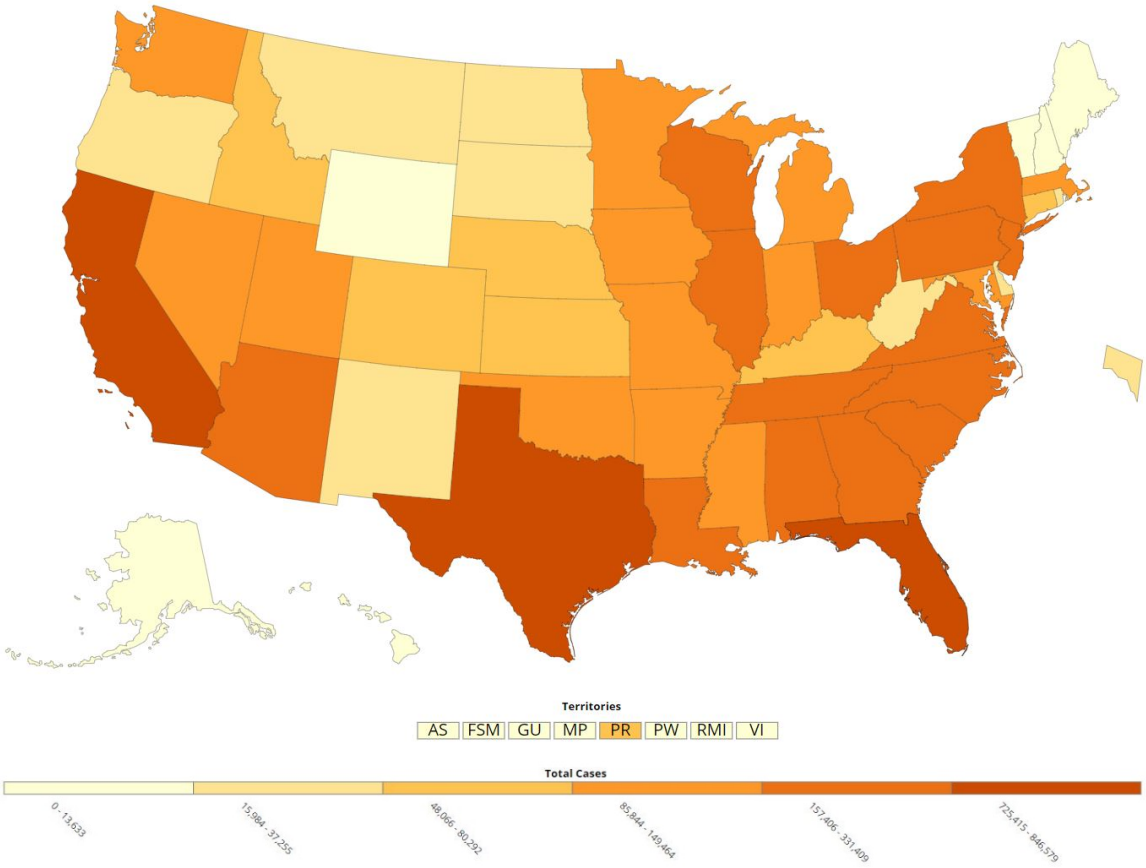
OVERVIEW OF COVID-19 IN THE UNITED STATES

In late December 2019, officials in Wuhan, the capital of China's central Hubei province, confirmed dozens of cases of pneumonia from an unknown cause in the region.[1] In January 2020, the outbreak was confirmed as a new coronavirus, and on March 11, the World Health Organization declared the outbreak of coronavirus (COVID-19) to "be characterized as a pandemic."[2] The first confirmed COVID-19 case in the United States was reported on January 21, 2020.[3] The outbreak initially appeared contained through February; however, by mid-March, transmission of SARS-CoV-2, the virus that causes COVID-19, had accelerated, with rapidly increasing case counts indicating established transmission in the United States. Factors that contributed to the rapid acceleration of the spread of COVID-19 included continued importation of the virus by travelers infected elsewhere; attendance at professional and social events, which amplified the transmission of COVID-19 in the host locations and multistate spread; introduction of the virus into facilities or settings prone to amplification such as long-term care facilities and high-density urban areas; and challenges in virus detection, including limited testing, emergence

during the peak months of influenza circulation and influenza and pneumonia hospitalizations, and other cryptic transmission including from persons who were asymptomatic or presymptomatic.[3]

As of October 12, 2020, a total of 7,740,934 cases and 214,108 deaths in the United States were reported to the Centers for Disease Control and Prevention (CDC) since January 21, 2020. The states with the highest number of cases include California (846,579); Texas (792,478); Florida (725,415); New York (475,540) and Georgia (331,409). New York City leads the country in the number of total cases (251,618) in a city.[4] The map in Figure 1 highlights the total number of COVID-19 cases in the U.S. reported to the CDC by state/territory.

Figure 1 Total number of COVID-19 Cases in the US by state/territory reported to the CDC as of September 15, 2020



Source: CDC COVID Data Tracker, 2020

As the number of confirmed cases in the United States continued to grow, so did concern for the hospitals and health care facilities' capacity to respond to the pandemic. In 2005, the U.S. Department of Health and Human Services (HHS) developed the inaugural Pandemic Influenza Plan, which was most recently updated in 2017 to model the potential health care impact of moderate and severe influenza pandemics.[5] It suggested that a moderate pandemic would infect about 64 million Americans, with about 800,000 (1.25%) requiring hospitalization and 160,000 (0.25%) requiring beds in the intensive care unit (ICU). The plan also suggested that a severe pandemic would dramatically increase these demands. The 2017 Plan identified the following seven domains to support planning for the next decade:

- Surveillance, epidemiology, and laboratory activities;
- Community mitigation measures;
- Medical countermeasures: diagnostic devices, vaccines, therapeutics, and respiratory devices;
- Health care system preparedness and response activities;
- Communications and public outreach;
- Scientific infrastructure and preparedness; and
- Domestic and international response policy, incident management, and global partnerships and capacity building.

These domains expanded upon the original four key pandemic response elements of the original 2005 plan to reflect an end-to-end systems approach to improving the way preparedness and response are integrated across sectors and disciplines, while remaining flexible for the conditions surrounding a specific pandemic.[6] Of note, education, including medical education at all levels, was not included as a distinct domain that needed to be supported with planning, which complicated the development of a strategic response.

According to the American Hospital Association, there were 5,198 community hospitals and 209 federal hospitals in the United States in 2018. In community hospitals, there were 792,417 beds, with 3,532 emergency departments and 96,500 ICU beds, of which 23,000 were neonatal and 5,100 pediatric, leaving just under 68,400 ICU beds of all types for the adult population.[6] The extraordinary and sustained demands of responding to patients affected by COVID-19 on public health, health systems, and providers of essential community services created the need to ration medical equipment and interventions.[7] The earliest example was the near-immediate recognition that there were not enough high-filtration N-95 masks for health care workers, prompting contingency guidance on how to reuse masks designed for single use.[8] In addition, acute care hospitals in the United States currently have about 62,000 full-function ventilators and about 98,000 basic ventilators, with an additional 8,900 in the Office of the Assistant Secretary for Preparedness and Response Strategic National Stockpile.[9] While all hospitals have some lifesaving ventilators, that number of available ventilators is proportional to the number of hospital beds in the institution. As a surge of need develops in a particular community, all hospitals in the area then compete for a finite number of resources, which could lead to difficult decisions regarding who gets access to a ventilator and who does not.[10]

To prevent overburdening U.S. hospitals and health care facilities, immediate efforts were implemented to slow the spread of COVID-19. This was known as “flattening the curve.” These efforts included strict social distancing practices and stay-at-home orders. Social distancing has been identified as the most effective preventive strategy since the emergence of COVID-19 pending development of a vaccine, treatment, or both.[11] California Governor Gavin Newsom was the first governor to issue a stay-at-home order on March 19, and by early April many states had restrictions in place to mitigate the spread of the disease.[12]

THE IMPACT OF COVID-19 ON U.S. UNDERGRADUATE MEDICAL EDUCATION

Prior to COVID-19, most medical schools convened students in physical settings during the first 12 to 18 months of classes for interactive problem-solving or discussions in small groups, the students’ physical presence in both inpatient and outpatient settings being an accepted tenet of early clinical immersion experiences and the clerkship curriculum. The last 18 months of medical school may be individualized, with students participating in advanced clinical rotations, subinternships prior to residency, or scholarly projects. While efforts to provide individualized

instruction for asynchronous learning existed prior to COVID-19, students still convened in-person for small-group interactions, laboratory sessions, simulations, and technology sessions, as well as for clinical instruction with standardized patients and in authentic patient care environments.[13] The advent of strict social distancing altered undergraduate medical education in a multitude of ways. The traditional classroom experience shifted to virtual instruction, which severely limited on-campus activities and interactions, to minimize gathering in large groups and spending prolonged time in close proximity with faculty, staff, and students in spaces such as classrooms, learning studios, lecture halls, or small-group rooms. These changes also required faculty to rethink how they teach.

On March 17, 2020, the Association of American Medical Colleges (AAMC) issued a guidance document recommending that member schools suspend medical student participation in activities that involve patient contact.[14] The high probability that medical students in the hospital would be exposed to COVID-19 and the need to conserve personal protective equipment (PPE) seemed to outweigh the educational benefits of students' participation. By decreasing non-essential personnel in health care settings, including medical students, medical schools contributed to national and global efforts to "flatten the curve."[15]

With the removal of students from clinical sites, medical schools quickly developed curricula for their clinical students who were unable to see patients in person. For example, a teaching hospital affiliate of the University of Minnesota Medical School created a database of about 1,400 patients at risk of SARS-CoV-2 infection. The hospital implemented a system to send daily emails to these patients asking about COVID-19 relevant symptoms, such as fever, cough, and shortness of breath. Any patient who reported one or more of the symptoms would then receive a call from a third- or fourth-year medical student. The student would take a history and staff the patient with a supervising resident. Similarly, the Boonshoft School of Medicine in Ohio created an elective in which students worked through online modules on psychological first aid and behavioral activation. Each student was then paired with an isolated older adult in the community with whom they made weekly virtual social visits to ensure patient access to food, water, shelter, and medications, as well as the ability to pay bills. In another example, the Association of Professors of Gynecology and Obstetrics (APGO) at the University of Vermont Larner School of Medicine developed a two-week elective using APGO's medical student educational objectives and vast library of basic science videos. Students completed about six video cases per day in obstetrics and gynecology, sexuality, intimate partner violence, and sexual assault; with each requiring critical thinking and the development of differential diagnoses. An assessment of the student's knowledge was done through APGO-developed quizzes.[16] The AMA Medical Education Department curated a crowdsourced list of potential resources—both free and paid—for virtual or remote clinical and non-clinical learning (https://www.ama-assn.org/delivering-care/public-health/covid-19-resources-medical-educators). The AMA did not review or endorse any of the listings, aside from those created directly by the AMA. Rather, they were are provided as a resource to help medical educators determine the best ways to teach remote learners during the coronavirus pandemic.

Medical students also identified numerous ways to volunteer their time and efforts to support health care teams and patients during COVID-19. For example, medical students at the University of Texas Southwestern launched a wave of volunteerism as campus educational programs and research activities scaled back amid concerns over COVID-19. These students collaborated with institutional leadership to identify immediate as well as long-term needs to support and supplement the efforts of front-line clinical teams and staff; these efforts, which aligned with national guidelines for medical student volunteerism, allowed learners to provide maximum support while minimizing their own risk. Volunteer activities included helping to screen hospital visitors, answering phones, moving furniture, and delivering supplies.[17] In Chicago, students from

Northwestern University, Rosalind Franklin University of Medicine and Science, University of Chicago, Rush Medical College, Loyola University, Midwestern University, and University of Illinois at Chicago recruited more than 500 volunteers for the COVID Rapid Response Team Chicago to secure PPE and distribute them to the front lines of the epidemic, in addition to working to boost support for blood drives, performing laboratory tests, and organizing food drives for health care workers who did not have time to buy groceries.[18] Additionally, the AAMC established *iCollaborative (*https://icollaborative.aamc.org/collection/covid-19-student-service-projects*)* a compendium of student volunteer and relief initiatives

COVID-19 also prompted the creation of a process for early graduation of final-year medical students. On March 24, 2020, the Grossman School of Medicine at New York University (NYU) became the first medical school in the United States to announce an offer of early graduation to eligible students. The school's decision came as its hospitals were overwhelmed with an increasing number of COVID-19 patient cases, including in critical care.[19] Similar actions were taken by the medical schools at Tufts University, Boston University, and the University of Massachusetts following a request from the state of Massachusetts to help expand the medical work force. Massachusetts also provided 90-day provisional licenses for early graduates, allowing almost automatic entry into clinical work and making approximately 700 medical students in the state eligible to offer patient care at least eight weeks earlier than expected.[20]

While innovative efforts to respond to the health care demands of COVID-19 were rapidly and successfully implemented in some areas, uncertainty in other aspects of medical education proved problematic for medical students including administration of medical college admission and licensing examinations as well as the impact of testing center closures.

Aspiring premed college students were also impacted by disruptions to medical education. For example, the Medical College Admission Test (MCAT) is required by the AAMC to be taken in person. Due to COVID-19, the AAMC cancelled MCATs scheduled for March, April, and most of May, and the lack of communication regarding the cancellation of tests proved to be problematic. On May 7, the AAMC opened its MCAT scheduling system for applicants who needed to reschedule or make their initial testing appointment. However, the system was not prepared to handle the volume of individuals trying to schedule their exams, and it crashed. Additionally, those who needed special testing accommodations found the process to secure the necessary accommodations to be difficult. Additionally, MCAT test-taking stations were to be set up in accordance with social and physical distancing guidelines: Eight people can take the test together at one time and masks are required, among other changes. However, students expressed concern that the changes were insufficient to ensure safety or equality in taking the test and, in July, it was reported that three students had tested positive for COVID-19 from 2 to 7 days after taking the in-person MCAT exam.[20]

On March 18, 2020, Prometric, the private company that administers the United States Medical Licensure Examinations® (USMLE®) Step 1, Step 2 Clinical Knowledge (CK), and Step 3 exams closed its test centers in the U.S. and Canada through May 1, 2020. On May 1, 2020, Prometric resumed testing in a limited capacity in the U.S. and Canada for essential services programs and opened some of its locations for USMLE testing at 50% capacity. To accommodate this change, the company randomly selected thousands of appointments for cancellation.[21] On June 1, 2020, Prometric resumed testing, where possible, for all programs in numerous states and regions across North America. It is estimated that cancellations affected 17,000 medical students and residents through mid-May. Criticisms of Prometric's administration of the exams describe the process as "chaotic, poorly communicated, discriminatory, and outright harmful."[22] Inconsistent and often conflicting information from Prometric and the USMLE resulted in confusion and frustration for

test-takers. Last-minute cancellations of these exams continued through early June, sometimes just hours before exams were to start. Students also reported arriving at testing centers for exams, only to find them closed. In response to demand for increased testing capacity, USMLE developed a phased approached to expand testing centers. Phase one established a small number of testing sites in medical schools using Prometric equipment for different geographical regions across the U.S. Phase two sought to determine the school's level of interest and ability to participate in event-based testing to administer Step 1 and Step 2 CK among Liaison Committee on Medical Education (LCME)-accredited medical schools and American Osteopathic (AOA)-accredited medical schools.[22]

The situation also exposed inherent inequities in the system. Those who required testing accommodations were even further disadvantaged as they could not use the online system. People with learning disabilities, mobility impairments, type 1 diabetes, and anyone who was pregnant or breastfeeding was required to reschedule their exam by phone during business hours and often encountered hours-long waits. Additionally, equity concerns were raised when the National Board of Medical Examiners (NBME) announced that an abbreviated version of the examinations would be made available to those participating in event-based testing held at medical schools in July and August. The proposed changes would have cut approximately two hours from the total eight-hour test time. The shorter version also included the elimination of experimental questions, which are not scored but are used to determine whether they are valid indicators of a test-taker's performance. This plan met with an immediate backlash, and the USMLE announced on June 9, 2020, that a reduced-length test would not be offered to students taking Step 1 and Step 2 CK exams.[23]

Additionally, on May 26, 2020, the USMLE announced that Step 2 Clinical Skills (CS) exams would be suspended for a period of 12 to 18 months.[23] Step 2 CS aims to examine clinical skills in a performance-based setting; its primary purpose is medical licensure. Additionally, Step 2 CS is an important metric for international medical graduates looking to match into a U.S. residency program. Successful completion of Step 2 CS is a graduation requirement to begin the first year of residency. Suspension of the exam made meeting that requirement impossible for some medical students in the upcoming residency application cycle. A variety of factors influenced the suspension of Step 2 CS, including discouragement of non-essential travel as well as health and safety risks associated with using standardized patients.[24]

Similar to Prometric, the National Board of Osteopathic Medical Examiners' (NBOME) National Center for Clinical Skills Testing (NCCST), which administers the COMLEX-USA Level 2-Performance Evaluation, also temporarily closed its testing center due to COVID-19. On June 3, 2020, the NBOME announced its decision to postpone resumption of COMLEX-USA Level 2-PE testing until September 1, 2020. The scheduling change has complicated the ability of some students with 2021 graduation dates to complete examinations by the end of the 2020-21 academic year and has impacted DO students differently than their MD student counterparts. Following that decision, the Commission on Osteopathic College Accreditation (COCA) announced its decision to allow deans at colleges of osteopathic medicine to waive the requirement to pass the COMLEX Level 2-PE clinical skills exam for 2021 graduates.[25] Concerns have been raised by both DO and MD students regarding the differences in NBME & NBOME policies regarding testing during COVID-19.

The process for residency interview and selection was also impacted by COVID-19. The Coalition for Physician Accountability (CPA)—a national group of organizations concerned with the oversight, education, and assessment of medical students and physicians throughout their medical careers and of which the AMA is a member—issued recommendations concerning three major issues facing applicants and training programs as they prepare for the 2020-2021 residency

application cycle: away rotations, in-person interviews for residency, and the ERAS® (Electronic Residency Application Service) timeline. Specifically, the CPA recommended discouraging away rotations with limited exceptions; committing to online interviews and virtual visits for all applicants rather than in-person interviews for the entire cycle; and delaying both the opening of ERAS® for residency programs and the release of the medical student performance evaluation.[26]

These recommendations were not without consequences. For example, participation in away rotations is especially common within the competitive surgical subspecialties. In many of these fields, 50 percent or more of students completing away rotations match at a program where they rotated so suspension of these rotations could weaken students' applications.[27] Furthermore, as regions of the United States lift social distancing measures at different times throughout the coming year, a potential inequity could be created if some institutions accept external students for clinical rotations while other programs do not. Additionally, students attending school in an area where they must remain quarantined may be disadvantaged if students in other geographic areas are able return more quickly to clinical activities and travel to externship rotations.[27] Additional concerns were raised regarding the removal of financial constraints from in-person interviews, leading to a rise in qualified applicants over-applying for the limited number of available residency slots. Prior to COVID-19, the number of interviews an applicant could attend was limited by time and travel expense, but these constraints will be less relevant with virtual interviews. Students who are fearful of how their applications will be evaluated may respond by applying to even more programs and accepting more interview invitations which could lead to an increase in both the number of unmatched applicants and unfilled programs.[28]

To support and protect medical students during this time of uncertainty, the AMA Council on Medical Education developed guiding principles for conscientious oversight of the deployment of medical students. (see Appendix 2).

THE IMPACT OF COVID-19 ON U.S. GRADUATE MEDICAL EDUCATION

The process for onboarding early graduation medical students into residency programs was an evolving one beginning in April 2020. At NYU Langone Health, early graduates were initially anticipated to be supplemental to the teams caring for non-COVID-19 patients. However, due to the demand, these graduates were integrated into the health system's internal medicine and emergency medicine departments regardless of their match specialty. While both the current residents and early graduates expressed concerns about the transition from medical school to the wards during a national pandemic, NYU created a boot camp for them to address circumstances specifically related to COVID-19. The curriculum focused on the proper use of PPE, treatment protocols related to the virus, physician and patient isolation, and the moral distress physicians may feel treating COVID-19 patients. NYU also paired early graduates with residents who were not on service during the boot camp as part of the orientation.[29] To conform with their Match agreements, early graduates were not part of any specific residency program at NYU. Under an executive order from New York Governor Andrew Cuomo, graduates of medical schools accredited by the LCME and AOA, and matched into an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency program in or outside New York, were eligible to temporarily practice medicine in New York under the supervision of a licensed physician prior to reporting to their matched program and did not have to apply for a license to do so.

Residents have been on the front lines during the COVID-19 response and like other health care workers, experienced some of the highest exposure risk situations and have the same need for PPE. Unfortunately, health care systems across the United States have reported substantial PPE shortages since the start of COVID-19 pandemic, compromising their ability to keep health care

professionals (including residents) safe while treating increasing numbers of patients.[30] The situation became so dire that some providers utilized social media with tags like #GetMePPE to raise public awareness. The Society for Healthcare Epidemiology of America (SHEA) conducted a survey in April 2020, among epidemiologists and infectious disease specialists at health care facilities in the United States, Canada, and abroad regarding how their facilities were adapting their PPE policies as shortages and knowledge about the coronavirus evolved. SHEA found that 52 percent of respondents said they had to ask health care workers in certain hospital units to use the same disposable N95 respirator for a whole day, 71 percent who reported PPE at "limited" or "crisis" levels practiced extended respirator use or reuse, and 48 percent said they reprocessed respirators. Some health care workers used surgical or cloth masks over their respirators and stored them in a paper bag to preserve them for reuse. Moreover, 59 percent of respondents who said their hospitals' supply of gowns was "limited" or "crisis-level" were having to wear gowns for an extended time or reuse them, and 13 percent said they were making their own PPE, including face shields, eye shields, coveralls, gowns, and surgical masks.[31]

Involvement of residents and fellows in COVID-19 care has varied by specialty and rapidly evolved. Some of these residents may have cared for patients with COVID-19 during assigned rotations. Others were asked to assume roles that were not a prescribed part of their specialty training, being deployed to medical units and emergency departments away from their roles in operating rooms and outpatient clinics. Residents may have been compelled to acquire skills on the job that were not an expectation when they began residency. Furthermore, time spent providing these services may not meet the requirements for graduation and certification in their discipline, leading to concerns that their training may need to be extended when routine clinical duties resume. Additionally, some subspecialty fellows were asked to serve in attending physician roles in their core disciplines (e.g., gastroenterology fellows serving as general internal medicine attending physicians). While they may have been board-certified in these specialties, their compensation and malpractice coverage were not guaranteed to be commensurate with the role. This is important, since resident salaries are low compared to those of other health care workers, particularly on an hourly basis. Given average resident salaries and an 80-hour work week, resident salaries equate to approximately $15 to $20 per hour. In addition, residents carry significant debt loads related to their undergraduate medical education. The average student loan burden at medical school graduation exceeds $200,000.

COVID-19 also highlighted the need for flexibility in GME reimbursement. Medicare GME affiliated group agreements are often in place at the beginning of the academic year (i.e., prior to July 1) to transfer cap slots between institutions and allow the host institution to claim the inbound rotator for reimbursement. If a rotation is canceled, the home hospital may find itself claiming more resident full-time equivalents (FTEs) than its cap allows, and the host hospital may find itself with more cap slots than resident FTEs it has to claim, impacting the GME reimbursement for both. It should be noted, however, that it is possible to amend a Medicare GME affiliated group agreement during the ongoing academic year (i.e., prior to June 30), provided that any changes are made only to the original parties to the agreement. Additionally, financial issues may arise if residents become "off cycle" and require additional time to complete their training. Residents are only eligible for funding for the accredited length of their program, and additional time is not reimbursed by the Centers for Medicare & Medicaid Services (CMS).

On top of the issues already presented, some residents who became ill and/or required quarantine while caring for COVID-19 patients learned that their residency program leave policies did not adequately account for these unplanned absences during the pandemic response. In response to the concerns of residents and fellows, the AMA developed guidance for residency programs to

adequately address the personal, physical, and economic stresses that trainees face. Some key points of the guidance include:

- Residents who become ill as a result of their participation in the COVID-19 response must not be required to use vacation or personal time off while ill or quarantined.
- Residents who require leave under these circumstances must continue to receive their salary and benefits.
- Residents deployed to clinical areas unfamiliar to them must receive appropriate training and supervision for the tasks they will be asked to perform.
- Clinical work that residents perform during the pandemic response should be considered in assessments of a trainee's qualifications for program completion. Where possible, credit should be given for the work residents are doing during this time.
- Bodies overseeing certification requirements should allow flexibility in assessments of the competence of trainees, in light of the pandemic. Where possible, these assessments should not delay program completion nor eligibility for certification.
- Fellows who assume attending physician roles in core disciplines in which they are licensed and certified should receive pay and benefits commensurate with these roles. The impact of this activity on progress toward completion of the training program must be openly discussed with fellows prior to them assuming these responsibilities.

The guiding principles to protect resident and fellow physicians responding to COVID-19 are featured in Appendix 3.

THE IMPACT OF COVID-19 ON INTERNATIONAL MEDICAL GRADUATES ENTERING GME PROGRAMS IN THE U.S.

As states called for more doctors to help meet the demand of the growing number of COVID-19 cases, non-U.S. citizen international medical graduates (IMGs) faced unique challenges that prevented them from responding due to visa limitations. Currently, non-U.S. citizen IMGs with H-1B visas and J-1 waivers face restrictions on where they can work.[32] Furthermore, the U.S. Citizenship and Immigration Services (USCIS) announced on March 20, 2020, its suspension of premium processing for all Form I-129, Petition for a Nonimmigrant Worker and I-140, Immigrant Petition for Alien Workers due to the coronavirus (COVID-19) pandemic.[33] This suspension was anticipated to exacerbate physician shortages, particularly in rural areas, and at the leading academic and research organizations that depend on health care provided by non-U.S. citizen IMGs. On April 9, 2020, U.S. Senators Dick Durbin (D-IL), Tammy Duckworth (D-IL), Amy Klobuchar (D-MN) along with colleagues in both the House and the Senate wrote a bipartisan, bicameral letter urging the Administration to resume premium processing for physicians seeking employment-based visas.[34] On May 29, 2020, USCIS announced it would resume premium processing for Form I-129 and Form I-140 in phases beginning June 1, 2020.[35] Moreover, USCIS announced that non-U.S. citizen IMGs can deliver telehealth services during the public health emergency without having to apply for a new or amended Labor Condition Application and that it is temporarily waiving certain immigration consequences for failing to meet the full-time work requirement.

On June 22, 2020, the President of the United States issued a Presidential Proclamation. As it pertains to physicians, the Proclamation states that there are exemptions for:

- Sec. 4(a)(i)… [individuals who] are involved with the provision of medical care to individuals who have contracted COVID-19 and are currently hospitalized; are

involved with the provision of medical research at United States facilities to help the United States combat COVID-19…

- Or Sec. 3(b)(iv) any alien whose entry would be in the national interest as determined by the Secretary of State, the Secretary of Homeland Security, or their respective designees.

J-1 physicians have been given an exemption from the June 22, 2020 Proclamation. However, the Proclamation still applies to most H-1B physicians. Per the AMA letter to Vice President Pence sent on May 4, 2020, urging the Administration to allow J-1, H-1B, and O-1 International Medical Graduates (IMGs) to be exempt from any future immigration bans or limitations, AMA has been aware of, and advocating against, any physician immigration bans since before this Proclamation was issued.

In response to the Proclamation, the Department of State (DOS) issued a statement that "as resources allow, embassies and consulates may continue to provide emergency and mission-critical visa services. Mission-critical immigrant visa categories include applicants who may be eligible for an exception under these presidential proclamations, such as…certain medical professionals." As such, on June 26, 2020, the AMA sent a letter to the Department of Homeland Security (DHS) and the Department of State strongly urging the Administration to consider J-1 and H-1B IMGs and their families' entry into the U.S. to be in the national interest of the country so that families can remain together and non-U.S. citizen IMG physicians can immediately begin to provide health care to U.S. patients. The AMA understands that every physician is mission critical, especially at this time. Moreover, the AMA spearheaded a sign-on letter for specialty societies. The letter urges the DOS and DHS to issue clarifying guidance pertaining to the Proclamation by directing Consular Affairs to advise embassies and consulates that H-1B physicians and their dependent family members' entry into the U.S. is in the national interest of the country.

On July 6, 2020, the Student and Exchange Visitor Program (SEVP) announced that nonimmigrant F-1 and M-1 students attending schools operating entirely online could not take a full online course load and enter or remain in the United States. In response, on July 9, 2020, the AMA sent a letter urging the Administration to withdraw its modifications to the temporary exemptions for nonimmigrant students taking online classes due to the pandemic for the Fall 2020 semester, so that medical students seeking to study in the U.S. on an F-1 visa could enter or remain in the country. In part due to the advocacy efforts of the AMA, on July 14, 2020, the Trump Administration rescinded the directive.

In addition to advocating for non-U.S. citizen IMGs, the AMA developed guidance to help ensure that visa-related issues do not prevent non-U.S. citizen IMGs from continuing to care for patients during COVID-19; this document is featured in Appendix 4.

THE IMPACT OF COVID-19 ON EFFORTS TO INCREASE DIVERSITY AMONG MEDICAL STUDENTS AND RESIDENTS

As medical school enrollment doubled over the past two decades, the percentage of entering under-represented students actually fell by 16%.[36] Even prior to COVID-19, national data suggested medical education was already losing ground with respect to racial and ethnic parity. Diversity efforts are particularly vulnerable during times of disruption; hence institutions must heighten their commitment of attention and resources. Current disruptions related to COVID-19 may amplify underlying inequities in our educational system, similar to the pandemic's role in exacerbating health inequities. Broader initiatives to foster long-term change in medicine and address inequities in the entire United States educational system are imperative and are underway. To support these

efforts, the AMA developed guidance to protect underrepresented students and residents during COVID-19; this document is featured in Appendix 5.

THE IMPACT OF COVID-19 ON CONTINUING MEDICAL EDUCATION IN THE U.S.

With the increased demand for physicians to respond to COVID-19 cases, many physicians who had left practice had a desire to return. Like many professionals, physicians take time off to raise children, care for sick family members, or recover from their own illnesses. Some also switch to non-clinical jobs. But efforts to return to medicine are more difficult than in most careers, as clinical change occurs quickly. Drugs, devices, and surgical techniques that were standard a decade ago may now be obsolete, and a returning doctor's skills may simply be outdated. The AMA defines physician re-entry as "a return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment." Re-entry is a complicated, time-consuming, and expensive process. While inactive physicians may not lose their licenses, they must complete a physician reentry program if they stop practicing for a certain length of time (it varies by state but averages about three years). Unfortunately, there is a dearth of training programs for physicians who have already completed residency training and need retraining.[37] Reentry programs also cost most returning physicians between $3,000 and $10,000 per month, not including travel and relocation costs for the duration of the training. While each program has different features, they all require some type of assessment to determine the physician's skill set and clinical competence. After completing a reentry program, physicians who have let their license lapse have to petition their state board to reactivate it. Once licensure is granted, reentering physicians can then obtain hospital privileges and insurance coverage.

Likewise, many senior and retired physicians may have either wanted to return to work or were called upon to do so during the COVID-19 outbreak, which raised additional considerations. For example, the licensure status of retired physicians varies by state. In some states retired physicians maintain their regular license, while others create a separate category for retired or inactive physicians, and still others have no license category for retired physicians. The path to reentry from a licensing perspective also varies. For senior and retired physicians who maintain active licenses, there are no licensure restrictions on re-entry to practice. For physicians who maintain an inactive, retired physician, or similar license, their state may have temporarily waived any barriers to re-entry due to COVID-19.

The issue of whether senior physicians should be providing direct patient care for COVID-19 patients is a complex one that must balance a number of factors, such as whether the age of the physician and their family members puts them in a high risk group, whether PPE is readily available, and whether they can contribute meaningfully in a non-direct patient care role.

The Federation of State Medical Boards (FSMB) has developed a repository of state-issued guidelines for expediting licensure for health care workers whose licenses are inactive or expired. As of June 9, 2020, 39 states issued guidelines waiving some of the requirements for physician reentry in response to COVID-19, though most require that physicians be recently retired (within the last two to five years).[38] Forty-nine state medical boards have policies or regulations that dictate what physicians need to do to reenter medicine after "an extended period of clinical inactivity." That period differs for each state but ranges from 1 to 10 years. After the designated time allotment, the board usually requires an evaluation before granting a license to practice medicine.

Additional factors that need to be considered for senior physicians looking to go back to work include professional and medical liability, clarification of roles, and the effect of income on

retirement status. The AMA developed a resource guide, featured in Appendix 6, to assist senior physicians as they consider these important issues.

THE IMPACT OF COVID-19 ON THE MENTAL HEALTH OF STUDENTS, RESIDENTS, AND PHYSICIANS

Critical stressors for medical students, residents, and physicians during COVID-19 are the uncertainty surrounding the pandemic; trauma associated with knowing there is a risk to one's own health; and concern for the safety and well-being of one's patients, as well as one's family and friends.[39] Many students reported moral distress associated with watching patients in isolation from loved ones and described feeling distant from patients while wearing PPE as well as disappointment and frustration about not being able to help. Safety concerns among residents and fellows are complicated by the recognition that their decisions had implications for their loved ones and others outside the hospital. Some worried about transmitting infection to others in their homes. Feelings of vulnerability were exacerbated by rapidly changing conditions and recommendations. The fear of potential PPE shortages was prominent. Trainees not providing COVID-19 care because of personal health issues expressed guilt that colleagues had to step in. These feelings of anxiety and vulnerability among students and trainees compete internally with a desire and commitment to serve the sick.[39] A recent study reported in *JAMA* found that front-line health care workers who have been exposed to COVID-19 have a high risk of developing unfavorable mental health outcomes and may need psychological support or interventions.[41] However, many students, residents, and physicians continue to do more than has been required of them for patient care and within the community, despite the risks and challenges of COVID-19.

The AMA developed a guide, "Caring for our caregivers during COVID-19," for health system leadership to consider when supporting their physicians and care teams during COVID-19. The guide provides practical examples and strategies to encourage well-being and improve physician satisfaction as well as valuable strategies that address workload redistribution, institutional policies, meals, childcare, attention to emotional and mental well-being, and connecting with others. This guide is featured in Appendix 7.

EFFORTS BY KEY STAKEHOLDERS TO ADDRESS ISSUES ACROSS THE CONTINUUM OF EDUCATION, TRAINING, LICENSURE, CERTIFICATION, AND CREDENTIALING

The LCME is officially recognized by the U.S. Department of Education to accredit medical school programs leading to the MD degree in the United States and Canada. It is jointly overseen by the AAMC and AMA but is an independent organization. To achieve and maintain accreditation, a medical education program must meet the LCME accreditation standards and is required to demonstrate that their graduates exhibit general professional competencies appropriate for entry to the next stage of their training and that serve as the foundation for lifelong learning and proficient medical care. The LCME developed and disseminated numerous resources to offer guidance to medical schools during COVID-19. The LCME guiding principles are featured in Appendix 8.

The COCA accredits medical school programs granting the DO degree in the United States. COCA is recognized by the U.S. Department of Education as the accreditor of colleges of osteopathic medicine. COCA accreditation signifies that a college has met or exceeded the Commission's standards for educational quality. COCA developed and disseminated numerous resources to offer guidance to colleges of osteopathic medicine related to COVID-19. The guidance developed by COCA can be found on its website (https://osteopathic.org/accreditation/coca-covid-19/).

The National Resident Matching Program® (NRMP®), or The Match®, is a private, non-profit organization established to provide an orderly and fair mechanism for matching the preferences of applicants for U.S. residency positions with the preferences of residency program directors. NRMP created Frequently Asked Questions (FAQs) to address questions regarding the applicant transition to GME during the COVID-19 crisis. FAQs developed by NRMP can be found on its website (http://www.nrmp.org/covid-faqs-2-2/)

The ACGME is an independent, not-for-profit, physician-led organization that sets and monitors the professional educational standards essential to preparing physicians who deliver safe, high-quality medical care to all Americans and monitors compliance with those standards. During COVID-19, the ACGME has monitored the needs of the GME community and provided guidance, clarification, and resources. ACGME resources specific to COVID can be found on its website (https://acgme.org/COVID-19/ACGME-Guidance-Statements).

The Educational Commission for Foreign Medical Graduates (ECFMG) assesses the readiness of IMGs to enter residency or fellowship programs in the United States that are accredited by the ACGME. The ECFMG also acts as the registration and score-reporting agency for the USMLE for IMGs. It conducts three examinations: Step 1, Step 2CK, and Step 2CS. The ECFMG certificate is issued to physicians who pass the three exams within seven years. The ECFMG developed resources and launched a COVID-19 specific newsletter during the pandemic. These resources are available on the ECFMG website (https://www.ecfmg.org/annc/covid-19-coronavirus.html).

The NBME is an independent, not-for-profit organization that serves the public through its high-quality assessments of health care professionals. The NBME is also a co-sponsor of the USMLE®. The NBME provided updates related to assessments during COVID-19 which can be found on its website (https://www.nbme.org/news/coronavirus-covid-19-assessment-information-and-updates)

The American Board of Medical Specialties (ABMS) is an independent, not-for-profit organization founded to set professional standards for physician practice and board certification. The ABMS and its 24 Member Boards aim to improve the quality of health care by elevating the discipline of specialty medicine through board certification. The ABMS developed numerous resources for diplomates and their fellow health care professionals which can be found on its website (https://www.abms.org/initiatives/covid-19-information/).

The FSMB is a national, non-profit organization that represents the state medical and osteopathic boards of the United States and its territories. FSMB also co-sponsors the USMLE®. The FSMB developed recommendations for medical license portability during COVID-19 and other resources which can be found on its website (https://www.fsmb.org/advocacy/covid-19/).

The CPA is a cross-organizational group of national medical education organizations, including the AMA, concerned with the oversight, education, and assessment of medical students and physicians throughout their medical careers. During COVID-19, the CPA created several work groups to develop common recommendations to address urgent issues related to the COVID-19 pandemic and physician education. “Maintaining Quality and Safety Standards Amid COVID-19” is a product of one of the work groups and offers guidance for health care administrators and credentialing staff members supporting the contributions of new or volunteer physicians during the COVID-19 pandemic. This product is featured in Appendix 9.

RELEVANT AMA POLICY

The AMA has developed several policies in response to addressing pandemics. These policies are featured in Appendix 1.

SUMMARY

The rapid spread of COVID-19 disrupted life, including medical education. Fortunately, the response of key stakeholders was equally rapid and multifactorial. Strategic planning for future pandemics needs to focus on equipping individuals at various points in their medical careers to redeploy while ensuring patient safety. As many of the issues presented in this report are interrelated, it will also be necessary for key stakeholders to collaborate to minimize negative unintended consequences for students, residents, physicians, and most importantly patients. The Council on Medical Education expects there to be evolving issues related to COVID-19 and will continue to monitor the evolution.

APPENDIX 1: RELEVANT AMA POLICY

9.2.1, "Medical Student Involvement in Patient Care"

Having contact with patients is essential for training medical students, and both patients and the public benefit from the integrated care that is provided by health care teams that include medical students. However, the obligation to develop the next generation of physicians must be balanced against patients' freedom to choose from whom they receive treatment.

All physicians share an obligation to ensure that patients are aware that medical students may participate in their care and have the opportunity to decline care from students. Attending physicians may be best suited to fulfill this obligation. Before involving medical students in a patient's care, physicians should:

(a) Convey to the patient the benefits of having medical students participate in their care.

(b) Inform the patients about the identity and training status of individuals involved in care. Students, their supervisors, and all health care professionals should avoid confusing terms and properly identify themselves to patients.

(c) Inform the patient that trainees will participate before a procedure is undertaken when the patient will be temporarily incapacitated.

(d) Discuss student involvement in care with the patient's surrogate when the patient lacks decision-making capacity.

(e) Confirm that the patient is willing to permit medical students to participate in care.

9.2.2, "Resident & Fellow Physicians' Involvement in Patient Care"

Residents and fellows have dual roles as trainees and caregivers. Residents and fellows share responsibility with physicians involved in their training to facilitate educational and patient care goals.

Residents and fellows are physicians first and foremost and should always regard the interests of patients as paramount. When they are involved in patient care, residents and fellows should:

(a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care. They should notify the attending physician if a patient refuses care from a resident or fellow.

(b) Participate fully in established mechanisms in their training programs and hospital systems for reporting and analyzing errors. They should cooperate with attending physicians in communicating errors to patients.

(c) Monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting" or other activities that interfere with adequate rest during off hours) might be harmful to themselves and patients.

Physicians involved in training residents and fellows should:

(d) Take steps to help ensure that training programs are structured to be conducive to the learning process as well as to promote the patient's welfare and dignity.

(e) Address patient refusal of care from a resident or fellow. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from the patient's care. If appropriate, the physician may transfer the patient's care to another physician or nonteaching service or another health care facility.

(f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise.

(g) Observe pertinent regulations and seek consultation with appropriate institutional resources, such as an ethics committee, to resolve educational or patient care conflicts that arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully.

11.1.3, "Allocating Limited Health Care Resources"

Physicians' primary ethical obligation is to promote the well-being of their patients. Policies for allocating scarce health care resources can impede their ability to fulfill that obligation, whether those policies address situations of chronically limited resources, such as ICU (intensive care unit) beds, medications, or solid organs for transplantation, or "triage" situations in times of scarcity, such as access to ventilators during an influenza pandemic.

As professionals dedicated to protecting the interests of their patients, physicians thus have a responsibility to contribute their expertise to developing allocation policies that are fair and safeguard the welfare of patients.

Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients, in keeping with the following criteria:

(a) Base allocation policies on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics.

(b) Give first priority to those patients for whom treatment will avoid premature death or extremely poor outcomes, then to patients who will experience the greatest change in quality of life, when there are very substantial differences among patients who need access to the scarce resource(s).

(c) Use an objective, flexible, transparent mechanism to determine which patients will receive the resource(s) when there are not substantial differences among patients who need access to the scarce resource(s).

(d) Explain the applicable allocation policies or procedures to patients who are denied access to the scarce resource(s) and to the public.

H-140.900, "A Declaration of Professional Responsibility"

Our AMA adopts the Declaration of Professional Responsibility

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE's SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to: (1) Respect human life and the dignity of every individual. (2) Refrain from supporting or committing crimes against humanity and condemn any such acts. (3) Treat the sick and injured with competence and compassion and without prejudice. (4) Apply our knowledge and skills when needed, though doing so may put us at risk. (5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others. (6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being. (7) Educate the public and polity about present and future threats to the health of humanity. (8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being. (9) Teach and mentor those who follow us for they are the future of our caring profession. We make these promises solemnly, freely, and upon our personal and professional honor.

H-295.860, "Promoting Transparency in Medical Education and Access to Training"

Our American Medical Association: (1) strongly encourages medical schools and graduate medical education training programs to communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities at their respective institutions; and (2) will work with the Accreditation Council for Graduate Medical Education and other appropriate stakeholders to support transparency within medical education, recommending that medical schools and graduate medical education training programs communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities.

H-295.868, Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training

1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs.

2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness.

3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians.

4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs.

5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG).

6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education.

7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies.

8. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices.

9. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision.

10. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency.

11. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical Response Corps and American Red Cross, and not as spontaneous volunteers.

12. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency.

H-295.939, Protecting Medical Trainees from Hazardous Exposure

1. Our AMA will encourage all health care-related educational institutions to apply the Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen standard and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows.

2. Our AMA recommends: (a) that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site; (b) (i) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and (ii) that medical school policies on continuity of educational requirements toward degree completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to minimize the risks of hazardous exposures that may affect the trainee's and/or fetus' personal health status; (c) that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff; and (d) medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff.

H-310.912, Residents and Fellows' Bill of Rights

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

H-310.929, Principles for Graduate Medical Education

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.
Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.
(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES
Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate

degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.
(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.
(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.
(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

H-440.835, "AMA Role in Addressing Epidemics and Pandemics"

1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members. 3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.
4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels. 5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola. 6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.

H-440.847, Pandemic Preparedness for Influenza

In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the

CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.

APPENDIX 2: AMA GUIDING PRINCIPLES TO PROTECT LEARNERS RESPONDING TO COVID-19

Updated May 1, 2020

This article is part of a series of COVID-19 articles and resources on medical education.
In their efforts to meet workforce demands in response to COVID-19, medical schools and health systems must make responsible decisions about engaging medical students. There are many opportunities for students to contribute to the clinical care of patients without engaging in direct physical contact with patients. However, in some institutions the workforce demands may be great enough that it is appropriate to consider including medical students in direct patient care.

Some students may be permitted to graduate early from medical school and may subsequently contribute as employed members of medical staffs prior to entering their planned residency training. Some students may be enlisted while retaining the status of student, on a voluntary basis, with appropriate supervision and with attention to infection control.

It is the responsibility of the AMA to support and protect medical students as we rely on them during this time. We stand with key stakeholders across the continuum of medical education, including but not limited to the Association of American Medical Colleges, Liaison Committee on Medical Education LCME), Accreditation Council for Graduate Medical Education, American Osteopathic Association, American Association of Colleges of Osteopathic Medicine and the Educational Commission for Foreign Medical Graduates in support of conscientious oversight of the deployment of medical students. The AMA Council on Medical Education recommends observance of the following principles:

For all institutions engaging medical students in physical contact with patients:

1. Thoughtful planning will allow the safe re-engagement of students in the direct care of patients and thus support the continuation of student training. For required coursework involving direct patient contact, schools should provide reasonable accommodations to learners who are unable to participate.
2. Medical students should be included in conversations as direct patient interaction activities are being explored, developed and implemented.
3. Medical students must be provided proper training and oversight in the use and reuse of personal protective equipment (PPE). This includes fit testing for N95 or other respirators, donning and doffing of enhanced PPE, and institutional policies related to the use of one's own PPE to augment hospital-supplied PPE.
4. Appropriate COVID-19 testing protocols for students and health care workers should be in place to reduce risk of transmission and to monitor trends in disease burden among students.
5. Each clinical environment in which students will come into direct contact with patients should be assessed for safety and educational readiness, including:
    - Burden of COVID-19 exposure
    - Stability of care protocols and clarity of roles
    - Appropriate patient mix to support learning goals
    - Faculty capacity to provide supervision, teaching and feedback
6. Health systems and medical schools should support the wellbeing of all providers and recognize that learners face an added stressor of uncertainty about their educational pathways.
7. Medical students should not be financially responsible for diagnosis and treatment of their own disease should they become ill due to care of COVID-19 patients through school-approved activities.
8. Medical schools should use a competency-based approach to redesign educational and assessment activities, considering alternatives to direct patient contact to meet desired learning outcomes.
9. Medical schools should work with the LCME to identify viable options to assess students' competency and meet curricular requirements in order to avoid, to the extent possible, any delay in medical students' graduation or progression in medical school.

Additionally, for institutions implementing early graduation to allow students to join the physician workforce:

10. Early graduation should be enacted on a voluntary basis and founded upon attainment of core competencies.
11. To the extent possible, early graduates should serve under the supervision of an approved graduate medical education program.
12. Medical school graduates should not be compelled to work for their matched residency institution prior to the intended date of employment.
13. Institutions deploying early graduates should grant these providers full status as health care employees with appropriate salary and benefits, while continuing efforts to mitigate their personal risk.
14. Institutions and medical school graduates should remain mindful of graduates' contractual obligations to their matched residencies, including consideration of the potential for quarantine and/or illness due to care of COVID-19 patients.
15. Financial institutions overseeing all loans, public and private, for medical school graduates deployed into the workforce between graduation and beginning residency should exercise forbearance and/or forgiveness of debt service during this time.

APPENDIX 3: GUIDING PRINCIPLES TO PROTECT RESIDENT & FELLOW PHYSICIANS RESPONDING TO COVID-19

Updated April 13, 2020

This article is part of a series of COVID-19 articles and resources on medical education.

Background
There are over 135,000 residents and fellows ("residents") working in graduate medical education (GME) programs in the United States. They are participating in supervised clinical experiences that will qualify them for certification and independent practice in a wide array of medical specialties. While acquiring this experience, residents are the frontline physician workforce in the health systems that employ them.

During the response to the COVID-19 pandemic, residents are experiencing personal, physical and economic stresses. Many of these stresses are common to all health care workers affected by the pandemic; some are unique to their status as employed trainees. These include the following:

- Residents are on the front lines during the COVID-19 response and like other health care workers, such as first responders and ED nurses, experience some of the highest risk situations for exposure and have the same need for personal protective equipment (PPE). They are at personal risk, and their work creates a risk to family members. Residents themselves may become ill and/or require quarantine while caring for COVID-19 patients, and residency program leave policies may not adequately account for these unplanned absences during the pandemic response.
- During the response to COVID-19, many residents are being asked to assume roles that are not a prescribed part of their specialty training, being deployed to medical units and emergency departments from their roles in operating rooms and outpatient clinics. Their preparation for these roles is variable, and residents may be compelled to acquire skills on the job that were not an expectation when they began residency. Furthermore, time spent providing these services may not meet the requirements for graduation and certification in their discipline, leading to concerns that their training may need to be extended when routine clinical duties resume.
- Some subspecialty fellows are being asked to serve in attending physician roles in their core disciplines (e.g., gastroenterology fellows serving as general internal medicine attending physicians). While they may be board certified in these specialties, their compensation and malpractice coverage may not be commensurate with the role.
- Resident salaries are low compared to those of other health care workers, particularly on an hourly basis. Given average resident salaries and an 80-hour work week, resident salaries equate to approximately $15 to $20/hour. In addition, residents carry significant debt loads related to their undergraduate medical education. The average student loan burden at medical school graduation exceeds $200,000.
- Residents are particularly vulnerable in their negotiating ability as a labor force. Although they are employed health care workers, their status as trainees makes them dependent upon their employer for their professional development. As such, their influence over the environment in which they work is limited.

Guiding principles
In managing the engagement of residents during the response to COVID-19, the AMA Council on Medical Education strongly supports observance of the following principles by programs, sponsoring institutions and national organizations:

1. Residents must be actively engaged in COVID-19 response planning regarding deployment of health care workers, including field promotion of fellows to attending roles, in order for the specific interests of trainees to be considered.
2. Residents must be free to raise concerns about their personal safety and the safety of those around them without recrimination or consequence to their employment and training.
3. Residents must have access to, and instruction in, the use of adequate personal protective equipment (PPE), as should all health care workers.
4. Residents deployed to clinical areas with which they are unfamiliar must receive appropriate training and supervision for the tasks they will be asked to perform.

5. Residents who become ill as a result of their participation in the COVID-19 response must not be required to use vacation and/or personal time off while ill and/or quarantined. Residents who require leave under these circumstances must continue to receive their salary and benefits.
6. Sponsoring institutions and residency programs must continue to comply with the Accreditation Council for Graduate Medical Education (ACGME) requirement to provide access to confidential, affordable mental health assessment, counseling and treatment, including access to urgent and emergency care 24 hours a day, seven days a week.
7. The clinical work that residents perform during the pandemic response must be considered in assessments of a trainee's qualifications for program completion. Where possible, credit should be given for the work residents are doing during this time.
8. The ACGME review committees (RCs), the American Board of Medical Specialties (ABMS) specialty boards and the American Osteopathic Association (AOA) specialty boards should consider their program and certification requirements, in light of the pandemic, to allow flexibility in assessments of the competence of trainees. Where possible, these assessments should not delay program completion nor eligibility for certification.
9. Residents must be permitted to remain in their programs to complete necessary requirements that qualify them for board certification. They must continue to receive salary and benefits and have access to necessary clinical experiences.
10. Residents should be candidates for hazard pay in a way that is equitable to other health care workers.
11. Residents should be granted forgiveness and/or forbearance for all or portions of their student loan debt to ease the financial stress they may experience in caring for themselves and their families. This is particularly important during this time of compromised access to opportunities to supplement their income, such as moonlighting.
12. Fellows who assume attending physician roles in core disciplines in which they are licensed and certified should receive pay and benefits commensurate with these roles. The impact of this activity on progress toward completion of the training program must be openly discussed with fellows prior to them assuming these responsibilities.
13. The Centers for Medicare & Medicaid Services (CMS) should ensure flexibility in GME reimbursements to hospitals to accommodate variations in training due to the COVID-19 response. This flexibility should lengthen the initial residency period (IRP) for residents to allow them to extend their training, if necessary, to meet program and board certification requirements. In addition, CMS should expand the residency funding cap at institutions where residents must extend their training, in order to support an increased number of residents, as new trainees begin, while existing trainees remain to complete their programs.
14. As hospitals and health systems confront the economic impact of the pandemic response, we urge early consideration of effects on the training environment and the sustainability of GME programs. Health systems should also proactively manage opportunities for residents to continue their professional development.
15. In the event of program contraction or closure that may result from the pandemic response, disruptions to resident education may be mitigated through active planning for resident relocation. In the event of closures, the AMA stands with other organizations ready to assist should the need arise.

APPENDIX 4: COVID-19 FAQS: GUIDANCE FOR INTERNATIONAL MEDICAL GRADUATES

Updated June 26, 2020

International Medical Graduate (IMG) physicians are a critical part of the U.S. health care workforce. During the COVID-19 pandemic, the AMA is advocating for IMG physicians, whether currently licensed to practice in the U.S. or seeking such licensure, and helping to ensure that visa-related issues do not stop their ability to continue to care for patients during this challenging time.

FAQs about the work the AMA is doing to support IMGs

How is the AMA working to ensure that I am supported after the COVID-19 pandemic subsides?
Ensuring that underserved and under-resourced communities have ample access to physicians is a chronic challenge in normal times, and the COVID-19 pandemic is expected to exacerbate this issue. Physicians practicing in underserved communities either via an H-1B visa or as part of the Conrad State 30 program play a key role in providing much needed health care to vulnerable populations. As such, we are supporting and working with U.S. Senator Amy Klobuchar, U.S. Representative Bradley Schneider, and the other bipartisan, bicameral Congressional members to pass legislation that will increase the number of doctors in rural and other medically underserved areas. Additionally, we are continuing to fight against a proposal by U.S. Immigration and Customs Enforcement (ICE) to modify the period of authorized stay for certain categories of nonimmigrants traveling to the United States by eliminating the availability of "duration of status" and by providing a maximum period of authorized stay with options for extensions for each applicable visa category. The AMA joined with other leading organizations in medical education and health care, to urge the Administration to not change duration of status, or to at the very least, exempt medical residents from such a proposal.

FAQs about visa processing

How will COVID-19 impact the processing of my visa?
Originally the U.S. had stopped processing visas. However, the U.S. Department of State (DoS) agreed to begin processing visa applications for foreign-born medical professionals after the AMA urged the DoS to expedite visa processing at U.S. embassies and consulates around the world.
The DoS encourages individuals with an approved U.S. non-immigrant or immigrant visa petition (I-129, I-140 or similar), or a certificate of eligibility in an approved exchange visitor program (DS-2019), to review the website of their nearest embassy or consulate for procedures to request a visa appointment. For any applicants who had an appointment scheduled with an Application Service Center (ASC) after their closure on March 18 or who have filed a Form I-765, Application for Employment Authorization, they will have their application processed using previously submitted biometrics. This announcement is consistent with U.S. Citizenship and Immigration Services' (USCIS) existing ability to reuse previously submitted biometrics. This will remain in effect until ASC resumes normal operations.
Is there premium processing for visas right now?
No. On March 20, 2020, USCIS announced that it will not accept any new requests for premium processing. This temporary suspension includes petitions filed for H-1B visas. The AMA is strongly urging USCIS to reconsider this suspension and to temporarily expand and expediate the premium processing option for H-1B physicians so they can provide health care to U.S. patients during this pandemic.

FAQs for IMG examinees and students

How will my medical licensing examination be affected?
The United States Medical Licensing Examination (USMLE) program is extending eligibility periods for all examinees who currently have a scheduling permit. The eligibility period ending in 2020 will be extended to have an end date of December 2020, regardless of the country in which examinees are testing. Extensions will be processed in order of expiration date, with all extension processing expected to be completed by the week of April 13. Examinees will receive a notification and new scheduling permit when their eligibility extension has been processed. Examinees will need to use the new permit once received. Extending the eligibility period for your Step 1, Step 2 CK, or Step 3 examination will not impact already scheduled

appointments. No fees will be charged for these eligibility extensions. Eligibility periods will be extended automatically, requiring no action from examinees. For more information, visit the USMLE program website which has published a COVID-19 page that includes information and FAQs about its responses to the pandemic.

Can special exceptions be made to allow exchange visitors to renew their J-1 visas without traveling back to their home country?

Exchange visitors currently on an exchange program whose visas have expired and who do not plan to travel outside of the U.S. do not need to renew their visa. If the exchange visitor does travel outside of the United States during their current exchange visitor program and after their J-1 visa has expired, they must apply for a new J-1 visa in their home country in order to re-enter the United States to continue their program. In addition, in accordance with AMA's letter, the State Department announced that J-1 physicians (medical residents) may consult with their program sponsor, to extend their programs in the United States, and confirmed that J-1 physicians can engage in revised clinical training rotations/assignments in keeping with the ACGME's "Response to Pandemic Crisis."

FAQs for IMGs currently practicing in the United States

As a physician on a H-1B visa, can I move to a different location to practice during the COVID-19 pandemic?

A physician on a H-1B visa must obtain a certified Labor Condition Application (LCA) covering each location where the physician will perform services as required under Department of Labor (DOL) regulations. The term "place of employment" means the worksite or physical location where an H-1B nonimmigrant worker actually performs his or her work.

The LCA will apply to any worksites within this "area of employment" meaning the area within normal commuting distance of the place (address) of employment, or worksite, where the H-1B nonimmigrant is, or will be, employed. However, in certain circumstances, an H-1B visa holder can temporarily work in a different geographic location without requiring a new LCA for up to 60 days in a one-year period. Moreover, the AMA is urging the Administration to permit H-1B physicians that are currently practicing in the U.S. with an active license and an approved immigrant petition, to apply and quickly receive authorization, to work at multiple locations and facilities with a broader range of medical services for the duration of the COVID-19 pandemic.

I am a foreign doctor not licensed in the U.S. but with practice experience in another country. How can I assist with the COVID-19 pandemic in my state?

The licensure requirements and steps to practice medicine in the U.S. remain the same. The licensure requirements and steps to practice medicine in the U. S. would require you to have additional years of residency training, pass the USMLE exams, become ECFMG certified and apply for licensure within the state that you want to practice medicine.

I'm an H-1B visa holder. What happens if I lose my job during the COVID-19 pandemic? How will this affect my H-4 visa family members?

An H-1B visa holder must remain employed for their visa to continue to be valid. If an H-1B visa holder loses their job they have a 60-day grace period within which they can remain in the U.S. and try to find a new job and sponsoring employer. If they are unsuccessful in finding a new position, then they must leave the country. The AMA understands how difficult losing a job is especially during this time, as such we are advocating to temporarily extend the 60-day grace period to 180 days to try and better accommodate IMGs during this time. An H-1B visa holder's spouse and unmarried children under 21 years of age may seek admission to the U.S. as H-4 nonimmigrants. However, the H-4 visa is completely dependent on the H-1B visa holder's status. As such, the H-1B visa holder must remain in compliance with all visa requirements, including meeting relevant employment requirements. If the H-1B visa holder loses their job due to COVID-19 and cannot find new employment within the grace period, the H-4 visa is no longer valid and the H-4 visa holder must leave the country.

Can I be removed from the United States if I overstay my H-1B visa due to COVID-19?
Yes. Deportation or removal is the same for H-1B visa holders as it is for all visa holders. In order to stay in status, an H-1B employee must continue working for the H-1B employer while in the United States. Generally, an H-1B employee must be in status in order to change, extend or adjust status. If an H-1B visa holder is terminated before the end of the period of authorized stay, the employer is liable for reasonable costs of the visa holder's return transportation unless the visa holder voluntarily resigns. As a matter of prosecutorial discretion, DHS may permit an H-1B visa holder who is present in the United States unlawfully, but who has pending an application that stops the accrual of unlawful presence, to remain in the United States while that application remains pending. In this sense, the H-1B visa holder's remaining can be said to be "authorized."
However, the fact that the H-1B visa holder does not accrue unlawful presence does not mean that their presence in the United States is lawful. If an H-1B visa holder accrues unlawful presence in the United States, they may be barred from reentering the U.S. for three years, ten years, or permanently depending on how long they overstayed the visa. For example, an H-1B professional who has been legally employed in the U.S. in H-1B status is permitted by federal regulation to continue living in the U.S. and working for the sponsoring employer for up to 240 days while an extension petition is pending – as long as the extension petition is filed prior to the expiration of the prior H-1B petition. However, due to significant processing backlogs, USCIS very often takes six months or longer to adjudicate H-1B extension petitions. During that time the previous H-1B petition may expire, leaving the H-1B professional solely dependent on the 240 days of work authorization permitted under the regulation – and without any underlying H-1B status unless/until the H-1B extension petition is approved. If the petition is ultimately denied, then such a person would be deemed unlawfully present as of the date of the denial and, a Notice To Appear would be issued. Petitions for nonimmigrant (temporary) visas may be filed up to six months in advance of the anticipated work start date. Extensions may be filed up to six months in advance of the expiration date of the current petition. Employers should plan to file petitions at the earliest possible moment.

AMA advocacy efforts supporting IMGs

- AMA June 26 letter: Urging the Administration to consider J-1 and H-1B IMGs and their families' entry into the U.S. to be in the national interest of the country so that families can remain together and IMG physicians can immediately begin to provide health care to U.S. patients.
- AMA May 8 letter: Supporting the Healthcare Workforce Resilience Act and to urging the Senate and House to quickly pass the legislation so that we could recapture 15,000 unused employment-based physician immigrant visas from prior fiscal years which would help enable our U.S. physicians to have the support they need and our U.S. patients to have the care they deserve.
- AMA May 4 letter: Urging Vice President Michael Pence to allow J-1, H-1B and O-1 IMGs to be exempt from any future immigration bans or limitations so IMGs can maintain their lawful non-immigrant status while responding to the COVID-19 pandemic.
- AMA April 14 letter: Urging U.S. Citizenship and Immigration Services (USCIS) to temporarily extend visas automatically for one year and expedite approvals of extensions and changes of status for IMGs.
- AMA April 3 letter: Asking Vice President Pence and USCIS to address the situation of thousands of IMGs in temporary status.
- AMA March 24 letter: Urging U.S. Department of State to let IMGs either continue, or begin, to serve a vital role in caring for patients during the COVID-19 pandemic.
- AMA March 24 letter: Petitioning USCIS to temporarily expedite extensions and changes of status for foreign national doctors currently in the U.S.

Additional federal guidance

- USCIS: Special situations
- Department of Homeland Security (COVID-19)
- Department of State:
    - Coronavirus disease 2019 (COVID-19)
    - Update on visas for medical professionals

APPENDIX 5: PROTECTING UNDERREPRESENTED STUDENTS AND RESIDENTS DURING COVID-19

Updated July 6, 2020

The current pandemic is impacting all segments of society—but not equally—and it has created significant disruptions in medical education. Even prior to the pandemic, national data suggested medical education was already losing ground with respect to racial and ethnic parity.[1]

Recent weeks have brought additional stressors to the fore as our society continues to grapple with structural racism. The medical education community must remain vigilant for potential inequities in educational outcomes across the medical education continuum. Diversity efforts are particularly vulnerable during times of disruption, hence institutions must heighten their commitment of attention and resources.
It is the responsibility of the AMA to advocate for medical students, to act to reverse the historic active exclusion of racially marginalized groups (specifically, Blacks, Latinx and Native Americans) from the practice of medicine and to drive advancement of multiple dimensions of diversity in the medical profession. Broader initiatives to foster long-term change in medicine and address inequities in the entire United States educational system are imperative and are underway.
Current disruptions related to COVID-19, however, may amplify underlying inequities in our educational system, similar to the pandemic's role in exacerbating health inequities. Recent societal unrest in response to ongoing public racist acts of violence further compounds immediate concerns. Detailed examples of pressing risks for inequity in educational outcomes are provided here.
Concerns span the continuum of pre-medical education, transition to medical school, performance during medical school, residency selection and performance in graduate medical education. Although this highlights immediate risks posed by current circumstances, these recommendations should be applied as long-term interventions.

Recommendations

Colleges, medical schools and residency programs should:

- Increase attention to structural determinants of academic success and provide a clear process by which students can report challenges and seek assistance.
- Engage students, residents and faculty from underrepresented backgrounds (particularly racial and socioeconomic) in the process of planning adjustments to curriculum, assessment and application processes in order to better consider the diverse circumstances of students.
- Amplify efforts to create inclusive learning and working environments across the continuum of pre-medical education, medical school, graduate medical education and practice.
- Heighten monitoring of learner well-being at all levels of medical education and minimize barriers to mental health care.
- Implement a systems approach to promoting well-being that serves to complement the resilience of individuals. Organizational-level efforts should be undertaken to provide:
    - Consistent and inclusive communication.
    - Clarity regarding changes in curriculum, performance expectations or administrative processes.
    - Allyship to address microaggressions in clinical and learning environments.
    - Responsiveness to student and resident concerns.
    - Processes for addressing student and resident grievances.
- Adjust medical school admissions and residency selection processes to:
    - Mitigate bias (e.g. review of applications blinded to academic metrics bias training for admissions committees and interviewers).
    - Apply novel screening practices (e.g. situational judgment tests).
    - Incorporate more holistic, inclusive selection criteria (e.g. distance traveled score).
    - Monitor outcomes for potential bias related to any newly implemented or modified approaches in admissions and selection.
- Improve communication in medical school admissions and residency selection processes by:

    - Implementing robust outreach to students from disadvantaged and underrepresented backgrounds.
    - Developing targeted platforms to foster bilateral exchange of information between applicants and medical schools or residency programs respectively.
    - Reducing complexity and improving transparency in application and selection processes.
    - Minimizing the disparities in candidates' access to coaching in selection processes, such as by providing tips for success at the level of the receiving medical school or graduate medical education (GME) program.
- Increase commitment to, and investment in, pathway and retention programs and other initiatives that intentionally promote equity, diversity and inclusion.

Examples of inequity in educational outcomes due to recent disruptions

Similar themes apply across the continuum of pre-medical education, transition to medical school, performance during medical school, residency selection and performance in GME.

- The shift to virtual platforms of educational delivery has revealed inequities that may further limit the academic achievement of students from under-resourced urban and rural communities, such as in:
    - Access to technology, including internet access and appropriate devices.
    - Home circumstances, including dedicated space and a quiet environment in which to work.
- Students are losing enrichment activities that carry particular importance to candidates who are from backgrounds underrepresented in medicine or who have perceived weaknesses in other aspects of their portfolios. Activities such as research, shadowing, global health experiences and clinical electives serve to instill confidence in pursuing a medical career, support exploration among medical disciplines, spur mentoring, and provide opportunities for distinction that contribute to successful advancement.
- Geographic inconsistency in administration of Medical Colleges Admissions Test (MCAT) and United States Medical Licensing Examination (USMLE) Step examinations has induced some students to consider travel for testing, which will amplify existing disparity in access and in completeness of application portfolios.
- Geographic variations in COVID-19 impact and response—such as physical distancing requirements, testing availability, and availability of personal protective equipment—will create inconsistency in recovery of medical student clinical activities among schools and may disproportionately impact under-resourced schools.
- Limited clinical activities may reduce medical students' access to advocacy in the residency application process (as in the form of letters of recommendation or other communication) which is particularly valuable to disadvantaged candidates.
- Limitations on medical student participation in away rotations, of particular importance for students to demonstrate their abilities to prospective GME programs and to assess the culture of those programs, may disproportionately disadvantage candidates who are underrepresented or who have perceived weaknesses in other aspects of their portfolios.
- The shift to virtual interviews for both medical school and residency selection may have disproportionately negative impacts on students from underrepresented groups or under-resourced communities, due to limitations in technology and appropriate dedicated space as well as less time and personal presence to overcome bias.
- Because people of color are experiencing COVID-19 disproportionately, there may be a corresponding emotional toll on students and residents who lose family and friends to the disease.
- The families of students and residents of color or those who are from lower socioeconomic status may be experiencing greater economic burden from COVID-19, perhaps due to losing employment or increased costs of essential goods. Students may prioritize the need to help support their families over school-related obligations.
- The current environment of racial and societal unrest may have disproportionately negative impacts on the well-being of students and residents from minority communities, impairing their ability to succeed in course work and to navigate application processes.

- Pathway and recruitment programs may suffer from disrupted opportunities to interact with students; and financial strain on many academic centers may result in decreased support to such programs, both in financial resources and in the engagement of participating faculty.

Additional resources
ACGME News: Increasing Graduate Medical Education Diversity and Inclusion, McDade
AAMC: Holistic Review in Medical School Admissions

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[1]Talamantes, et al. Closing the Gap - Making Medical School Admissions More Equitable. *NEJM* 2019. (As medical school enrollment doubled over the past two decades, the percentage of entering under-represented students actually fell by 16%)

APPENDIX 6: SENIOR PHYSICIAN COVID-19 RESOURCE GUIDE

Updated March 28, 2020

The AMA has curated a selection of resources to provide guidance to senior and retired physicians who may wish to return to work or are called upon to do so during the coronavirus (COVID-19) outbreak.

1. License considerations
The licensure status of retired physicians varies by state. In some states retired physicians maintain their regular license while others create a separate category for retired or inactive physicians, and still others have no license category for retired physicians. In response to COVID-19, many states have taken action to allow retired physicians to temporarily return to practice through an Executive Order, Department of Health Order or Board of Medicine directive. Often these actions specify the physician's license must have been in good standing at the time of retirement. Many states have also indicated the physician must have been in active practice within the last 2-5 years.
The path to reentry from a licensing perspective varies. For senior and retired physicians who maintain an active license, there are no licensure restrictions on re-entry to practice. For physicians who maintain an inactive, retired physician, or similar license, your state may have temporarily waived any barriers to re-entry. We encourage you to check the Federation of State Medical Boards' COVID-19 resource on state actions on license status for inactive/retired physicians for guidance: As this landscape continues to evolve, we strongly encourage physicians to check with their respective state medical boards for the latest information.

2. Providing assistance that does not involve direct patient care
Whether senior physicians should be providing direct patient care for COVID 19 patients is a complex issue that must balance a number of factors, such as whether the age of the physician and their family members puts them in a high risk group, whether personal protective equipment (PPE) is readily available, and whether they could contribute meaningfully in a non-direct patient care role. Below is a list of important contributions to consider:

- Many health systems are assigning senior physicians to telehealth and administrative activities, which may free up others to be on the front line.
- Contact your local or state health department. Many are keeping listings of needed roles for volunteer physicians and health care workers.
- Medical schools are using senior physicians for online teaching and mentoring of medical students. Contact your medical school's dean's office to find out how you can participate.
- Consider making an appointment at your local Red Cross to donate blood.
- Provide online outreach to residents of nursing homes or senior residential communities to combat isolation

Assist local practices in creating patient education materials and information sheets with local/regional resources.

3. Re-entering practice
Explore opportunities to provide mentoring or training in your practice location. Many institutions have developed algorithms for telephone triage and/or assessment of symptomatic patients.

4. Professional liability
Explore coverage with your local health system. If you are licensed and volunteer, the third federal economic COVID-19 stimulus package (H.R. 748) includes liability protections for volunteer health care professionals during COVID-19 emergency response. In addition, if you are authorized to prescribe and administer certain countermeasures to treat COVID-19, you may be immune from liability under the Public Readiness and Emergency Preparedness Act (PREP Act). Also check with your state medical association; you may have additional liability protections under state law, a recent Gubernatorial Executive Order, or other emergency response programs, such as the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) or the Emergency Management Assistance Compact (EMAC).

5. Retirement status
Some physicians are receiving retirement income that may be affected by a return to paid employment. Check the status of your retirement income according to the role you are being asked to perform.

6. Role clarification
Clarity on the following questions may be helpful if you are planning to volunteer your assistance.

- What are the activities I'm being asked to do?
- Do those activities align with my skill set?
- What types of training/refreshers/mentoring will be provided?
- Will I be provided with PPE?

7. COVID-19 resources

- *JAMA Network* Coronavirus disease 2019 resource center
- AMA COVID-19 resource center
- AMA licensure chart (PDF)

APPENDIX 7: CARING FOR OUR CAREGIVERS DURING COVID-19

Updated June 5, 2020

Resources for health care leadership
Amid the COVID-19 global outbreak, it's likely to be a stressful time for those who work on the front lines of health care.

Now more than ever, it's important for health systems and health care organizations to create and ensure an infrastructure and resources to support physicians, nurses and care team members.
The following lists provide practical strategies for health system leadership to consider in support of their physicians and care teams during COVID-19.
Note that any activities involving medical students or other health professions students should be part of a voluntary, student-led program overseen by their school in compliance with guidance from the LCME or other accreditor. No direct solicitation of individual students should occur.
Some items in the list are suggestions, while others have already been implemented by health systems.

Assess physician stress and identify specific drivers

- Surveys can be used to track trends in stress levels, identify specific drivers of stress, and develop supportive infrastructures based on these drivers. The American Medical Association is offering two no-cost surveys to help health care organizations monitor the impact COVID-19 has on their workforce during this pandemic.

Building a resilient organization

- The AMA's caregiver resource, Creating a Resilient Organization, provides 17 steps that health care organizations can take in order to effectively care for health care workers during times of crises. Successful organizations will take a systems approach and focus on becoming a resilient organization prior to times of crises, rather than limiting their efforts to a focus on individual resilience. Resilient organizations will need to rapidly reconfigure their well-being priorities to meet the biggest new drivers of stress in a crisis setting.

Workload redistribution

- Physicians/APPs who are at home (on quarantine or for childcare) manage the inboxes and phone calls of those who are at work and provide telemedicine care. Organizations have the ability to redirect or create physician work (wRVU) credit for this work.
    - Atlantic Medical Group has shifted their ambulatory practice care model to telephonic and telemedicine and has reduced office visits significantly. They are considering splitting their offices into teams of staff and physicians and rotating the teams in/out of the office. Rotating shifts would reduce staffing in the office such that everyone isn't in the same very close spaces together. Clinicians not in the office can do phone visits, telemedicine, answer patient questions or be deployed to call centers and testing centers.
- Retraining and/or enhancing the skills of who have not recently worked in the intensive care unit to increase workforce. AMA has curated guidance and resources for those who may wish to return to work or are called upon to do so during the coronavirus (COVID-19) outbreak.
- COVID Staffing provides and online resource to help hospitals understand and manage their staffing needs during the COVID-19 pandemic.
- Administrators and clinicians with extra time due to decreased regular services have offered assist with insurance needs (finding old claims, updating bad addresses, etc.).
- Set up triage hotline. Medical students at multiple states are providing extra staffing for the medical school call center. The purpose of this triage hotline is to provide students/staff/faculty who have traveled or have symptoms of COVID-19 with real-time information on protocol and next steps.
- Allow medical assistants and nurses to make contributions according to their ability, with physician or APP oversight and discretion. This may include nurses or MAs taking verbal orders, performing computerized order entry, doing medication reconciliation or assisting further with visit note documentation. This will alleviate some of the workload on physicians and APPs.

Institutional policies

- Ensure that paid time off and sick days remain unaffected for all employees for COVID-19 related illnesses.
- Ensure no out-of-pocket expenses for employees with COVID-19 related illnesses.
- CMS, Surgeon General, CDC and American College of Surgeons have called for cancellation of all elective surgeries and the rescheduling all non-urgent outpatient visits.
- CMS has implemented several blanket waivers (PDF) for COVID-19. This includes additional flexibility for verbal orders. View additional CMS policies and regulatory flexibilities.
- Six ways to address physician stress during COVID-19
- The Center for the Study of Traumatic Stress offers information for how health care teams notify families (PDF) after a COVID-19 death.

Meals

- SweetGreen will deliver free salads and bowls to hospitals in the cities they serve: DC, Philadelphia, Boston, New York City, San Francisco, Los Angeles, Chicago and Houston. To request free salads, please visit their site to order.
- GrubHub and DoorDash are now offering contact-free deliveries. Both companies have reduced or eliminated commission fees for local restaurants to support restaurants that are mandated to only have carry-out/delivery only service.
- Medical students at multiple states have volunteered to deliver supplies/meals and run errands on behalf of individuals in quarantine.
- A Denver community has reported the development of "Lunches for Clinicians" in which clinicians can order meals from local restaurants for delivery during shifts. Community members are raising funds to help pay for these meals. Many communities across the country have launched similar efforts.

Childcare and pet care

- Medical students in Minnesota, St. Louis (Washington University in St. Louis) and Chicago (Northwestern University) are offering childcare and pet care services for physicians and care teams. To facilitate logistics, both students and families register for services and students volunteer for shifts. Students are then matched with families based on need and availability. Students have reported that the need is overwhelming, with some systems reporting more than 100 families signed up for childcare or pet care services.
  Mount Sinai offers similar services through their Sinai Kids and Sinai Together initiatives. UW Health has partnered with Epic and Meriter to transform Epic's old headquarters into a 24/7 childcare center for children of clinicians that are working at local hospitals during COVID-19.
- Several organizations have partnered with their local YMCA to provide additional childcare for their health care workers.
- One system reported a program in which staff members who must stay home to care for their children are still paid their regular rate if they agree to care for children of two other staff members.

Personal protective equipment (PPE)

- American Dental Association and state dental associations are encouraging dentists to donate their PPE to local hospitals.
- Consider the use of Mask Match in order to request masks (if you are a health care professional) or to donate masks if you have extra. Masks are not for purchase or for sale. Those who are matched with a health care worker are expected to cover the cost shipping and handling.
- Mount Sinai has developed guidelines for health care workers to consider for keeping their family and friends safe when returning home from work.

Attention to emotional and mental well-being

- Headspace is a meditation and sleep app that can have a positive impact on health professionals' personal and professional lives.

- Organizations like Mount Sinai and UNC provide online toolkits where all well-being resources are centralized and easy for clinicians to access.
- Consider assigning therapists to strategic locations (e.g., cafeteria, staff lounges, emergency department) to provide easy access for staff. Several health systems offer drop-in hours with a psychologist onsite for their physicians and care teams. Several organizations are offering 24/7 emotional support through their behavioral health teams. In many cases, this includes emotional support for family members of clinicians as well.
- Continue to monitor the ability of the Employee Health and Well-Being Unit to meet workload demands, personnel health and safety, resource needs and documentation practices.
- Supervisors can conduct a 5-minute debrief at the end of every shift with their care team. Make debriefing a routine part of the day.
- Several wellness committees and Chief Wellness Officers have shared that intensive in-person rounding to frontline health care workers has proven enormously helpful. Rounding may include:
    - Supplying basic wellbeing needs (food, drinks, hygiene items)
    - Provide in the moment support, direct pathway for more intensive support needs through behavioral health teams, peer support, etc.
    - Elicit concerns/needs that require escalation and advocacy (has led to countless system changes, including prepaying of childcare, scrub service, transparency efforts, creation of a caregiver relief fund, etc)
    - Increase awareness of available support resources
- Consider making mental health resources available to families of clinicians (PDF), as traumatic experiences from COVID-19 will affect them as well.
- The Department of Psychiatry at SUNY Downstate Health Sciences Center has created a COVID-Stress Hotline that can be accessed by everyone at the medical center. The hotline can be accessed by SMS text, email, or call in and was set up using Updox. A second line was established for leadership to communicate about groups that might need help sessions or immediate group interventions.
- AMA offers strategies and resources to manage mental well-being while also caring for patients during the pandemic or any other crisis.
- With the goals of ensuring physicians and advanced practitioners receive the psychological support they need and of paving the way for them to successfully access existing resources through their Physician Assistance Program, the Washington State Medical Association called on Employee Assistance Programs/Physician Assistance Programs with clients in the health care industry to consider the following actions:
    - Change the pre-recorded greeting message on the 1-800 number to clearly communicate that all calls are confidential and HIPAA compliant.
    - Establish a triage system at entry that allows people to identify themselves as clinicians at the frontline of the COVID-19 response. Deploy your most highly trained and skilled staff to support this population, including the provision of cognitive behavioral therapy.
    - Develop custom communication materials targeted to clinicians at the frontline of the COVID-19 response that clearly explain that your mental health care professionals are equipped to help them navigate the COVID-19 crisis and that the services are completely confidential.
    - Work with each of your clients to provide just-in-time group and 1:1 sessions to frontline clinicians while protecting the health of your staff. For example, use telehealth technology to plant multiple virtual mental health professionals inside the most impacted hospitals and/or at health care provider quarantine facilities for easy on-demand access.
    - Ensure your organizations' emergency response plan includes strategies to adequately handle a surge in requests for services.

Social support

- Several organizations, including Methodist Hospital, UCSF and Mount Sinai, are using video conferencing tools to set up peer support "connection groups" in which physicians and care teams can support one another and discuss ongoing challenges. UCSF's anesthesia department provides virtual support sessions via Zoom for faculty and trainees. These sessions are held once per week—

one for faculty and one for trainees. Discussion questions for these sessions includes: What worries you? How are you feeling and what are you experiencing now? How are you processing all of this? Here are some Zoom and moderator tips provided by UCSF.

- **Virtual session tips:**
    1. Have everyone turn on their cameras (if possible)
    2. Open Zoom chat function so participants can bring up items and moderators can discuss with the group
    3. If more than 15 people consider using Zoom breakout rooms
    4. Acknowledge each person as they join the Zoom meeting
- **Moderator tips:**
    1. Psychological safety is key
    2. It may take time for participants to open up, resist the urge to "fill the silence" if there are lulls
    3. Let conversations unfold naturally
    4. Try to focus more on emotions vs. clinical details or how to fix the problem

Christiana Care is offering "COVID Conversations," topic-driven group support sessions. These sessions allow caregivers to connect with another and share thoughts, feelings and ideas about life during the pandemic.

PeerRxMed is a free, peer-to-peer program for physicians and others working in health care designed to provide support, connection, encouragement, resources and skill-building in order to help participants advance along the Burnout to Thriving Index toward optimal well-being, however you would define that state for yourself. This program provides regular reminders for weekly, monthly and quarterly check-ins with a peer. Reminders include exercises that provide structure for you to connect with a colleague or friend.

Jo Shapiro, MD (Harvard Medical School) discusses the importance of peer support, the fundamentals for operationalizing a peer-support system in health systems and practices and how it can potentially change organizational culture especially during the COVID-19 pandemic.

Nebraska Medicine offers 1:1 peer support through their Peers in Need of Support (PiNS) program. More than 120 volunteers were specifically trained for COVID-19 response using just-in-time training (PDF).

A new Slack channel, "Medical Students vs. COVID-19," allows medical students from across the country to connect and share helpful strategies for how students can continue to support physicians and care teams. Join the Slack channel.

An ambulatory care clinic in Arizona has set up games for clinicians and patients to play throughout the day to keep morale high.

AMA COVID-19 news coverage

Through interviews with health system leaders, the AMA highlights programs and initiatives from around the country that are supporting the health care workforce during the COVID-19 outbreak.

- COVID-19 front line: Mount Sinai keeps physician well-being in focus
- 6 ways to address physician stress during COVID-19 pandemic
- Peer support program strives to ease distress during pandemic
- COVID-19 physician well-being initiatives embrace family needs
- 5 wellness task force tactics designed to prioritize physician health
- 6 ways a health system attacks stress during the COVID-19 crisis

APPENDIX 8: LCME GUIDING PRINCIPLES

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Medical Students, Patients, and COVID-19: A Community Conversation about Education and Safety

March 12, 2020

LCME Guidance Principles

1. Your faculty has defined your school's **educational program objectives (EPOs) and graduation requirements** and the assessments you will use to ensure that those objectives and requirements are met. It is likely that you will need to change the mechanisms through which medical student learning occurs (e.g., online content delivery and/or interactive work) and is assessed (e.g., paper cases, simulation exercises when onsite clinical interactions might be limited). The LCME completely understands that, and while the LCME Secretariat is always happy to speak with, provide a sounding board to, or guide you, **you do not need to notify the LCME of these adjustments in instructional and assessment methods.**
2. The goal of accreditation is to assure all stakeholders (i.e., the public, medical students, medical schools, graduate medical education programs, health systems, licensing bodies, Department of Education) of educational program quality. This means that, together, **our goal is to provide that by ensuring that our graduates meet their school's EPOs, course and clerkship learning objectives, and required clinical experiences** in this most challenging of times. It is likely that the schools will face the greatest challenges in accomplishing this for students' required clinical experiences. From national data that you have shared, the LCME knows that most of our medical schools have several elective weeks/months in the last year or phase of the curriculum. **Should you need to interrupt or postpone clerkships or other required clinical experiences because of the real and important pressures and stresses of the clinical environment, these elective weeks are available to adjust your students' clinical training schedules without having to delay completion of these required experiences before graduation.** In other words, in looking at your own graduation requirements, you can and should be flexible with the elective weeks built into your curriculum; the LCME understands the need to repurpose elective time to achieve the required clinical experiences. The LCME also recommends that all changes in the required clerkships pass through the school's curriculum governance committee (e.g., Curriculum Committee) prior to implementation.
3. **The LCME is you.** Fifteen of its 19 members are deans and associate deans, perhaps at your school and at other LCME-accredited schools; there are two public and two medical student members. **It completely understands and is experiencing the exceptional pressures you are under,** as a result of both the national and local environment.
4. If you are contemplating **significant changes in the structure** (e.g., major shift in clinical training sites from the inpatient to outpatient setting); **timing** (e.g., delay in student progression to graduation); **duration** (e.g., below the 130-week expectation); or **location** (e.g., due to local variation in the spread of COVID-19), please email the Secretariat (lcme@aamc.org), and we will speak with and work with you to think through your particular situation and approach before you

notify the LCME of the major curriculum changes you are anticipating/making. Remember that any and all conversations you have with the Secretariat are completely confidential and are never shared with the LCME.

Know that we are being challenged along with you, learning from you, and thinking about this with you, every step of the way. We will be creating and updating a page on the LCME website for additional accreditation-related resources and information as they become available. This document, as well as the March 5, 2020 memo from Alison Whelan, Geoffrey Young, and Veronica Catanese will be posted there, and the AAMC COVID-19 resource site will contain links to this LCME resource collection.

APPENDIX 9: "MAINTAINING QUALITY AND SAFETY STANDARDS AMID COVID-19"

Coalition for Physician Accountability

Maintaining Quality and Safety Standards Amid COVID-19

May 11, 2020

The member organizations of the Coalition for Physician Accountability (www.physicianaccountability.org) have released the following statement and table of resources to provide guidance and support to healthcare administrators and credentialing staff who are supporting the contributions of new or volunteer physicians to patient care during the COVID-19 pandemic.

The Coalition for Physician Accountability (Coalition), a cross-organizational group including AACOM, AAMC, ABMS, ACCME, ACGME, AMA, AOA, CMSS (OPDA), ECFMG, FSMB, LCME, NBME, and NBOME, was established in 2009 to promote professional accountability by improving the quality, efficiency, and continuity of the education, training, and assessment of physicians. Its membership includes the national organizations responsible for the accreditation of medical education and training and the assessment, licensure and certification of physicians throughout their medical career, from medical school through practice. Our membership also includes members of the public and the profession. We share a strong commitment to protecting the public's health and safety through the delivery of quality health care.

The pandemic has created a public health emergency that is rapidly altering the provision of health care services across the country. Physicians and other clinicians have responded with offers to provide care outside of their previously licensed jurisdiction and beyond their typical scope of practice.

The Coalition members overseeing physician workforce and training have developed the following guidance and resources for the deployment of physicians, physicians in training (interns, residents and fellows), and retired or inactive physicians, to ensure the safe delivery of quality clinical care during this unprecedented emergency.

The Coalition's Guidance for Maintaining Quality and Safety Standards Amid COVID-19 Pandemic include:

- **Planning:** The pandemic poses a direct threat of over-burdening the health system. The stress to health systems is variable, but all health care facilities should be developing strategies for the optimal use of physician resources as the disease spreads and resource demands fluctuate.
- **Verification:** Acknowledging the additional flexibility that regulators have provided, administrators should access readily available licensing, credentialing, and certification data to verify the attestations of volunteers and new recruits.
- **Provision of Care:** The American Medical Association's *Code of Medical Ethics: Guidance in a Pandemic* states that physicians have an ethical obligation to "provide urgent medical care during disasters," an obligation that holds "even in the face of greater than usual risk to physicians' own safety, health or life." In a crisis, "(t)he risks of providing care to individual patients today should be evaluated against the ability to provide care in the future."
- **Protection:** Healthcare professionals must be equipped with appropriate Personal Protective Equipment (PPE) to safeguard their health and that of their patients, families, and the general public, and physicians must use this protection. The more transmissible the disease, and the higher the risk of occupational exposure, the more urgent the need for protection.
- **Training, Education, and Support:** Healthcare professionals who may be asked to practice outside their areas of training and expertise must have access to training and educational resources for the type(s) of care they are asked to provide during the COVID-19 pandemic to assure safe patient care. Appropriate mentorship, support, training, and supervision must also be available for healthcare professionals who are asked to provide care to which they are unaccustomed.
- **Maintenance of Safety Standards:** Health care facilities should have contingency plans to maintain customary safety standards in the face of a demand surge. Guidance for the adoption of crisis standards of care is available to help leaders make informed decisions that optimize resources while mitigating the risk of harm.

The following are some steps that can be taken to prepare for the arrival of a new volunteer:

	Action Step	Resource	Additional questions/resources
1	Check what licenses the physician has (and/or ECFMG certification if an international medical graduate)	www.Docinfo.org (free service) Physician Data Center www.fsmb.org/PDC/ ECFMG Certification Verification	Email: pdc@fsmb.org Email: cvsonline@ecfmg.org or call ECFMG at 215-386-5900
2	Determine applicable licensing waivers or exceptions (if licensed elsewhere)	FSMB COVID-19 Page for a summary of changes Please check applicable state or territorial medical board website	
3	Check Information on a volunteer's education and training	Physician Data Center www.fsmb.org/PDC/ ECFMG (for IMGS)	Email: pdc@fsmb.org Email: cvsonline@ecfmg.org or call ECFMG at (215) 386-5900
4	Determine if the volunteer has a valid controlled substance license	Obtain copy of existing license and see https://apps.deadiversion.usdoj.gov/webforms2/spring/dupeCertLogin?execution=e1s1	https://deanumber.com/default.aspx?relID=33637
5	Check a volunteer's board certification status	ABMS certification AOA certification https://certification.osteopathic.org/validate/	Call: ABMS Solutions at (800) 733-2267 with questions. Call: AOA at (888) 626-9262
6	Confirm: a) vaccination record b) malpractice insurance c) Review any history of malpractice	Recommended vaccinations for healthcare workers: https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html Guidance on medical liability insurance during the COVID- 19 crisis available from the Medical Professional Liability Association	Call: CDC at (800) 232-4636 See also: The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, H.R. 748), *Section 3215: Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response*

		National Practitioner Data Bank*: https://www.npdb.hrsa.gov/hcorg/howToSubmitAQuery.jsp	Email: help@npdb.hrsa.gov
7	Other Important Credentialing Resources	NAMSS COVID-19 Resources	Email: info@namss.org

**Only Accessible by Eligible Entities*

If the volunteer is a recently graduated physician, refer to the following resources:

8	Refer to guidance from AAMC, AACOM, ACGME and FSMB	AAMC guidance AACOM Coronavirus Resources ACGME guidance FSMB COVID-19 Page (for training license information)	

To support the volunteer as they start providing care:

9	Provide guidance to the physician	AMA volunteer guide AMA Code of Medical Ethics: Guidance in a Pandemic FSMB COVID-19 Page (for emergency licensure information) AOA COVID-19 Resources	
10	Provide training resources to the physician	ACCME training resources CDC guidance HHS COVID-19 Workforce Virtual Toolkit	Email: info@accme.org
11	Provide information on PPE	CDC guidance for PPE	

12	Share resources on managing telehealth	ACCME telehealth resources AMA Telehealth playbook HRSA Telehealth Website (hhs.telehealth.gov)	Email: info@accme.org

For more information on how to prepare for an anticipated surge in demand for scarce resources during an epidemic

13	Expand contingency plans to include a process for adopting crisis standards of care to manage scarce physician and other resources	National Academy of Medicine -Discussion Paper on Crisis Standards of Care in response to SARS-CoV-2 National Academy of Medicine -Systems framework for crisis standards of care	

Workgroup Members:

American Board of Medical Specialties (ABMS)
Accreditation Council for Continuing Medical Education (ACCME) Accreditation Council for Graduate Medical Education (ACGME) Council of Medical Specialty Societies (CMSS) Educational Commission for Foreign Medical Graduates (ECFMG) Federation of State Medical Boards (FSMB) National Resident Matching Program (NRMP) Public Member

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