

REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by Russ Kridel, MD, Chair:

1. 2019 GRANTS AND DONATIONS

Informational report; no reference committee hearing.

HOD ACTION: **FILED**

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	<u>467</u>
Government Funding		<u>837</u>
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	<u>15</u>
Nonprofit Contributors		<u>213</u>
Contributions less than \$5,000	International Medical Graduates Section Reception	5
Other Contributors		<u>5</u>
Total Grants and Donations		\$ <u>1,055</u>

2. UPDATE ON CORPORATE RELATIONSHIPS

Informational report; no reference committee hearing.

HOD ACTION: FILED

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

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
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 sponsorship 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	Arizona Association of Medical Staff Services (AAMSS)	3/7/2019

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
35036	<p>Association of Medical Staff Services (MAMSS) 2019 Annual Conferences – AMA sponsorship with name and logo.</p> <p>Association of Clinical Documentation Improvement Specialists (ACDIS) Clinical Documentation Integrity (CDI) Week Marketing Sponsorship – Sponsorship with AMA name and logo.</p>	<p>Association of Clinical Documentation Improvement Specialists (ACDIS)</p>	4/2/2019
35073	<p>National Minority Quality Forum Leadership Summit 2019 – Sponsorship with AMA name and logo use.</p>	<p>The National Minority Quality Forum (NMQF)</p>	4/3/2019
35169	<p>The Tenth Annual Patient Experience: Empathy & Innovation Summit – AMA name and logo use to announce collaboration.</p>	<p>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 Kyrus Medigate Oneview Healthcare The Continuous Ambient Relaxation Environment (C.A.R.E.) Channel Twistle, Inc. West – TeleVox Solutions Wolters Kluwer Financial Services, Inc.</p>	4/29/2019
35186	<p>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.</p>	<p>Rush University Medical Center</p>	4/29/2019
35198	<p>American Health Information Management Association (AHIMA) World Congress Sponsorship – Sponsorship with AMA name and logo.</p>	<p>American Health Information Management Association (AHIMA) World Congress (AWC)</p>	5/3/2019
35268	<p>American Health Information Management Association (AHIMA) Clinical Coding Meeting – Sponsorship of event dinner with AMA name and logo.</p>	<p>American Health Information Management Association (AHIMA) World Congress (AWC)</p>	5/21/2019

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
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.) Simplr 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 Chicago Booth – Rustandy Center for Social Sector Innovation	6/27/2019
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

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
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	9/9/2019

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
		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 Chicago United	
36094	2019 Chicago United Bridge Awards Dinner – Sponsorship with AMA name and logo.		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 Chicago Urban League	10/9/2019
36290	2019 Chicago Urban League, Annual Golden Fellowship Dinner – Sponsorship with AMA name and logo.		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 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

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
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) American College of Physicians (ACP) American Chemical Society (ACS)	2/18/2019
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

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
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 sponsorship with AMA name and logo use.	America’s Health Insurance Plans (AHIP)	2/12/2019
34737	Social Enterprise Alliance Membership – Member sponsorship 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 Biggen 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

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
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

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
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

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
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

3. AMA PERFORMANCE, ACTIVITIES, AND STATUS IN 2019

Informational report; no reference committee hearing.

HOD ACTION: FILED

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 health 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."

4. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2019 THROUGH FEBRUARY 2020

Informational report; no reference committee hearing.

HOD ACTION: FILED

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.

5. FDA CONFLICT OF INTEREST

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 216-A-18
REMAINDER OF REPORT FILED**

See Policies H-100.992 and H-265.989

At the 2018 Annual Meeting of the House of Delegates (HOD), Resolution 216-A-18, "[Food and Drug Administration] FDA Conflict of Interest," was referred for report back at the 2019 Annual Meeting. Resolution 216-A-18, sponsored by the Medical Student Section, asked that:

Our American Medical Association (AMA) advocate (1) that the Food and Drug Administration [(FDA)] place a greater emphasis on a candidate's conflict of interest when selecting members for advisory committees and (2) for a reduction in conflict of interest waivers granted to Advisory Committee candidates.

There was mixed testimony on Resolution 216 during the reference committee. Testimony was offered that disclosure and transparency into conflicts of interest (COI) are important, but on the other hand challenges may exist to find qualified individuals without COIs. Others offered that the FDA should utilize generally accepted COI policies and should limit waivers of such policies for advisory committees. The HOD referred Resolution 216 to the Board of Trustees (Board) for report back at the 2019 AMA Annual Meeting.

During the 2019 Annual Meeting, the Board presented Report 19-A-19, “FDA Conflict of Interest” to the HOD in response to the HOD’s referral of Resolution 216. At the 2019 Annual Meeting, the HOD referred Report 19-A-19 back to the Board for further consideration, because the HOD wanted the report to include in the report’s recommendations language urging the FDA to reduce administrative burdens associated with, and otherwise streamlining, its advisory committee COI process to facilitate physician participation on its advisory committees, since participation continues to be a challenge. This report, i.e., Board Report 10-A-20, contains the revisions to Board Report 19-A-19 that the HOD requested, and the Board presents this report for the HOD’s further consideration.

FDA AND THE ROLE OF ADVISORY COMMITTEES

The FDA utilizes advisory committees to obtain independent expert advice and recommendations on scientific, technical, and policy matters related to FDA-regulated products. There are 50 advisory committees and panels.¹ The recommendations of advisory committees do not bind the FDA. Although the advisory committees include permanent non-voting members who are FDA employees (typically responsible for administering the meetings), the majority are external experts who are considered special government employees (SGEs) while performing their advisory committee duties. The advisory committees cover a range of products.²

The FDA’s advisory committees are governed by several federal laws and regulations that: (1) establish standards for convening advisory committees; (2) specify criteria for what constitutes a COI; and (3) outline the requirements for disclosing, assessing, and managing COIs. In addition, the FDA has issued guidance documents interpreting government-wide regulations pertaining to the appearance of COIs as well as guidance related to the public availability of advisor COI disclosures and associated FDA waivers. For the most part, the federal laws, regulations, and guidance are generally the same whether a committee advisor is a permanent federal employee or SGE with some exceptions as outlined below. For over a decade, the FDA and Congress have implemented reforms to the FDA’s process for assessing COIs, managing COIs including waivers, and public disclosure.³ Members of the FDA’s advisory committees are subject to Federal COI laws (18 USC section 208) as well as government-wide standards of ethical conduct regulations (5 CFR section 2635.502). Even where a member has no financial interests that would require the member to refrain from participating in an advisory committee meeting (“recuse”) under Federal COI laws, the member may be disqualified from participation under the government-wide Federal regulation at 5 CFR section 2635.502 if the member has interests or relationships that may create the appearance that the member lacks impartiality on the issue before the advisory committee.

As specified in federal law, the FDA has a process for determining whether to grant a waiver for an advisory committee member with an actual financial COI. The FDA also has guidance outlining how the Agency evaluates whether an advisory committee member has potentially disqualifying interests or relationships that fall into the second category of interests: appearance of a COI. (In this latter case, the regulations provide that an authorization to participate would be issued as opposed to issuance of a waiver.) In both cases, the decision to permit voting, permit participation, or recusal will be made by the FDA.

PROHIBITION AGAINST FINANCIAL COI

Unless granted a waiver, a federal employee may not “personally and substantially participate” in an official capacity in any particular matter which, to the employee’s knowledge, the employee or a related person or organization (whose interests are imputed to the employee under 18 USC section 208) has a “financial interest” if the particular matter will have a “direct and predictable effect” on that interest (5 CFR section 2640.103(a)). In this analysis, federal employees include FDA advisory committee members who are considered SGEs. A financial interest is defined as the potential for gain or loss as a result of governmental action on the particular matter which includes stock options, a salary, job offer, indebtedness, and similar interests (5 CFR section 2640.103(b)). Under this law, the financial interests of other, related persons and organizations (as defined in law and statute)⁴ are imputed to the employee and may disqualify an employee to the same extent as the employee’s own interests. Under the law, a COI arises when the employee participates in an official matter and there is a direct and predictable link between the matters in which the federal employee participates and the employee’s financial interests. The link cannot be contingent and dependent on other events.

Process for Reviewing Financial COIs and Granting Waivers

The FDA reviews financial COI disclosures made by potential advisory committee members and the member's expertise with respect to the specific product or policy to be evaluated at a particular meeting. Each adviser is required to certify to the truth and completeness of any information provided.⁵ The Agency can issue a waiver to permit participation despite a current conflict or one that ended during the 12 months preceding a meeting consistent with applicable law. The FDA is required by law to apply different standards to SGEs (who constitute the majority of advisory committee members) and permanent government employees in order to determine if an applicable standard for granting a waiver pursuant to 18 USC section 208 is met.

If the individual is a SGE, the FDA's "determination must be based on a certification that the need for the [SGE's] ... services outweighs the potential for a conflict of interest created by the financial interest involved," (5 CFR section 2640.302). The FDA considers a number of factors, including the type of interest that is creating the disqualification, the relationship of the person whose financial interest is involved to the SGE, the uniqueness of the SGE's qualifications, the difficulty of locating a similarly qualified individual without a disqualifying financial interest, the dollar value of the disqualifying financial interest, and the extent to which the disqualifying financial interest could be affected by the actions of the advisory committee.⁶ If the individual is a permanent government employee, the FDA determines whether the member's financial interest is not so substantial as to be deemed likely to affect the integrity of the services provided by that individual. In making this determination, the FDA considers a number of factors, including the type of financial interest that is creating the disqualification, the relationship of the person whose financial interest is involved to the member, the dollar value of the disqualifying financial interest, the nature and importance of the employee's role in the matter, and the need for the employee's services in the particular matter.⁷ FDA guidance provides that a common factor to be considered for both categories of advisory committee members is the "need" for the individual's services. In deciding whether there is a need, the FDA will consider: (1) the uniqueness of the member's qualifications; (2) the difficulty locating similarly qualified individuals without a disqualifying financial interest; (3) the value and utility of the member's expertise to the matter being addressed by the committee; and (4) the nature and extent of the disqualifying financial interest.

In addition, the FDA must apply one more standard to members serving on drug or biologic advisory committees that provide scientific advice and recommendations regarding a clinical investigation or marketing approval. For these members, the standard for a waiver to permit voting is whether a waiver is "necessary" to afford the committee "essential expertise."⁸ Where a financial COI exists, the FDA determines whether the member may: (1) participate as a non-voting member; or (2) not participate in the advisory committee.⁹ Individuals with financial COIs are not permitted to vote as a matter of FDA policy. A waiver may not be granted when the member's own scientific work is involved.¹⁰

The Food and Drug Administration Amendments Act of 2007 included a provision capping the number of COI waivers the FDA could grant in any given year. Subsequently, this cap was rescinded in the Food and Drug Administration Safety and Innovation Act of 2012.¹¹ A recent analysis of FDA COI waivers found that in fiscal year (FY) 2012, the waiver rate did not exceed one percent and this was less than in earlier years.¹² Additionally, the FDA reports COI waiver rates of less than one percent for FYs 2013, 2014, 2015, and 2016 on its online [FDA-TRACK Advisory Committees Dashboard](#).¹³

Public Disclosure

The FDA publicly discloses¹⁴ on the Agency's website the type, nature, and magnitude of the financial interests of each advisory committee member who has received a waiver under 18 USC section 208. The FDA also provides the reasons for granting each waiver prior to the advisory committee meeting,¹⁵ including, as appropriate, the public health interest in having the expertise of the member with respect to the particular matter.¹⁶

APPEARANCE OF A CONFLICT OF INTEREST – PERSONAL AND BUSINESS RELATIONSHIPS

Federal law also contains provisions to help ensure that an employee takes appropriate steps to avoid an appearance of loss of impartiality in the performance of his or her official duties. Under 5 CFR section 2635.502 where an agency employee (including FDA advisory committee members), "knows that a particular matter involving specific parties is likely to have a direct and predictable effect on the financial interest of a member" of the employee's household, or knows that a person with whom the employee has a "covered relationship is or represents a party to such matter," and

“where the employee determines that the circumstances would cause a reasonable person with knowledge of the relevant facts” to question the employee’s impartiality in the matter, the employee should not participate in the matter unless the employee has informed the agency designee of the appearance problem and received authorization from the agency designee. An employee has a “covered relationship” with:

- a person other than a prospective employer with whom the employee has or seeks a business, contractual or other financial relationship that involves other than a routine consumer transaction;
- a person who is a member of the employee’s household, or who is a relative with whom the employee has a close personal relationship;
- a person for whom the employee’s spouse, parent or dependent child is, to the employee’s knowledge, serving or seeking to serve as an officer, director, trustee, general partner, agent, attorney, consultant, contractor or employee; any person for whom the employee has, within the last year, served as officer, director, trustee, general partner, agent, attorney, consultant, contractor or employee; or
- an organization, other than a political party,¹⁷ in which the employee is an “active participant.”¹⁸

Granting a Section 502 Authorization

If the FDA concludes that an appearance issue exists, a determination is made whether the Agency’s interest in the member’s participation outweighs the concern that a reasonable person may question the integrity of the Agency’s programs and operations. If so, the FDA may grant an authorization (i.e., a waiver) before the meeting to allow the member to participate. The FDA may limit authorization or deny authorization. The Agency takes into consideration a number of factors including, but not limited to: (1) the nature of the relationship involved; (2) the effect that resolution of the matter would have upon the financial interests of the person involved in the relationship; (3) the nature and importance of the member’s role in the matter, including the extent to which the member is called upon to exercise discretion in the matter; (4) the sensitivity of the matter; (5) the difficulty of reassigning the matter to another expert; and (6) adjustments that may be made in the member’s duties that would reduce or eliminate the likelihood that a reasonable person would question her impartiality.

RESEARCH ON COI AND FDA ADVISORY COMMITTEE RECOMMENDATIONS

Despite long-standing federal laws governing COIs and waivers applicable to FDA advisory committee members, there have remained persistent concerns in the general public that waivers of COIs negatively impact the trustworthiness and independence of advisory committee recommendations. However, the research and investigations into this matter have produced mixed results. In a 2014 study of FDA advisory committee member COIs, a researcher found that, where an advisory committee member had an exclusive financial relationship with the manufacturer (referred to as a sponsor) of the product under review, the member appeared to be biased in support of the product sponsor.¹⁹ No similar bias was found where members had financial ties to both a sponsor and its competitors.²⁰ The study author noted that “[t]hese findings point to important heterogeneities in financial ties and suggest that policymakers will need to be nuanced in their management of financial relationships of FDA advisory committee members.”²¹ In another study, the researchers found little significant evidence that advisory committee members vote in their financial interests.²² The authors also found that the perverse exclusion of “financially-conflicted members resulted in a sharp drop in average member expertise, and an unintended increase in approval voting.” The study authors concluded that “[e]liminating conflicts could sharply reduce the level of expertise of the decision makers and lead to unexpected voting tendencies.”²³ More recently, an investigation of FDA advisory committee members COIs has called into question: (1) the completeness of COI disclosures submitted by members; (2) whether the FDA does enough to verify the completeness and accuracy of such disclosures; and (3) whether past or current COI assessments are inadequate as pay-later COIs may play a more significant role in influencing a member’s deliberations and vote. Specifically, a 2018 investigation found that, at the time of or in the year leading up to the advisory committee meetings under scrutiny, many of the members received payments or other financial support from the sponsoring drug firm or key competitors for consulting, travel, lectures, or research.²⁴ The investigators concluded that the FDA did not publicly disclose those ties even though this information was disclosed in scholarly journals.²⁵ In the same investigation, a review was undertaken of compensation records from drug sponsors to advisory committee members who advised the FDA on whether to approve 28 psychopharmacologic, arthritis, and cardiac or renal drugs between 2008 and 2014.²⁶ The investigators concluded that there were “widespread after-the-fact payments or research support to panel members.”²⁷ As correctly noted by the investigators: “[t]he agency’s safeguards against potential conflicts of interest are not designed to prevent such future financial ties.”

AMA POLICY

The AMA has policy addressing COIs applicable to FDA advisory committees (Policy H-100.992, “FDA”) as well as ethics policy concerning COIs in the areas of research (Ethics Opinion 7.1.4/ AMA Principles of Medical Ethics: II, IV,V, “Conflicts of Interest in Research”) and clinical practice guidelines (Policy H-410.953, “Ethical Considerations in the Development of Clinical Practice Guidelines”).

DISCUSSION

The resolve clauses in Resolution 216 would have the AMA adopt policy that specifies that the FDA should place a greater emphasis on advisory committee member COIs and seek a further reduction in the number of COI waivers granted by the FDA. While there is widespread consensus that COI policies are appropriate and necessary along with a measured approach to granting COI waivers for FDA advisory committee members, there is also concern that an overzealous approach to waivers will undermine the actual or perceived quality of advisory committee recommendations. The FDA has reduced the number of waivers granted, but there are conflicting reports with regard to the magnitude of the challenge the Agency faces filling advisory committee vacancies. For example, one article reported that in FY 2017, “218 advisory committee positions of the 600-plus on the FDA’s 49 advisory committees had not been filled.”²⁸ Yet, data disclosed by FDA indicates that in FY 2017 there were 64 vacancies out of 564²⁹ and in FY 2018 there were 57 total vacancies out of 547 members.³⁰ A 10 percent vacancy is substantially lower than a nearly 50 percent vacancy. Nonetheless, the COI waiver rate has remained consistently below one percent. Lowering this percentage further is reasonably likely to increase vacancies which are hovering at 10 percent.

Existing AMA ethics policy provides a clear set of parameters concerning COIs and waivers regarding clinical practice guidelines development and clinical research that should be utilized to expand upon AMA policy concerning FDA advisory committee member COIs and waivers. Our current AMA policy related to advisory committee members provides that a FDA decision to approve a new drug, to withdraw a drug’s approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute and evidence of such should be evaluated by the FDA, in consultation with its advisory committees (Policy H-100.992). The policy also provides that the FDA should not let COIs overrule scientific evidence in making policy decisions. Building on the above policy, our AMA has ethics policy noting how minimizing and mitigating COIs in clinical research is imperative to justify and maintain trust in the medical research community (7.1.4, “Conflicts of Interest in Research”). This is equally true for FDA advisory committee member recommendations. This same policy provides that physicians who engage in research should disclose material ties to companies whose products they are investigating or other ties that create real or perceived COIs. Similarly, AMA ethics policy concerning clinical practice guidelines provides that patients, the public, physicians, and other stakeholders must have confidence that published guidelines are the ethically and scientifically credible product of development processes that are rigorous, independent, transparent, and accountable (Policy H-410.953). Notably, while Policy H-410.953 specifies that published guidelines/updates are to be developed independent of direct financial support from entities that have an interest in the recommendations, it does specify consideration for COIs (actual and perceived) for individuals associated in the development of the guidelines. The policy states: “ideally, all individuals associated with guideline development will be free of conflicts of interest during the development process and will remain so for a defined period following the publication of the guideline.” In order to ensure credibility, our AMA policy provides that:

formal procedures would be adopted to minimize the potential for financial or other interests to influence the process at all key steps (selection of topic, review of evidence, panel deliberations, development and approval of specific recommendations, and dissemination of final product). These should include: a) required disclosure of all potential conflicts of interest by panel members, consultants, staff, and other participants; b) clearly defined criteria for identifying and assessing the seriousness of conflicts of interest; and c) clearly defined strategies for eliminating or mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when participation by an individual with a conflicting interest cannot be avoided.

The policy provides for a clear statement of methodology, COI policy and procedures, and disclosures of panel members’ COIs. The Board recommends extending the foregoing policies to FDA advisory committee member COIs and waivers to underscore the importance of existing FDA laws, regulations, and policies. And since AMA policy

does not address concerns that advisory committee members may not be fully disclosing conflicts and independent targeted auditing for sufficiency may be warranted, the Board recommends adopting new policy to that effect.

The Board recognizes that ensuring that COIs do not compromise the integrity of the FDA advisory committee process is paramount. At the same time, the Board understands that there is an ongoing, pressing need to fill FDA advisory committee vacancies. Therefore, the Board believes that, in accordance with the position outlined above, the AMA should also adopt new policy urging the FDA to streamline the COI process to reduce any unnecessary documentation, administrative barriers, or delays that might hinder the participation of qualified physicians on FDA advisory committees.

Finally, existing policy does not address the impact of pay-later COIs (e.g., where a FDA advisory committee member develops a financial COI only after his or her initial appointment on the advisory committee has expired). Since there is limited research on the topic, this is an important area for the FDA and researchers to more fully evaluate and craft appropriate policy.

RECOMMENDATIONS

In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of Resolution 216-A-18 and the remainder of this report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-100.992, "FDA," which supports that FDA conflicts of interest should not overrule scientific evidence in making policy decisions and the FDA should include clinical experts on advisory committees.
2. That our AMA adopt the following new policy:

It is the position of the American Medical Association that decisions of the Food and Drug Administration (FDA) must be trustworthy. Patients, the public, physicians, other health care professionals and health administrators, and policymakers must have confidence that FDA decisions and the recommendations of FDA advisory committees are ethically and scientifically credible and derived through a process that is rigorous, independent, transparent, and accountable. Rigorous policies and procedures should be in place to minimize the potential for financial or other interests to influence the process at all key steps. These should include, but not necessarily be limited to: a) required disclosure of all relevant actual or potential conflicts of interest, both financial and personal; b) a mechanism to independently audit disclosures when warranted; c) clearly defined criteria for identifying and assessing the magnitude and materiality of conflicts of interest; and d) clearly defined processes for preventing or terminating the participation of a conflicted member, and mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when an individual's participation cannot be terminated due to the individual's unique or rare skillset or background that is deemed highly valuable to the process. Further, clear statements of COI policy and procedures, and disclosures of FDA advisory committee members' conflicts of interest relating to specific recommendations, should be published or otherwise made public. Participation on advisory committees should be facilitated through appropriate balancing of the relative scarcity or uniqueness of an individual's expertise and ability to contribute to the process, as compared to the feasibility and effectiveness of mitigation measures. Finally, our AMA urges the FDA to streamline the COI process to the greatest extent possible, thereby eliminating any unnecessary documentation, delays, or administrative barriers to qualified physicians' participation on FDA advisory committees.

3. That our AMA adopt the following new policy:

It is the position of the American Medical Association that the FDA should undertake an evaluation of pay-later conflicts of interest (e.g., where a FDA advisory committee member develops a financial conflict of interest only after his or her initial appointment on the advisory committee has expired) to assess whether these undermine the independence of advisory committee member recommendations and whether policies should be adopted to address this issue.

REFERENCES

- 1 [FDA Advisory Committees](#), Accessed on February 25, 2019
- 2 Id. Products include blood, vaccines and other biologics; human drugs; food; medical devices; patient engagement; pediatric; radiation-emitting products; risk communication; science board; toxicological research; veterinary; and tobacco.
- 3 See, for example, the FDA Amendments Act (FDAA) of 2007 which mandated that by 2012 no more than thirteen percent of committee advisors per year could receive COI waivers. The FDA reduced the maximum size of financial interests eligible for waivers from a combined financial interest of up to \$100,000, to a maximum of \$50,000. See also [Draft Guidance for the Public, FDA Advisory Committee Members, and FDA Staff on Procedures for Determining COI and Eligibility for Participation in FDA Advisory Committees](#) (March 2007); [Public Availability of Advisory Committee Members' Financial Interest Information and Waivers-Final Guidance](#) (2014); and, [Procedures for Evaluating Appearance Issues and Granting Authorizations for Participation in FDA Advisory Committees](#) (2016).
- 4 Related persons and organizations include: the employee's spouse, minor child, or general partner; an organization or entity for which the employee serves as officer, director, trustee, general partner, or employee; and a person with whom the employee is negotiating for, or has an arrangement concerning, prospective employment.
- 5 In preparation for advisory committee meetings involving particular matters, SGEs invited to participate in the meetings are required to report to FDA any financial interests related to the subject matter of the advisory committee meeting. 5 CFR § 2634.904(a)(2). Permanent government employees also report financial interests on a yearly basis and/or just prior to the advisory committee meeting they are planning to attend. 5 CFR §§ 2634.202 and 2634.904(a)(1). The FDA reviews not only the financial interests of a potential advisory committee participant and the individual's immediate family, but also the financial interests, of which the individual has knowledge, of the participant's business partners, organizations for which the individual serves as officer, director, trustee, general partner, or employee, and any prospective employer of the member (if there are ongoing employment negotiations or an agreement regarding future employment). See 18 U.S.C. § 208(a).
- 6 5 CFR 2640.302(b)
- 7 5 CFR 2640.301(b)
- 8 [Food, Drug, and Cosmetic Act section 505 \(n\)\(4\)](#) "Each member of a panel shall publicly disclose all conflicts of interest that member may have with the work to be undertaken by the panel. No member of a panel may vote on any matter where the member or the immediate family of such member could gain financially from the advice given to the Secretary. The Secretary may grant a waiver of any conflict of interest requirement upon public disclosure of such conflict of interest if such waiver is necessary to afford the panel essential expertise, except that the Secretary may not grant a waiver for a member of a panel when the member's own scientific work is involved."
- 9 Draft Guidance for the Public, FDA Advisory Committee Members, and FDA Staff on Procedures for Determining COI and Eligibility for Participation in FDA Advisory Committees March 2007
- 10 Id.
- 11 Wood SF, Mador JK. *Science and regulation. Uncapping conflict of interest?* Science (2013)
- 12 Lurie P. *Suggestions for Improving Conflict of Interest Processes in the US Food and Drug Administration Advisory Committees—Past Imperfect.* JAMA Intern Med. 2018;178(7):997–998. doi:10.1001/jamainternmed.2018.1324
- 13 Report to Congress Food and Drug Administration Safety and Innovation Act, Section 712 (e) of the Federal Food, Drug, and Cosmetic Act, [Fiscal Year 2016 Annual Report on FDA Advisory Committee Vacancies and Public Disclosures](#) Accessed on February 27, 2019
- 14 The FDA does not publicly disclose financial interest information if it is exempt from disclosure under the Freedom of Information Act or otherwise protected from disclosure by statute or regulation, except if necessary to describe the type, nature, and magnitude of the financial conflict being waived.
- 15 This information must be published within specified time frames before advisory committee meetings. Food, Drug, and Cosmetic Act section 712(c).
- 16 [FDA Guidance on Publication of Financial COI waivers.](#)
https://www.fda.gov/RegulatoryInformation/Guidances/ucm391034.htm#_ftn11
- 17 Political party as described in 26 U.S.C. 527(e)
- 18 Participation is active if, for example, it involves service as an official of the organization or in a capacity similar to that of a committee or subcommittee chairperson or spokesperson, or participation in directing the activities of the organization. In cases, significant time devoted to promoting specific programs of the organization, including coordination of fundraising efforts, is an indication of active participation. Payment of dues or the donation or solicitation of financial support does not, in itself, constitute active participation.
- 19 Pham-Kanter G., *Revisiting Financial Conflicts of Interest in FDA Advisory Committees*, Milbank Quarterly, September 2014 Volume 92, Issue 3 (pages 446–470), DOI: 10.1111/1468-0009.12073
- 20 Id.
- 21 Id.
- 22 Cooper J., Golec J. [Conflicts of Interest on Expert Committees: The Case of FDA Drug Advisory Committees](#), University of Connecticut School of Business Research Paper No. 17-02, April 2018 Accessed February 24, 2019
- 23 Id.
- 24 Piller C., You J. [Hidden conflicts? Pharma payments to FDA advisers after drug approvals spark ethical concerns](#), Science Magazine, July 5, 2018 Accessed February 24, 2019
- 25 Id.
- 26 Id.

- 27 Piller C., You J. [Hidden conflicts? Pharma payments to FDA advisers after drug approvals spark ethical concerns](#), Science Magazine, July 5, 2018 Accessed February 24, 2019
- 28 Sullivan, T., FDA Conflicts of Interest Rules Means Fewer Experts on Advisory Panels, Policy and Medicine Blog, May 5, 2018 Accessed on February 24, 2019.
- 29 FDA website – online [Percent of FDA advisory committee member positions vacant at the end of the month](#) Accessed February 27, 2019
- 30 FDA website – online [Percent of FDA advisory committee member positions vacant at the end of the month](#) Accessed February 27, 2019

APPENDIX - RELEVANT AMA POLICY

Policy H-100.992, “FDA”

- (1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug’s approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
- (2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA’s decision-making process in the course of FDA devising either general or product specific drug regulation.
- (3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

E-7.1.4, “Conflicts of Interest in Research”

Increasing numbers of physicians, both within and outside academic health centers, are becoming involved in partnerships with industry to conduct biomedical and health research. As they do so, physicians must be mindful of the conflicts such engagement poses to the integrity of the research and the welfare of human participants. In addition to financial conflicts of interest created by incentives to conduct trials and recruit subjects, physicians must be sensitive to the differing roles of clinician and investigator, which may require them to balance dual commitments to participants and science. This conflict of commitment is particularly acute when a physician-investigator has treated or continues to treat a patient who is eligible to enroll as a participant in a clinical trial the physician is conducting.

Minimizing and mitigating conflicts of interest in clinical research is imperative if the medical community is to justify and maintain trust in the medical research community.

Physicians who engage in research should:

- (a) Decline financial compensation that awards in excess of the physician’s research efforts and does not reflect fair market value. Physicians should not accept payment solely for referring patients to research studies.
- (b) Ensure that the research protocol includes provision for funding participants’ medical care in the event of complications associated with the research. A physician should not double-bill a third-party payer for additional expenses related to conducting the trial if he or she has already received funds from a sponsor for those expenses.
- (c) As part of the informed consent process, disclose to prospective participants the nature and source of funding and financial incentives offered to the investigators. This disclosure should be included in any written consent materials.
- (d) Avoid engaging in any research where there is an understanding that limitations can be placed on the presentation or publication of results by the research sponsor.
- (e) Refrain from knowingly participating in a financial relationship with a commercial entity with whom they have a research relationship until the research relationship ends and the research results have been published or otherwise disseminated to the public.
- (f) Disclose material ties to companies whose products they are investigating or other ties that create real or perceived conflicts of interest to:
 - (i) institutions where the research will be carried out;
 - (ii) organizations that are funding the research;
 - (iii) any journal or publication where the research results are being submitted.
- (g) Physicians who have leadership roles in institutions that conduct biomedical and health research as well as the entities that fund research with human participants should promote the development of guidelines on conflicts of interest that clarify physician-investigators responsibilities.

AMA Principles of Medical Ethics: II,IV,V; The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. Issued: 2016

Policy H-410.953, “Ethical Considerations in the Development of Clinical Practice Guidelines”

Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. Clinical practice guidelines help inform physician judgment and decision making by physicians and patients. Clinical practice guidelines also have significant

potential to meaningfully inform efforts to provide care of consistently high quality for all patients and to help shape development of sound public policy in health care. To achieve those ends, clinical practice guidelines must be trustworthy. Patients, the public, physicians, other health care professionals and health administrators, and policymakers must have confidence that published guidelines are the ethically and scientifically credible product of development processes that are rigorous, independent, transparent, and accountable.

To that end, the development or updating of clinical practice guidelines should meet the following expectations:

1. Guidelines/updates are developed independent of direct financial support from entities that have an interest in the recommendations to be developed.
2. Formal, scientifically rigorous methods and explicit standards are adopted for the review and weighting of evidence, the integration of expert judgment, and the strength of clinical recommendations.
3. Guideline panels have access to appropriate expertise among members or consultants, including not only relevantly qualified clinical experts but also appropriately qualified methodologists, representatives of key stakeholders, and, ideally, one or more individuals skilled in facilitating groups.
4. Ideally, all individuals associated with guideline development will be free of conflicts of interest during the development process and will remain so for a defined period following the publication of the guideline.
5. Formal procedures are adopted to minimize the potential for financial or other interests to influence the process at all key steps (selection of topic, review of evidence, panel deliberations, development and approval of specific recommendations, and dissemination of final product). These should include: a) required disclosure of all potential conflicts of interest by panel members, consultants, staff, and other participants; b) clearly defined criteria for identifying and assessing the seriousness of conflicts of interest; and c) clearly defined strategies for eliminating or mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when participation by an individual with a conflicting interest cannot be avoided.
6. Guidelines are subject to rigorous, independent peer review.
7. Clear statements of methodology, COI policy and procedures, and disclosures of panel members' conflicts of interest relating to specific recommendations are published with any guideline or otherwise made public.
8. Guidelines are in the first instance disseminated independent of support from or participation by individuals or entities that have a direct interest in the recommendations.

6. COVENANTS NOT TO COMPETE

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 10-A-19
REMAINDER OF REPORT FILED
See Policy D-265.988**

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) considered Resolution 10, "Covenants Not to Compete," introduced by the New Mexico Delegation, which directed:

1. Our American Medical Association consider as the basis for model legislation the New Mexico statute allowing a requirement that liquidated damages be paid when a physician partner who is a part owner in practice is lured away by a competing hospital system.
2. Our AMA ask our Council on Ethical and Judicial Affairs to reconsider their blanket opposition to covenants not to compete in the case of a physician partner who is a part owner of a practice, in light of the protection that liquidated damages can confer to independent physician owned partnerships, and because a requirement to pay liquidated damages does not preclude a physician from continuing to practice in his or her community.

Mixed testimony regarding Resolution 10-A-19 was received by the reference committee. A number of speakers suggested that more information was necessary regarding the issues raised by the resolution and that it should be referred to the Board of Trustees for further study. Testimony also suggested that the Board and not the Council on Ethical and Judicial Affairs (CEJA), was the appropriate entity to study the concerns that prompted the resolution. Individuals testifying also expressed hesitation about both basing model legislation on the New Mexico statute and basing AMA policy on a specific state law. Following the reference committee's recommendation, the HOD referred Resolution 10-A-19 to the Board.

Although Resolution 10-A-19 uses the phrase “Covenants Not to Compete,” this report uses “Restrictive Covenants,” to be consistent with AMA policy.

Use of the term “partner” or “partners”

While this report uses the terms “partner” or “partners” to refer to physician ownership interests in a group practice, this report’s use of these terms should not be interpreted in any way as being limited to physician ownership interests in group practices formed as partnerships. Rather, the term “partner” or “partners” encompasses *any* type of physician ownership interests in a group practice, e.g., as a member in a limited liability corporation, a shareholder in a corporation, a partner in a partnership etc., regardless of the group practice’s legal structure.

DISCUSSION

Concerns about Restrictive Covenants’ Potential Negative Effects

There is growing concern among many AMA members regarding the negative impact of restrictive covenants. Some AMA members oppose restrictive covenants, in part because of the negative impact that restrictive covenants may have on them and their families if restrictive covenant enforcement compels a physician to move out of his or her community to continue practicing medicine. Members may also be disturbed about the potential negative effects that restrictive covenants may have on patient choice, patient access and the patient-physician relationship.

An Increase in Employed Physicians

The reason restrictive covenants are becoming more problematic for many AMA members is perhaps due to that fact that, for the first time ever, there are more employed physicians than physician-practice owners.¹ Recent state legislative activity is consistent with this trend, as several states have either enacted or amended restrictive covenant statutes applicable to physicians specifically or to health care generally.

Reasons why AMA members may support reasonable restrictive covenants

Other physicians, e.g., owners of physician practices or physician leaders of integrated health systems, may strongly support reasonable restrictive covenants. A reasonable restrictive covenant may, for example, give a medical practice peace of mind about committing the significant resources needed to help a new physician succeed, without having to fear that the physician will then leave, taking patients to a competitor and/or using sensitive information to gain a competitive advantage over his or her former employer. Further, physician practice owners may view reasonable restrictive covenants as necessary to ensure that all of the owners are mutually committed to the joint investments in the equipment and/or facilities that the entire practice must make in order to meet the agreed-upon business plan. CEJA Ethical Opinion 11.2.3.1, entitled, “Restrictive Covenants,” does state, in part, that physicians should not agree to restrictive covenants that are unreasonable with respect to geography or duration and that do not make reasonable accommodation for patients’ choice of physician. This report presents the entire text of Ethical Opinion 11.2.3.1 in the discussion concerning the second resolve of the resolution.

New Mexico

The New Mexico statute is a relatively recent development, enacted in 2015 and amended in 2017. The New Mexico law is a legislative compromise between physicians who are practice owners and physicians who are employees, acknowledging that there are physicians on both sides of the restrictive covenant issue.

The statute applies to “health care practitioners,”² which includes physicians, and to “agreements,” which means “a written contract to which a health care practitioner is a party.”³ The New Mexico law states that a restrictive covenant in an agreement that restricts the right of a health care practitioner to provide clinical health care services is “unenforceable upon the termination of: (1) the agreement; (2) a renewal or extension of the agreement; or (3) a health care practitioner’s employment with a party seeking to enforce the agreement.”⁴ Consequently, under the New Mexico statute, a restrictive covenant in an agreement such as an employment or practice partnership agreement, cannot be enforced against a former employee or partner. The law also states that such a provision in an agreement for clinical health care services is void, unenforceable and against public policy if the provision: (1) makes the agreement subject to the laws of another state; or (2) requires any litigation arising out of the agreement to be conducted in another state.

Although the New Mexico law precludes restrictive covenant enforcement, the party, e.g., a former employer, retains significant rights. First, if a physician has worked for an employer for an initial period of less than three years and then leaves, the employer may require the physician to repay: (1) a loan; (2) relocation expenses; (3) a signing bonus or other remuneration bonus or other remuneration to induce the health care practitioner to relocate or establish a health care practice in a specified geographic area; or (4) recruiting, education, and training expenses. Second, a party may enforce a nondisclosure provision relating to confidential information and trade secrets. Third, the physician or health care practitioner may be required to comply with a non-solicitation provision with respect to patients and employees of the party seeking to enforce the agreement for a period of one year or less after the last date of employment.

The statute achieves a compromise between physicians who are only employees and practice owners by differentiating between the two when it comes to liquidated damages. As noted above, if a physician was an employee who has worked for an employer for an initial period of less than three years and leaves, the former employer can recover (1)-(4) above. This is the statute's way of protecting the former employer financially by enabling it to recover amounts incurred to bring the employee to the community and to help the physician establish a practice. After the initial three-year period, however, the employer cannot recover (1)-(4) because the statute presumes that the employer has, by then, recovered those costs. Further, since monetary recovery is limited to (1)-(4), the former employer may not obligate the physician to pay liquidated damages. By limiting monetary recovery and prohibiting restrictive covenant enforcement, the statute protects the employed physician who may have entered into an employment agreement with little or no bargaining power.

With respect to physician partners, the statute does not allow the practice to enforce a restrictive covenant against a former partner but does permit the practice to require the former partner to pay reasonable liquidated damages. This disparate treatment of physician owners and employees recognizes that physician partners owe duties to one another that do not apply to employed physicians. Unlike employees, a physician partner has a duty to protect other partners, the partnership itself and the large investment that the physician and the other partners have collectively made in the practice. If a practice makes investments that count on an individual partner's continued financial and other commitments to the practice, the New Mexico statute permits, as a matter of fairness, that the departing physician partner pay the practice reasonable liquidated damages if the partner leaves.

First Resolve of Resolution 10-A-19

The Board does not recommend that the AMA develop state model legislation at this time. The Board fully understands, however, that restrictive covenant issues are of great concern to many AMA members and believes that the AMA should provide members with further guidance and resources than currently exist. Accordingly, this report recommends that the AMA develop a state restrictive covenant legislative template, for reasons described below.

Difference Between a Model Bill and a Legislative Template

The AMA Advocacy Resource Center (ARC), the state legislative and regulatory unit of the AMA, makes model bills and state legislative templates available to state and national medical specialty societies to assist in their respective state legislative and regulatory strategy development and implementation. Model bills are prescriptive in the sense that they present a single, optimal approach to an issue. A model bill usually has little commentary or explanation concerning the underlying rationale for the bill's specific provisions.

A state legislative template, on the other hand, is not prescriptive. A template is an environmental scan of relevant state law and presents multiple legislative options for addressing a topic that is so diverse and complex across the states that the more one-size-fits-all approach that a model bill represents may not be adequate. The ARC has developed legislative templates for a variety of issues including health courts, scope of practice issues, and medical liability reforms, to name a few.

Reasons Favoring a State Legislative Template

The Board has three reasons for recommending the creation of a state legislative template over a model bill.

First, state restrictive covenant statutes are very diverse, differing in terms of issues addressed, e.g., the role, if any, that liquidated damages may play in restrictive covenant analyses. Further complicating the matter is that many states

have restrictive covenant-related legal decisions going back years, regardless of whether the state also has a statute on the books. The wide variation in states' legislative and judicial treatment of restrictive covenants can be particularly present when it comes to physician restrictive covenants. This is especially true where temporal and geographic reasonableness, the legitimacy of business interests involved, patient demographics, physician specialty and public policy considerations like patient choice and patient access may differ greatly from one case to another. The Board is concerned that any model legislation may be too specific to be of much use, since a bill would only present one set of legislative solutions to the myriad restrictive covenant issues. Not drafting a model bill would also avoid concerns expressed by reference committee testimony about basing model legislation on a specific state solution, e.g., the New Mexico statute, and AMA policy, more broadly, on one state law.

A legislative template could, on the other hand, capture at least some of the diversity discussed above and offer several options for legislative language and accompanying rationale. Issues covered could include, but not be limited to: identification of legitimate business interests; reasonableness of geographic scope; reasonableness of duration; damages; consideration given to the impact that restrictive covenant enforcement may have on the individual physician; termination events that trigger a restrictive covenant's application; and differing treatment of physician-owners and employees. The template could, of course, discuss key aspects of the New Mexico statute, and present potential solutions based on that law.

Second, restrictive covenants are a highly sensitive issue for AMA members. Many members have very strong opinions for and against restrictive covenants. The Board is concerned that any AMA- initiated model bill would fail to strike the proper balance between competing points of view, assuming a balance could be achieved across a membership that is diverse in a great many respects, e.g., in terms of specialty, geography, practice environment, etc. The Board notes that Policy H-383.987, "Restrictive Covenants in Physician Contracts," states that, "Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies." This policy ensures that the AMA's development of any restrictive covenant model bill is informed by guidance that has been fully vetted at the state medical association or national medical specialty society level to ensure that the bill reflects the likely compromises that the association or society has worked out among its members. A state legislative template is, on the other hand, less likely to invite division among AMA members, since the template would simply provide an environmental scan of the issues raised above and possible legislative options.

Third, with respect to making revisions and updates, a template is more flexible than a model bill. The AMA Council on Legislation (COL) works with AMA ARC staff to develop the AMA's model state bills. The COL approves the final draft of a model bill during one of its quarterly in-person meetings. The COL then submits that draft to the Board for consideration at the next Board meeting. The model bill is only final if the Board approves the bill. Any significant revisions to a model bill must go through the same process. Creating and revising a legislative template does not involve the more formal process that applies to official AMA model state bills. Again, this is because templates are environmental scans providing varying legislative language options rather than constituting a model bill's more definitive approach. Consequently, the AMA has more flexibility when it comes to timely updating its state legislative templates. This flexibility may be particularly important now given state medical associations', national medical specialty societies' and legislatures' increasing attention to restrictive covenants.

Second Resolve of Resolution 10-A-19

The Board does not recommend that the HOD adopt the second resolve in Resolution 10, since that resolve does not accurately reflect CEJA's position concerning restrictive covenants. Ethical Opinion 11.2.3.1, "Restrictive Covenants," states:

Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.

Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.

Physicians should not enter into covenants that:

- a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and

- b) Do not make reasonable accommodation for patients' choice of physician.

Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

Ethical Opinion 11.2.3.1 does not express a blanket opposition to restrictive covenant agreements, and does not prohibit physicians from using, or agreeing to, restrictive covenants. Ethical Opinion 11.2.3.1 simply states that physicians should not enter into a restrictive covenant that is unreasonable in terms of duration, geographic scope and does not make a reasonable accommodation for patients' choice of physician. Ethical Opinion 11.2.3.1 is consistent with the majority of states where courts will enforce physician restrictive covenants so long as the covenants protect a legitimate business interest, are reasonable with respect to duration and geography and are not otherwise against public policy, of which patient choice may be a consideration in some jurisdictions.⁵ Accordingly, the Board does not recommend adopting the second resolve of the resolution.

Nevertheless, given the importance of restrictive covenants to AMA members, the HOD may have an interest in asking CEJA to incorporate into Ethical Opinion 11.2.3.1 the distinction recognized by the New Mexico law between physician partners and physicians who are only employed. CEJA could, for example, state that partners in a practice have an ethical obligation to protect the practice, their fellow partners, and partners' investment in the practice. CEJA could further recognize that these mutual obligations apply when a partner chooses to leave the practice, e.g., if he or she chooses to work at a competing hospital, entailing that both the physician and the partners owe one another an ethical obligation to treat one another fairly upon the physician's exit. These duties could, depending on the circumstances, obligate the departing physician to compensate the partnership via the payment of reasonable, liquidated damages. Such an addition to Ethical Opinion 11.2.3.1 could further the opinion's emphasis on accommodating patient choice—ensuring that practices are treated fairly upon a partner's exit and enabling the practice to stay financially viable, thus remaining an option for patient choice.

AMA POLICY

In addition to the CEJA Ethical Opinion 11.2.3.1 and Policy H-383.987, other AMA policies discuss restrictive covenants. Policy H-310.929, "Principles for Graduate Medical Education," states that restrictive covenants must not be required of residents or applicants for residency education; and Policy H-225.950, "AMA Principles for Physician Employment," discourages physicians from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

AMA EDUCATIONAL RESOURCES

Finally, as noted above, AMA has many resources that educate medical students, physicians-in-training, and physicians about restrictive covenants. For example:

- The AMA Career Planning Resource webpage has a wealth of information discussing physician employment issues, which includes information and tips regarding restrictive covenants. The AMA Career Planning Resource webpage may be accessed at <https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts>.
- The AMA also has two model employment agreements that discuss restrictive covenants: the Annotated Model Physician-Hospital Employment Agreement, 2011 edition: E-Book, free for AMA members at https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod1240028&sku_id=sku1240037 and the Annotated Model Physician-Group Practice Employment Agreement: E-Book, free for members at https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod2530052&sku_id=sku2530104. These resources contain model restrictive covenant language for potential physician employees to consider, which may prove useful in the employment negotiation process.
- Finally, AMA ARC staff work extensively on physician employment issues. AMA members are encouraged to contact the Advocacy Resource Center at arc@ama-assn.org, if they would like to obtain more information and resources concerning restrictive covenants.

RECOMMENDATION

In light of these considerations, the Board recommends that the following be adopted in lieu of Resolution 10-A-19 and the remainder of this report be filed:

Our American Medical Association create a state restrictive covenant legislative template to assist state medical associations, national medical specialty societies and physician members as they navigate the intricacies of restrictive covenant policy at the state level.

REFERENCES

- 1 “Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees,” American Medical Association, Policy Research Perspectives, Carol Kane, PhD. (2019). This resource can be accessed at <https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf>.
- 2 NMSA 1978, § 24-11-1(B).
- 3 NMSA 1978, § 24-11-1(A).
- 4 NMSA 1978, § 24-11-2(A).
- 5 Some states have enacted statutes prohibiting restrictive covenants, either generally or specifically with respect to physicians. States that more generally prohibit restrictive covenants include California, North Dakota, and Oklahoma. States that prohibit physician restrictive covenants include Colorado, Delaware, Massachusetts, New Hampshire, and Rhode Island. These statutes differ with respect to damages.

7. INVOLUNTARY CIVIL COMMITMENT FOR SUBSTANCE USE DISORDER

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 22-A-19
REMAINDER OF REPORT FILED
TITLE CHANGED**
See Policies H-95.912 and D-95.963

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 22-A-19, “Opposition to Involuntary Civil Commitment,” introduced by the delegations from Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont, which asked:

That our American Medical Association oppose involuntary civil commitment without judicial involvement of persons for reasons solely related to substance-use disorder; and

That our AMA work to advance policy and programmatic efforts to address gaps in voluntary substance use treatment services.

Testimony on Resolution 22 was limited and mixed. Some speakers suggested that involuntary civil commitment was sometimes important to help save lives. Other speakers highlighted the positive role that judicial oversight can play for a person with a substance use disorder (SUD). The resolution sponsors noted the role of consent and questionable medical evidence justifying involuntary civil commitment. This report provides an update on the current use of some civil commitment proceedings and a review of relevant AMA policy, and it also makes policy recommendations.

DISCUSSION

Background

Involuntary civil commitment can be broadly described as “a legal intervention by which a judge, or someone acting in a judicial capacity, may order that a person with symptoms of a serious mental disorder, and meeting other specified criteria, be confined in a psychiatric hospital or receive supervised outpatient treatment for some period of time.”¹

There are at least three key aspects to consider regarding this definition. First, the fact that an involuntary civil commitment is a legal proceeding that allows the state to intercede into a person's right to liberty for non-criminal reasons. Second, the loss of liberty is predicated on the existence of a mental disorder, and for the purposes of this report, "other specified criteria" includes a SUD. And third, bedrock to the AMA *Code of Medical Ethics* is that "[p]hysicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm." (*Code of Medical Ethics*. Opinion 9.7.2, Court-Initiated Medical Treatment in Criminal Cases)

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) says that "[s]ubstance use and mental disorders are closely linked." The 2018 National Survey on Drug Use and Health (NSDUH) presented data that "illicit substance use increases risk for other hazardous substance use and mental illness; and that [m]ental illness is a risk factor for illicit substance use."² In 2018, 36 percent of those with a serious mental illness (SMI) received no treatment while more than 20 million Americans had a (SUD), but only 10 percent received any treatment—roughly the same percentage of treatment for those with an SUD and SMI.³ Detailing the scope of why the treatment gap continues is beyond the scope of the report, but among the predominant factors is the lack of access to health care professionals and appropriate medical services.⁴

Involuntary civil commitment

Proponents of involuntary civil commitment policies for the treatment of a SUD focus on the opportunity to help an individual receive treatment because that individual is a threat to him- or herself and/or others.⁵ More than 30 states have a variation of law that allows for involuntary civil commitment for a SUD that variously define the nature of the harm and/or threat. This might include severe incapacitation, lack of decisional capacity, danger to property, abusing while pregnant or a repeated pattern of failing to meet social, financial or occupational responsibilities. The length of the involuntary commitment also can vary from up to one month to an indefinite period of time. The Associated Press reports that use of involuntary civil commitments has increased.⁶

Commentators have highlighted multiple concerns with involuntary civil commitment for SUD, including a lack of infrastructure to ensure that persons involuntarily committed are treated in medical facilities. There also is concern that law enforcement—and not a physician—might be able to initiate an involuntary civil commitment before a judge or magistrate.⁷ And if a person is involuntarily committed for a SUD, will treatment be forced upon the person, including the taking of medications to treat withdrawal and/or maintenance medications? Or would such medications be denied to a person? The AMA *Code of Medical Ethics* counsels that physicians should: "Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control." (*Code of Medical Ethics*. Opinion 9.7.2, Court-Initiated Medical Treatment in Criminal Case) In opposition to a bill allowing for involuntary civil commitment for a SUD, the Massachusetts Medical Society raised further concerns that, "There is no research to suggest that this treatment option will save lives. Therefore, more studies are needed before Massachusetts should institute a law with far-reaching consequences."⁸

While testimony before the HOD indicated that there may be benefits for select individuals, and there are news reports of positive individual outcomes, the studies that have been done on the subject note that dangers of involuntary civil commitment are high. A Massachusetts Department of Public Health review found that persons "who received involuntary treatment were 2.2 times as likely to die of opioid-related overdoses and 1.9 times as likely to die of any cause compared to those with a history of voluntary treatment only."⁹ A review of nine studies found:

There is limited scientific literature evaluating compulsory drug treatment. Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. Given the potential for human rights abuses within compulsory treatment settings, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms.¹⁰

Some of these abuses have ranged from placing persons civilly committed into the general population in a criminal facility, making persons wear prison garb (e.g. an orange jumpsuit) and forcing detoxification. For comparison, American Society of Addiction Medicine (ASAM) placement criteria for persons with a substance use disorder emphasize:

[s]eparate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over

five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided.¹¹

This is not to suggest that all facilities where a person subject to involuntary civil commitment might be placed primarily house criminal subjects or provide substandard care. Rather, the juxtaposition is to highlight the need for inpatient care to rely upon medical standards of care. It is questionable whether a criminal facility can accomplish this.

Also, this does not suggest there is no role for involuntary civil commitment, or that jails cannot play a positive role for providing medical care to those incarcerated,¹² but as testified by members of the HOD, legal, ethical and other safeguards need to be put in place if a person is to lose his or her liberty and is civilly committed without his or her consent. As a threshold matter, it is worth noting that, “The availability of effective, comprehensive, community-based systems of care for persons suffering from serious mental illnesses will diminish the need for involuntary commitment and/or court-ordered treatment,”¹³ according to the National Alliance of Mental Illness (NAMI). That is, using jails as stand-ins for medically-based treatment centers would not be necessary if there were sufficient public support and resources for community-based care for mental illness and SUDs. And it should be clear that while jails and prisons can and do provide medical care, a correctional facility’s core purpose is to imprison, not treat patients.

NAMI’s policy position further highlights elements to balance patient autonomy with the proper role of the judicial system when considering involuntary civil commitment. This includes ensuring a person potentially subject to involuntary civil commitment receive an expeditious hearing, medical decisions be made by medical professionals—and not courts—and that, “Involuntary inpatient and outpatient commitment and court-ordered treatment should be used as a last resort and only when it is believed to be in the best interests of the individual.” This also includes ensuring the individual has an opportunity to oppose the involuntary commitment.¹⁴

The patient’s right to be a part of the medical decision-making process is central to an effective patient-physician relationship. The ability to make decisions is central to the issues in this report. Among the detailed recommendations put forward by the American Psychiatric Association Council on Psychiatry and Law, “States authorizing involuntary outpatient commitment should provide due process protections equivalent to those afforded patients subject to involuntary hospitalization.”¹⁵

An update on AMA efforts to advance policy and programmatic efforts to address gaps in voluntary substance use treatment services

The AMA, through its ongoing state and federal advocacy as well as its work through the AMA Opioid Task Force, continues its efforts to address gaps in evidence-based treatment for mental health and substance use disorders. At the state level, in the past two years, the AMA has helped advance and enact state laws in more than one dozen states to remove prior authorization for medications to help treat opioid use disorder—commonly referred to as medication assisted treatment (MAT). The AMA’s work in this area has included technical support to state medical societies, development of model state legislation and presentations by AMA leadership and staff to influential stakeholders such as the National Governors Association, National Association of Insurance Commissioners (NAIC), National Academies of Sciences, Engineering and Medicine, as well as the U.S. Congress.¹⁶

In 2019, the AMA also released with Manatt Health a “National Roadmap on State-Level Efforts to End the Opioid Epidemic,” which highlighted best practices from multiple states on areas including reducing the treatment gap. While it is beyond the scope of this report to detail all of the best practices, with respect to reducing the treatment gap, the AMA-Manatt Health report¹⁷ highlighted examples such as:

- The Pennsylvania state insurance commissioner helping forge a voluntary agreement with the Commonwealth’s major commercial payers to remove prior authorization for MAT;
- The Colorado Division of Insurance implementing a law establishing an office of the ombudsman to assist state residents in accessing behavioral health care;
- The establishment of Centers of Excellence in Pennsylvania as part of hub-and-spoke models of care to help promote evidence-based care; and
- Community-based collaborative practice models led by the North Carolina Medical Society to enhance access to physicians and other health care professionals.

The AMA also continues its advocacy with partners such as the American Psychiatric Association (APA), ASAM and others in support of mental health and substance use disorder parity oversight and enforcement. In February 2020, after sustained advocacy in partnership with the APA, the NAIC approved a new charge for a newly formed Mental Health Parity and Addiction Equity Act (MHPAEA) Working Group that will continue to raise the importance of parity enforcement in the states. The AMA will continue to work with the NAIC and others as they develop parity-specific recommendations and actions.

With respect to payment reform to support increased access to treatment services, the AMA worked with the ASAM to develop a concept paper for an alternative payment model to support a team-based approach to office-based management of treatment for opioid use disorder (OUD), called “Patient-Centered Opioid Addiction Treatment model” (P-COAT). This model concept provided the foundation for Section 6042 of the SUPPORT Act, which requires the U.S. Centers for Medicare & Medicaid Services to implement a demonstration project supporting treatment of Medicare patients with OUD consistent with the comprehensive biopsychosocial model of care in the P-COAT approach. The P-COAT model also formed the basis for AMA and ASAM advocacy on a new Medicare payment policy that, effective in 2020, provides a bundled payment for office-based treatment of OUD. As AMA and ASAM recommended, the bundled payments include a higher payment for the first month of treatment to cover the cost of developing and getting the patient engaged in a treatment plan and educating the patient about self-management of their condition, and monthly payments of about \$367 for as long as the patient remains in treatment. The payments support development of a treatment plan, care coordination, individual and group therapy and counseling for patients with OUD, with the cost of medications used in treatment paid separately.

The AMA has also been working to eliminate the requirement for physicians to get a special waiver from the U.S. Drug Enforcement Administration (DEA) in order to prescribe buprenorphine for the treatment of OUD. The AMA has supported legislation introduced in the U.S. House of Representatives that would eliminate this requirement and has met with senior Administration officials to seek the Administration’s support for this policy change.

The AMA was encouraged by the Centers for Disease Control and Prevention’s (CDC) recognition that its opioid prescribing guidelines have been misapplied and have had serious unintended consequences. CDC recently embarked on an effort to update its guidelines and the AMA has strongly cautioned the agency to heed the advice of the U.S. Department of Human and Health Services’ Pain Management Task Force that patients with painful conditions need to be treated as individuals and that one-size-fits-all approaches must be avoided.

The AMA also has repeatedly urged the DEA to update its rules for electronic prescribing of controlled substances, especially outdated multifactor authentication rules. Regardless, even though federal law required an update in 2019, the DEA has not yet done so. This is important because federal law requires e-prescribing controlled substances starting in 2021.

AMA POLICY

The AMA has both Ethics and HOD policy on the areas covered in this report. The AMA *Code of Medical Ethics (the Code)* makes clear that:

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. (*Code of Medical Ethics*. Opinion 2.1.1, Informed Consent)

The Code also covers situations when a patient may lack decision-making capacity. In those situations, the Code reiterates that, “Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient’s decision-making capacity.” (*Code of Medical Ethics*. Opinion 2.1.2, Decisions for Adult Patients Who Lack Capacity) The Code further advises:

Even when a medical condition or disorder impairs a patient’s decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf. (*Code of Medical Ethics*. Opinion 2.1.2, Decisions for Adult Patients Who Lack Capacity)

For situations involving children and adolescents, the Code also suggests respect not only for the parent's (or guardian's) responsibility, but also the need to include children in the decision-making process. The Code advises that:

Respect and shared decision making remain important in the context of decisions for minors. Thus, physicians should evaluate minor patients to determine if they can understand the risks and benefits of proposed treatment and tailor disclosure accordingly. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to seek minor patients' assent to treatment. (*Code of Medical Ethics*. Opinion E-2.2.1, Pediatric Decision Making)

The Code further provides that, "Except when immediate intervention is essential to preserve life or avert serious, irreversible harm, physicians and parents/guardians should respect a child's refusal to assent, and when circumstances permit should explore the child's reason for dissent." (*Code of Medical Ethics*. Opinion E-2.2.1, Pediatric Decision Making)

Finally, the Code provides that, "All individuals have a fundamental right to be free from unreasonable bodily restraint." It further explains that, "At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient." These times must be governed by the physician's professional judgment. The Code goes on to state "In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. In such situations, the least restrictive restraint reasonable should be implemented and the restraint should be removed promptly when no longer needed." (*Code of Medical Ethics*. Opinion 1.2.7, Use of Restraints)

AMA policy also is clear on the benefits of shared decision-making, including support for "[p]rotecting the patient-physician relationship by continuing to advocate for: the obligation of physicians to be patient advocates." (Policy H-165.837, "Protecting the Patient-Physician Relationship") AMA policy also emphasizes the need for patients to be active partners in their health care, including support for "[t]he concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions." (Policy H-373.997, "Shared Decision-Making")

Finally, as briefly quoted in the body of the report, the Code provides important considerations for physicians' actions in court-initiated medical treatments. While the policy cited above mainly focuses on the rights of prisoners in a criminal setting, the Code provides guidance for physicians who do participate in court-initiated medical treatments. In addition to the discussion above, the Code includes the provision that:

Physicians who provide care under court order should be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given. (*Code of Medical Ethics*. Opinion 9.7.2, Court-initiated Medical Treatment in Criminal Cases)

RECOMMENDATIONS

The Board recommends that Resolution 22-A-19 be amended by addition and deletion and the remainder of the report be filed.

1. That our American Medical Association oppose civil commitment proceedings for patients with a substance use disorder unless: a) A physician or mental health professional determines that civil commitment is in the patient's best interest consistent with the *AMA Code of Medical Ethics*; b) Judicial oversight is present to ensure that the patient can exercise his or her right to oppose the civil commitment; c) The patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by his or her physician; and d) The facility is separate and distinct from a correctional facility.

2. That our AMA continue its work to advance policy and programmatic efforts to address gaps in voluntary substance use treatment services.

REFERENCES

- 1 Substance Abuse and Mental Health Services Administration: Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019. Available at <https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf>
- 2 The National Survey on Drug Use and Health: 2018. Presentation by Elinore F. McCance-Katz, MD, PhD Assistant Secretary for Mental Health and Substance Use. Substance Abuse and Mental Health Services Administration. U.S. Department of Health and Human Services. Available at <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Assistant-Secretary-nsduh2018-presentation.pptx>
- 3 Id.
- 4 See Christopher, MD, Paul, et al. "Nature and Utilization of Civil Commitment for Substance Abuse in the United States." J Am. Acad. Psychiatry Law 43:312-20, 2015. Available at <http://jaapl.org/content/jaapl/43/3/313.full.pdf>
- 5 Id.
- 6 Marcelo, Philip. "In the addiction battle, is forced rehab the solution?" Associated Press. May 23, 2018. "Florida reported more than 10,000 requests for commitment in both 2016 and 2015, up from more than 4,000 in 2000. Massachusetts reported more than 6,000 forced commitments for drug addiction in both fiscal years 2016 and 2017, up from fewer than 3,000 in fiscal year 2006. In Kentucky, judges issued more than 200 orders of involuntary commitment for alcohol or drug abuse in the last calendar year, up from just five in 2004, according to court records. The state has so far reported nearly 100 such commitments this year." Available at <https://apnews.com/75a4822a714b43a5b6f7b7b988d641f6/In-the-addiction-battle,-is-forced-rehab-the-solution?>
- 7 See, for example, 2017 Wisconsin Act 34. Available at <https://docs.legis.wisconsin.gov/2017/related/acts/34.pdf>
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- 9 "An Assessment of Opioid Related Deaths in Massachusetts (2013-2014)." The Massachusetts Department of Public Health. September 2016. Available at <https://www.mass.gov/files/documents/2016/09/pg/chapter-55-report.pdf>
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- 11 "What is the ASAM Criteria." American Society of Addiction Medicine. <https://www.asam.org/Quality-Science/the-asam-criteria/about>
- 12 "The Repurposing of the American Jail," Jessica Pishko. *The Atlantic*. November 19, 2019. Albany Sheriff Craig Apple converted 25 cells in a county correctional facility to allow for the provision of medication-assisted treatment for inmates, but this is primarily still for those convicted of a crime.
- 13 National Alliance on Mental Illness. Legal Issues. Available at <https://www.nami.org/About-NAMI/Policy-Platform/9-Legal-Issues>
- 14 Id.
- 15 Resource Document on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment. American Psychiatric Association Council on Psychiatry and Law. Approved by the Joint Reference Committee, October 2015. Note: The APA included the following disclaimer: "The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors."
- 16 Susan R. Bailey, MD, President-elect, AMA Board of Trustees. Statement of the American Medical Association to the U.S. House of Representatives Committee on Oversight and Reform Re: Medical Experts: Inadequate Federal Approach to Opioid Treatment and the Need to Expand Care. June 19, 2019. Available at <https://docs.house.gov/meetings/GO/GO00/20190619/109654/HHRG-116-GO00-Wstate-BaileyS-20190619.pdf>
- 17 National Roadmap on State-Level Efforts to End the Opioid Epidemic. American Medical Association and Manatt Health. September 2019. Available at www.end-opioid-epidemic.org/national-roadmap

8. WHITE HOUSE INITIATIVE ON ASIAN AMERICANS AND PACIFIC ISLANDERS

Informational report; no reference committee hearing.

HOD ACTION: FILED

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 Bush⁶ and Obama⁷ 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 month⁸.

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 II⁹ (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 businesses¹¹.

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 Philippines¹². 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 region¹³, 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 2015¹⁴. They are slated to account for 11 percent of the U.S. population by 2050¹⁵ 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 homes¹⁷.

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 Chinese¹⁸. 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 US¹⁹. 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 benefits²⁰. 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-compliance²¹ 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 outcomes²². 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 salaries²³ 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 1557²⁵, AAPI health research already cited the deep healthcare access barriers AAPIs faced²⁶, 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 liver²⁷—is still the leading cause of death²⁸, and where rates of tuberculosis and Hepatitis B²⁹ 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 Americans³². 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 rates³³. 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 figures³⁵.

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 physicians⁴². AAPI students, who tend to value and are reared in households where interdependence and family obligations are paramount over self-aspirations⁴³, 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 subgroup⁴⁴, 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 Act⁴⁶—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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9. BULLYING IN THE PRACTICE OF MEDICINE

Reference committee hearing: see report of Reference Committee D.

**HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 402-A-19
REMAINDER OF REPORT FILED**
See Policies H-215.978 H-295.955 H-515.951 H-515.966

INTRODUCTION

At the 2019 Annual Meeting Resolution 402-A-19, "Bullying in the Practice of Medicine," was introduced by the Young Physicians Section and referred by the House of Delegates (HOD) for report back at the 2020 Annual Meeting. The resolution asks the American Medical Association (AMA) to: (1) help establish a clear definition of professional bullying; (2) establish prevalence and impact of professional bullying; and (3) establish guidelines for prevention of professional bullying.

This report provides statistics and other information about the causes, prevalence, and impact of bullying in the practice of medicine, and makes recommendations for the adoption of a formal definition and guidelines for establishing policies and strategies for preventing and addressing incidents of bullying among the health care staff.

BACKGROUND

Bullying in the medical profession is a well-documented issue involving the abuse of power or control over a person and repeated offensive, intimidating, malicious, or insulting behavior.¹⁻⁶ A 2017 Workplace Bullying Institute (WBI) survey showed 63 percent of workers are aware of bullying in their workplace.⁷ Bullying in the workplace is more common than sexual harassment and is initiated by both men and women.⁸ This report focuses on bullying among medical students, residents/fellows, and practicing physicians. However, it is important to note that other health care workers such as nurses, medical assistants, and pharmacists, as well as workers in other industries, can also be victims and perpetrators of workplace bullying. Organizational and health system factors may also contribute to the overall workplace climate or culture that allows unprofessional behavior, such as bullying, to persist. This report will discuss some of those factors and the importance of addressing bullying at the individual and organizational levels.

The effects of bullying in medicine can reach beyond the target to the patients, care teams, organizations, and the families of the patients and victims. The effects of bullying on the organizational culture and professional attitudes of the medical staff are significant and lasting, emphasizing the importance of changing the culture to address the problem.⁹

Calls for change in medical education to stop the abuse and harassment of medical students by their teachers have been vocalized for decades.¹⁰ Yet, the unprofessional behavior exercised by some physicians, and the persistence of organizational cultures that enable the behavior, continue to degrade the medical profession. When patient safety, quality of care, and the overall health care industry are under increasingly high scrutiny, it is imperative that physicians, whose professional aims include caring for others and as a unified group following a code of ethics, stop the cycle of bullying. Physicians and organizations together need to foster an educational and workplace culture that is respectful, supportive, and conducive to learning and providing high-quality care.

AMA POLICY

The AMA encourages all health care facilities to adopt policies to assess and manage reported workplace violence and abuse, and policies to reduce and prevent all forms of workplace violence and abuse. The AMA recommends that

organizations develop a reporting tool that is easy for workers to find and complete and make training courses on workplace violence prevention available to employees and consultants (Policy H-515.966, "Violence and Abuse").

The AMA recommends that all medical education institutions have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

Code of Behavior

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unflinching honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, and inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments, or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People

in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients (Policy H-295.955, “Teacher-Learner Relationship In Medical Education”).

AMA policy also states that the AMA: (1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised; and (2) encourages physicians to: work with their hospital safety committees to address the security issues within particular hospitals; become aware of and familiar with their own institution's policies and procedures; participate in training to prevent and respond to workplace violence threats; report all incidents of workplace violence; and promote a culture of safety within their workplace (Policy H-215.978, “Workplace Violence Prevention”).

DISCUSSION

Definitions of bullying

Several definitions of “bullying” are offered throughout existing literature. Various types of bullying have been studied, offering multiple bases on which to define the construct. The variation in definitions may hamper the ability to consistently identify and address the issue. An article in the *International Journal of Environmental Research and Public Health* states “bullying is commonly defined by its social manifestations, which are clearly classifiable under the same umbrella as aggressive behavior that generally occurs during interpersonal interactions in work settings. Similarly, there seems to be a consensus that bullying can be defined in terms of intentionality, frequency (e.g., weekly) or duration (e.g., approximately six months), the targets’ reaction(s), perceived imbalance and misuse of power between the perpetrator and target, inadequate support, and the target’s inability to defend himself from such aggression, as well as having to cope with negative and constant social interactions, physical or verbal badgering, insulting remarks, and intense pressure.”¹¹

One study identified five categories of workplace violence:¹²

1. Threat to professional status (public humiliation)
2. Threat to personal standing (name calling, insults, teasing)
3. Isolation (withholding information)
4. Overwork (impossible deadlines)
5. Destabilization (failing to give credit where credit is due)

McAvoy et al. defined bullying as “persistent, offensive, abusive, intimidating, malicious, or insulting behavior; abuse of power; or unfair penal sanctions...that make the recipient feel upset, threatened, humiliated, or vulnerable, undermine their self-confidence and may cause them to suffer stress.”¹ Bullying has also been referred to as disruptive, disrespectful, or aggressive behavior. The WBI, a U.S.-based organization dedicated to the eradication of workplace bullying, defines it as repeated, health-harming mistreatment of one or more persons by one or more perpetrators. This definition is also used by The Joint Commission. It includes abusive conduct that is threatening, humiliating, or intimidating, as well as work interference and verbal abuse. The WBI also establishes that workplace bullying:¹³

- Is driven by perpetrators' need to control the targeted individual(s).
- Is initiated by bullies who choose their targets, timing, location, and methods.
- Is a set of acts of commission (doing things to others) or omission (withholding resources from others).
- Requires consequences for the targeted individual.
- Escalates to involve others who side with the bully, either voluntarily or through coercion.
- Undermines legitimate business interests when bullies' personal agendas take precedence over work itself.
- Is akin to domestic violence at work, where the abuser is on the payroll.

Workplace bullying has also been defined as “harassing, offending, or socially excluding someone or negatively affecting someone’s work. In order for the label bullying...to be applied to a particular activity, interaction, or process, the bullying behavior has to occur repeatedly and regularly and over a period of time.”¹⁴

A study published in *Innovations in Clinical Neuroscience* defines workplace bullying as “the repetitive and systematic engagement of interpersonally abusive behaviors that negatively affect both the targeted individual and the work organization.”¹⁵

The Advisory, Conciliation and Arbitration Service describes bullying as “offensive, intimidating, malicious or insulting behavior, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual against an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. Whatever form it takes, it is unwarranted and unwelcome to the individual.”

Harassment, while very similar to bullying and sometimes included in the definitions of bullying, should be distinguished for the purposes of this report. Workplace harassment has a legal definition and is prohibited by law in the context of certain protected classes. Harassment refers to cases in which enduring certain offensive conduct becomes a condition of continued employment, or cases in which unwanted, unwelcomed and uninvited behavior is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive. The law prohibits harassment based on race, sex, gender, ethnicity, disability, religion or sexual orientation.¹⁶ Conversely, bullying has no legal definition and is not prohibited by law.

Considering the lack of legal definition, the number and variety of definitions in use, and the continued need for more universally accepted policies to prevent bullying in the workplace, the AMA Board of Trustees recommends the establishment of this inclusive, universal definition:

Bullying is repeated, emotionally or physically abusive, disrespectful, disruptive, inappropriate, insulting, intimidating, and/or threatening behavior targeted at a specific individual or a group of individuals that manifests from a real or perceived power imbalance and is often, but not always, intended to control, embarrass, threaten, undermine, or otherwise harm the target.

Causes and prevalence of bullying in health care professions

Research suggests that bullying results from a combination of individual (e.g., gender, age, and psychological characteristics), organizational (e.g., structure, job characteristics, team setting, etc.), and contextual (service-oriented roles, bureaucracy, public vs. private sector) factors.¹¹ The inherent desire of physicians to perform at a high level and gain the approval of their superiors, the stressful nature of the physician’s role, and the organizational hierarchy in which they practice may create a perfect environment for workplace bullying.

Factors that contribute to workplace bullying include the following:¹²

- A bullying culture
- Poor staffing levels
- Excessive workloads
- Power imbalances
- Poor management skills
- Role conflict or ambiguity
- Stress
- Lack of autonomy

For physicians, bullying in the practice of medicine can begin in medical school. The majority of medical students report experiencing harassment or discrimination during their medical training.^{2, 3} Medical students report being harassed or belittled by other students, residents, clinical professors, attending physicians, or patients.^{2, 4, 17} Residents also report being bullied during their training, although the reports vary widely depending on the level of training and the country in which the study was completed.^{5, 6} The most recent data shows nearly 14 percent of residents have experienced some type of bullying, defined broadly as “harassment that occurs repeatedly (more than once) by an individual in a position of greater power,” since the beginning of their training.⁶ Studies of practicing physicians in several countries demonstrate that bullying among physicians is a global issue.^{11, 18-21}

Physicians and physician trainees are not the only perpetrators and victims of bullying in health care practices. Multiple studies show nurses also observe and experience bullying in their workplaces,^{22, 23} further pointing to organizational culture as a prime enabler of this type of conduct.

Effects of bullying in the workplace

Bullying in the workplace can have harsh and lasting effects on the victims, their colleagues and co-workers, and the organizations in which they work. Bullying can lead to negative personal or professional consequences including diminished professional satisfaction, unsatisfactory grades, decreased peer respect, social exclusion, distress, depression, anxiety, and burnout.¹⁵ Physical and medical effects of bullying in the workplace include neck pain,²⁴ acute pain,²⁵ musculoskeletal complaints,²⁶ fibromyalgia,²⁷ and cardiovascular disease.²⁸ Studies also suggest workplace bullying is associated with subsequent suicidal ideation.^{29, 30}

In the health care setting, individuals who reported being bullied experienced the following effects:⁶

- Feeling burned out—57 percent
- Worsened performance—39 percent
- Depression—27 percent
- Change in weight—15 percent
- Alcohol use—6 percent
- Improved performance—6 percent
- Left program—2 percent
- Illicit drug use—1 percent

Bullying among health care workers can also lead to numerous adverse effects for the organization.¹¹ The risk of adverse effects on patients is the subject of a 2008 Joint Commission alert that warns intimidating and disruptive behavior can result in medical error, poor patient satisfaction and preventable adverse outcomes.³¹ Bullying can increase absenteeism³², reduce overall quality and safety of care²³, and undermine an organization's attempts to foster a culture of respect and safety.^{8, 31} Bullying in the health care workplace can threaten patient safety by diverting the worker's attention away from the patient and affecting the worker's ability to think clearly, making unsafe acts and errors more likely.²³ Furthermore, increased absenteeism, reduced quality and safety of care, reputational damage, legal costs, and employee turnover resulting from bullying can all have significant financial effects for an organization.³³

Less discussed, but just as important, are the effects of workplace bullying on the physicians' family, which can involve withdrawal from family activities, emotional detachment from spouses and children, and sometimes domestic violence.³⁴

Addressing bullying in medicine

In the United States bullying is not against the law and there are no universal protections in place for victims of bullying unless there is physical harm involved or if the victim is a member of a protected class, such as people of color or individuals with disabilities. The Healthy Workplace Bill, first introduced in California in 2003, is the product of a grassroots campaign that organized to end workplace bullying. To date, 30 state legislatures and two territories have introduced the bill or some form of it. Only three states have enacted laws similar to the Healthy Workplace Bill, 21 legislatures have considered but ultimately voted down similar bills, and six states currently have bills under review.³⁵ The bill in its original form protects employers from vicarious liability risk by requiring plaintiffs to provide proof of health harm and providing sufficient reason to terminate or sanction offenders. The bill also provides employees an avenue for legal redress, allows victims to sue the offender as an individual and seek restoration of lost wages and benefits, and holds the employer accountable, compelling them to prevent future instances.³⁵ The bill has been criticized for overburdening employers with liability and opening the gates for frivolous complaints which would bog organizations down in expensive litigation.

The Occupational Safety and Health Administration (OSHA), part of the U.S. Department of Labor, ensures safe and healthful working conditions for U.S. workers by setting and enforcing standards and by providing training, outreach, education and assistance. OSHA provides guidance for employers in preventing and controlling workplace violence, which by their definition includes bullying, intimidation, and verbally abusive behaviors. OSHA does not have

enforced standards for workplace violence; however, OSHA's "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" provides a foundation for employers to build a workplace violence prevention program. The basic elements of a program should include:

1. Management commitment and employee participation
2. Worksite analysis
3. Hazard prevention and control
4. Safety and health training
5. Recordkeeping and program evaluation

OSHA's guidelines are comprehensive and should be considered integral in an organization's efforts to implement policies and procedures to prevent and address bullying in the workplace.

The Joint Commission has also published guidelines that provide actions organizations can take to effectively address disruptive and inappropriate behaviors in the workplace.³¹

1. "Educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.
2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
 - "Zero tolerance" for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.
 - Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.
 - Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior. Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.
 - Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.
 - How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).
4. Develop an organizational process for addressing intimidating and disruptive behaviors that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.
5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution. Cultural assessment tools can also be used to measure whether or not attitudes change over time.
6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.
7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services and patient advocates, both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods. Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.
8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal "cup of coffee" conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety. Make use of mediators and conflict coaches when professional dispute resolution skills are needed.

9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.
10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.
11. Document all attempts to address intimidating and disruptive behaviors.”

Effective workplace policies

Addressing bullying in the practice of medicine requires acknowledgement of the problem and acceptance of responsibility by the industry, the local organization, and the individual professionals. Incidents of workplace violence, including bullying, may be underreported³⁶ but building the right culture within an organization can help overcome this. The director of the Vanderbilt Center for Patient & Professional Advocacy identifies two key steps for organizations to address bullying in the workplace:³⁷

1. Make the administration aware that unprofessional behavior is a threat. If the team doesn't recognize that there is a problem, they won't have a plan to do something about it, nor recognize the threats to quality care.
2. Educate the entire staff—from physicians down to custodians—about why unprofessional—or hostile—behavior is a problem. If the staff recognizes that the leaders are concerned about bullying, they're more likely to come forward when they feel that bullying has occurred, or better yet, tell their co-worker that their behavior is inappropriate.

Health care organizations of all types and sizes should have some policy in place to prevent and address workplace violence, including bullying. A review of the OSHA and Joint Commission guidelines, in addition to existing codes of conduct and policies found online or provided directly by organizations, reveals common elements for organizations to consider in developing policies. An effective workplace policy should:

- Describe the management's commitment to providing a safe and healthy workplace. Show the staff that their leaders are concerned about bullying and unprofessional behavior and that they take it seriously.
- Clearly define workplace violence, harassment, and bullying, specifically including intimidation, threats and other forms of aggressive behavior.
- Specify to whom the policy applies (i.e., medical staff, administration, patients, contractors, etc.).
- Define both expected and prohibited behaviors.
- Outline steps for employees to take when they feel they are a victim of workplace bullying.
- Provide contact information and a clear process for a confidential means of documenting and reporting incidents.
- Prohibit retaliation and ensure privacy and confidentiality.
- Document training requirements.

In addition to formal policies, organizations should strategize to create a culture in which bullying does not occur. Fostering respect and appreciation among colleagues across disciplines and ranks can contribute to an atmosphere in which employees feel safe, secure, and confident in their roles and professions. Tactics to help create this type of organizational culture include:

- Surveying employees anonymously and confidentially to assess their perceptions of the workplace culture and prevalence of bullying behavior, including their ideas about the impact of this behavior on themselves and patients.
- Showing employees their feedback is taken seriously by using the survey results to inform the development of programs and resources for employees, such as Employee Assistance Programs, that allow them a place to confidentially address experiences of bullying.
- Encouraging open discussions in which employees can talk freely about problems and/or encounters with behavior that may constitute bullying.
- Assessing situations and intervening as soon as reports are received (as is appropriate per policies) and enforcing consequences for perpetrators of bullying.
- Establishing procedures and conducting interventions within the context of the organizational commitment to the health and well-being of all staff.

CONCLUSION

Bullying in the workplace is a complex type of unprofessional conduct. Bullying in medicine happens as a result of a combination of individual, organizational, and systemic issues. The first line of defense against this destructive behavior are physicians, residents, and medical students. There is no justification for bullying, disrespect, harassment, intimidation, threats, or violence of any kind to occur among professionals whose primary purpose is to heal. Physicians choose medicine as their life's work for many reasons, one of the most important being their desire to help and care for people. Naturally, physicians want and deserve to be treated with respect and recognized as professionals, not "providers." Avoiding and working to prevent unprofessional behavior like bullying are worthwhile steps toward earning that respect and assuring medicine keeps its purpose. Correcting the issue can't be viewed as a physician-only problem, however. To effectively reduce bullying in the workplace, organizations should establish policies and procedures and implement programs and training to address the problem at all possible levels.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 402-A-19 and that the remainder of this report be filed:

1. That our American Medical Association (AMA) reaffirm the following policies:
 - a. H-215.978, "Workplace Violence Prevention"
 - b. H-295.955, "Teacher-Learner Relationship In Medical Education"
 - c. H-515.966, "Violence and Abuse."
2. That our AMA define "workplace bullying" as repeated, emotionally or physically abusive, disrespectful, disruptive, inappropriate, insulting, intimidating, and/or threatening behavior targeted at a specific individual or a group of individuals that manifests from a real or perceived power imbalance and is often, but not always, intended to control, embarrass, undermine, threaten, or otherwise harm the target.
3. That our AMA adopt the following guidelines for the establishment of workplace policies to prevent and address bullying in the practice of medicine:

Health care organizations, including academic medical centers, should establish policies to prevent and address bullying in their workplaces. An effective workplace policy should:

- Describe the management's commitment to providing a safe and healthy workplace. Show the staff that their leaders are concerned about bullying and unprofessional behavior and that they take it seriously.
- Clearly define workplace violence, harassment, and bullying, specifically including intimidation, threats and other forms of aggressive behavior.
- Specify to whom the policy applies (i.e., medical staff, students, administration, patients, contractors, etc.).
- Define both expected and prohibited behaviors.
- Outline steps for individuals to take when they feel they are a victim of workplace bullying.
- Provide contact information for a confidential means for documenting and reporting incidents.
- Prohibit retaliation and ensure privacy and confidentiality.
- Document training requirements and establish clear expectations about the training objectives.

In addition to formal policies, organizations should strategize to create a culture in which bullying does not occur. Fostering respect and appreciation among colleagues across disciplines and ranks can contribute to an atmosphere in which employees feel safe, secure and confident in their roles and professions. Tactics to help create this type of organizational culture include:

- Surveying staff, and medical students in academic settings, anonymously and confidentially to assess their perceptions of the workplace culture and prevalence of bullying behavior, including their ideas about the impact of this behavior on themselves and patients. Use the results to inform the development of programs and resources, showing the respondents that their feedback is taken seriously.
- Encouraging open discussions in which staff can talk freely about problems and/or encounters with behavior that may constitute bullying.

- Establishing programs for staff and students, such as Employee Assistance Programs, that provide a place to confidentially address personal experiences of bullying.
- Establishing procedures and conducting interventions within the context of the organizational commitment to the health and well-being of all staff.

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10. COMPASSIONATE RELEASE FOR INCARCERATED PATIENTS

Reference committee hearing: see report of Reference Committee D.

**HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 430-A-19
REMAINDER OF REPORT FILED**
See Policy H-430.980

Resolution 430-A-19, introduced by the Medical Student Section and referred by the House of Delegates asked that:

Our American Medical Association support policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; collaborate with appropriate stakeholders to draft model legislation that establishes clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

BACKGROUND

Compassionate release, also known as medical release, is a program or policies that allow eligible, seriously ill prisoners early release or parole before sentence completion.¹ Compassionate release was authorized on the federal level under the Sentencing Reform Act of 1984 and subsequently adopted by 49 states and the District of Columbia.² Medical eligibility guidelines vary by jurisdiction, but most states require a terminal or severely debilitating medical condition, a condition that cannot be appropriately cared for within the prison, and a prisoner who poses no threat to society.¹

Compassionate release is a matter of ethics as the continued incarceration of patients with serious or debilitating illness can constitute a violation of human dignity if appropriate palliative care is unavailable.³ In addition to ethical reasons, compassionate release has been called for to address the aging prison population, overcrowded facilities, increasing deaths in custody, and soaring medical costs of the criminal justice system.^{1,4}

In 2016, a total of 6.6 million persons were involved in the US criminal justice system, including 1.5 million in state and federal prisons.⁵ From 1993 to 2013, the population in state prisoners age 55-and-older more than tripled, increasing from 3 percent to 10 percent.⁶ Between 2009 and 2013, the population of US federal prisoners aged 49 or younger decreased by 1 percent, whereas the number of prisoners aged 50 or older increased by 25 percent.⁷

Racial and ethnic minority groups are disproportionately represented in the justice-involved population. In 2017, blacks represented 12 percent of the US adult population but 33 percent of the sentenced prison population. Whites accounted for 64 percent of adults but 30 percent of prisoners. And while Hispanics represented 16 percent of the adult population, they accounted for 23 percent of inmates. From a health perspective, it is not uncommon for justice-involved individuals to experience multiple chronic conditions, mental health disorders, and physical disabilities at relatively young ages.⁹ They are also more likely to have experienced stress and trauma, have a substance use disorder, experienced homelessness, and have limited access to health care.⁹

EXISTING AMA POLICY

It is the AMA's position that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism (Policy D-430.997, "Support for Health Care Services to Incarcerated Persons"). The AMA supports of the National Commission on Correctional Health Care (NCCHC) standards that improve the quality of health care services, including mental health services, delivered to the nation's

correctional facilities, and encourages all correctional systems to support NCCHC accreditation (D-430.997, “Support for Health Care Services to Incarcerated Persons”).

The AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated individuals who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

The AMA encourages states to suspend rather than terminate Medicaid eligibility upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community. The AMA urges Congress, the Centers for Medicare & Medicaid Services, and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism (Policy H-430.986, “Health Care While Incarcerated”).

Furthermore, the AMA has urged the Society of Correctional Physicians and the NCCHC to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history (Policy H-280.948, “Long-Term Care Residents With Criminal Backgrounds”). The AMA does not have policy specific to compassionate release.

DISCUSSION

Compassionate release policies were authorized in recognition of the fact that appropriate care for patients with severe or debilitating illnesses is difficult, and sometimes impossible, to achieve in the correctional setting.^{3,10,11} In 2013, the U.S. Department of Justice, Office of the Inspector General found that the Federal Bureau of Prisons (BOP’s) compassionate release program was “poorly managed and implemented inconsistently,” resulting in eligible inmates likely not being considered for release and terminally ill inmates dying before their requests were decided.¹² During a one year span in the BOP, only 85 (3.24 percent) out of 2,621 requests for compassionate release were granted.¹² State prison systems are likely to have similar rates of release, though only 13 states are required to track and report compassionate release statistics and few of them are required to make the information publicly available.²

Barriers to Implementing Compassionate Release Policies

The limited use of compassionate release is due to barriers at the patient, professional, policy, and administrative levels. At the patient level, individuals who are incarcerated may not be aware that they are eligible for compassionate release or incorrectly believe that they are ineligible. In a survey of medically complex patients across three geographically disparate prisons and jails, 43 percent of respondents lacked the knowledge necessary to apply for compassionate release, and 75 percent indicated they would apply if eligible.^{11,13}

At the policy level, both the medical eligibility criteria, based on medical evidence, and the administrative approval process, based on legal and correctional evidence, can limit the compassionate release process.¹ The federal criteria for a reduction in sentence for medical circumstances require either a terminal medical condition (a life expectancy of 18 months or less) or a debilitated medical condition (See Table 1). While some states have adopted the federal medical eligibility criteria, others have adopted their own criteria, resulting in variability in requirements across jurisdictions.

In determining medical eligibility, clinicians may have concerns about the legal consequences of releasing someone who lives beyond the expected timeframe since there are terminal illnesses with unpredictable trajectories.⁴ Furthermore, the correctional evidence review process is often complex and time-consuming, requiring multiple layers of review.² A final decision may require approvals by the warden, a parole or review board, and even the state’s governor.¹⁰ These barriers can be compounded by administrative barriers such as objections by a victim advocate or prosecutor, concerns about public safety, and availability of post release community care plans to ensure placement in community hospice or return to the family home for care as well as arranging insurance coverage (i.e., applying for Medicaid coverage).^{3, 10}

CONCLUSION

The use of compassionate release laws has been advocated for as a mechanism to address the growing number of older prisoners, overcrowding, increasing numbers of in-prison deaths, and the soaring medical costs of the criminal justice system, but also as a matter of medical ethics as the continued incarceration of patients with serious or debilitating illness can constitute a violation of human dignity if appropriate palliative care is unavailable. While most jurisdictions have adopted laws authorizing compassionate release, this authority is being underutilized due to barriers at the patient, professional, policy and administrative levels. In order to increase the use of compassionate release policies, there needs to be better communication and education on these policies, not only to individuals who are incarcerated, but also to their families, correctional health care professionals, and parole board members.¹¹

The medical profession plays a significant role in the compassionate release process in that physicians are required to determine medical eligibility for potential candidates. The eligibility criteria should be clear to clinicians and they should be comfortable determining if someone meets the criteria without fear of liability. The Board of Trustees recommends that the AMA collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release. This guidance can be shared with legislators and other relevant stakeholders once it is developed.

Finally, to ensure that compassionate release laws are being appropriately managed and implemented consistently, the AMA should support the transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

RECOMMENDATION

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 430-A-19 and the remainder of this report be filed.

Our American Medical Association supports policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

Table 1. Federal Criteria for a Reduction in Sentence

Medical Circumstances

Terminal Medical Condition	Inmates diagnosed with a terminal, incurable disease and whose life expectancy is 18 months or less, and/or has a disease or condition with an end-of-life trajectory under 18 USC § 3582(d)(1)
Debilitated Medical Condition	Inmates who have an incurable, progressive illness or who have suffered a debilitating injury from which they will never recover.
	If the inmate is: completely disabled, meaning the inmate cannot carry on any self-care and is totally confined to a bed or chair or capable of only limited self-care and is confined to a bed or chair more than 50 percent of waking hours.
	Review should also include any cognitive deficits of the inmate. A cognitive deficit is not required in case of severe physical impairment, but may be a factor when considering the inmate's ability or inability to reoffend.

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11. REDEFINING AMA’S POSITION ON ACA AND HEALTHCARE REFORM

Informational report; no reference committee hearing.

HOD ACTION: FILED

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:

Cover Uninsured Eligible for ACA's Premium Tax Credits

- 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.

12. 2020 AMA ADVOCACY EFFORTS

Informational report; no reference committee hearing.

HOD ACTION: FILED

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 disproportionately 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.

13. MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) UPDATE

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTIONS 206-I-18, 231-I-18 AND 243-A-19
REMAINDER OF REPORT FILED**

*See Policies H-385.905, H-385.908, H-385.913, H-390.838, H-450.931, D-390.949,
D-390.950, D-395.998 and D-395.999*

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred two resolutions, and at the 2019 Annual Meeting, a third resolution was referred, for a combined Board of Trustees (Board) Report at the 2019 Interim Meeting related to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The first resolution, Resolution 206-I-18, "Repealing Potential Penalties Associated with MIPS," was introduced by the Florida Delegation and asks that:

Our American Medical Association advocate to repeal all potential penalties associated with the MIPS program.

The second resolution, Resolution 231-I-18, “Reducing the Regulatory Burden in Health Care,” was introduced by the Pennsylvania Delegation and asks that:

Our American Medical Association work to support the repeal of the Merit-Based Incentive Payment System (MIPS); and that upon repeal of MIPS, our AMA oppose any federal efforts to implement any pay-for-performance programs unless such programs add no significant regulatory or paperwork burdens to the practice of medicine and have been shown, by evidence-based research, to improve the quality of care for those served.

The third resolution, Resolution 243-A-19, “Improving the Quality Payment Program and Preserving Patient Access,” was introduced by the Texas Delegation and asks that:

Our American Medical Association strongly advocate for Congress to make participation in MIPS and alternative payment models (APMs) under the Quality Payment Program (QPP) completely voluntary, that our AMA strongly advocate for Congress to eliminate budget neutrality in MIPS and to finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians, and that our AMA call on the Centers for Medicare and Medicaid Services (CMS) to provide a transparent, accurate, and complete Quality Payment Program Experience Report on an annual basis so physicians and medical societies can analyze the data to advocate for additional exemptions, flexibilities, and reductions in reporting burdens, administrative hassles, and costs.

The reference committee heard mixed testimony on Resolutions 206, 231, and 243. Some testified that MIPS should be repealed, as many practices that serve Medicare beneficiaries cannot sustain additional reductions in their Medicare payments. Others testified that our AMA should continue working with Congress and the Administration to ensure that all physician practices, regardless of size or specialty, have the opportunity to succeed in the QPP. Also, there was significant testimony that our AMA should continue advocating to simplify and improve the MIPS program and increase the number and variety of APMs available to physicians.

BACKGROUND

Our AMA was supportive when Congress replaced the flawed, target-based sustainable growth rate (SGR) formula with a new payment system under MACRA. Scheduled payment cuts prior to the implementation of MACRA exceeded 20 percent. Those cuts would have had a devastating impact on physician practices and patient access to care. Under MACRA, the SGR formula was replaced with specified payment updates for 2015 through 2019, and for 2026 and beyond. MACRA also created an opportunity to address problems found in existing physician reporting programs, including the chance to earn incentives. In addition, the law sought to promote innovation by encouraging new ways of providing care through APMs.

Our AMA worked closely with CMS and Congress on implementation of the MIPS program, and AMA advocacy efforts resulted in a policy allowing physicians who reported on one measure, one time, for one patient to avoid a penalty in the first year. This transition period allowed many physician practices to be successful in the first performance year of MIPS, with 93 percent of eligible clinicians receiving a modest positive payment adjustment and nearly three-quarters qualifying for an additional exceptional performance bonus. (Notably, the exceptional performance bonus is funded at \$500 million annually in the MACRA statute and is not budget neutral.)

Following the first year of the MIPS program, our AMA was also successful in getting Congress to make needed technical changes to MACRA in the Bipartisan Budget Act of 2018. These changes helped many practices avoid penalties that they likely would otherwise have incurred under the MIPS program. Specifically, our AMA worked with Congress to exclude Medicare Part B drug costs from MIPS payment adjustments, as including these additional items and services created significant inequities in the administration of the program. In addition, our AMA helped achieve changes that allow CMS to reweight the Cost performance category to not less than 10 percent for the third, fourth, and fifth years of MIPS, instead of increasing it to 30 percent as the law previously required, and to set the performance threshold for three additional years instead of basing it on the mean or median of previous MIPS scores.

As a result of these efforts, CMS has continued to gradually implement the MIPS program. Based on the second performance period in calendar year 2018, 97 percent of eligible clinicians received a modest positive payment adjustment in 2020 with 84 percent qualifying for an additional exceptional performance bonus.

DISCUSSION

Ongoing AMA Advocacy Efforts

Since the enactment of MACRA, our AMA has worked closely with both Congress and CMS to promote a smooth implementation of the QPP. Despite these efforts, Resolutions 206, 231, and 243 illustrate that the implementation of a new quality and payment program for physicians is a major undertaking and significant improvements to the program are still needed. As is noted in the resolutions, numerous improvements must still be made to the MIPS program, including more accurate risk adjustment for cost and quality measures, timelier program feedback for physicians, and a more cohesive program structure. In addition, physician practices, especially small and rural physician practices, cannot shift to new payment models without adequate resources.

In an effort to address these outstanding issues, our AMA has convened MIPS and APM workgroups made up of representatives from across the physician community, which have developed creative solutions to improve the QPP. Feedback from the MIPS and APM workgroups, as well as other state and specialty medical societies, has led our AMA to focus its efforts to improve the QPP on several key issues: replacing the Medicare physician pay freeze with a stable revenue source that allows physicians to sustain their practice; replacing or supplementing budget neutrality provisions; extending the Advanced APM payments for an additional six years; simplifying the MIPS scoring system and creating a more meaningful MIPS program; expanding exceptions and flexibilities during the COVID-19 pandemic; and ensuring small and rural practices have the opportunity to succeed.

Implement Annual Positive Physician Payment Updates

Resolution 206 notes that many physician practices cannot sustain additional reductions in their Medicare payments. Our AMA agrees, and while MACRA included modest positive payment updates in the Medicare Physician Fee Schedule, it left a gap from 2020 through 2025, during which there are no updates at all. Following this six-year freeze, the law specifies physician payment updates of 0.75 percent or 0.25 percent for physicians participating in APMs or MIPS.

Our AMA recognizes that these payment updates are not sufficient, particularly while physicians are investing resources to shift to new payment models and provide quality patient care during the COVID-19 pandemic. Therefore, our AMA has advocated that Congress pass legislation providing physicians with positive payment updates beginning in 2020. As the COVID-19 pandemic continues to confront the nation, our AMA is calling on Congress to protect patient access to medical care and preserve the viability of physician practices across the country by implementing a positive payment update and providing additional financial assistance to physicians. Our AMA is working on a survey to determine the financial impact the COVID-19 pandemic is having on physician practices and the results are expected in September. We anticipate the results will support our AMA's advocacy for Medicare payment improvements.

Medicare physician payment will also be impacted by budget neutrality requirements in implementation of the AMA Current Procedural Terminology (CPT) Editorial Panel coding framework and AMA Specialty Society Relative Value Scale Update Committee (RUC) recommended values for office and outpatient visits starting January 1, 2021. Our AMA strongly supports implementation of CMS' new office visit policy and believes it will lead to significant administrative burden reduction and better describe and recognize the resources involved in office visits as they are performed today. However, we are deeply concerned that the corresponding budget neutrality cuts are deeply problematic during or immediately after the COVID-19 pandemic, during which physician practices have experienced severe reductions in revenue.

Physicians who do not report office visit codes, including radiologists, pathologists, and hospitalists, face estimated 2021 payment cuts of 8 percent solely due to budget neutrality. Specialties, including general surgeons, critical care physicians, anesthesiologists, and emergency physicians, face estimated cuts ranging from 5 percent to 7 percent. The budget neutrality driven cuts also will reduce the positive impacts of the office visit changes for primary care physicians, oncologists, pediatricians, and other specialties for whom the office visits are a high proportion of their services.

Our AMA, joined more than one hundred national specialty societies and health care professional organizations, in urging the U.S. Department of Health & Human Services (HHS) Secretary to use its authorities and flexibilities under

the public health emergency to implement the office visit increases and waive the requirement for CMS to adjust Medicare physician payments for budget neutrality when it implements the office visit coding and payment changes that it has finalized for 2021. Our AMA is pursuing all avenues for waiving budget neutrality, including Congressional action.

The Board strongly supports advocating for positive payment updates, which are needed to provide physicians a margin to maintain their practices, as well as transition to more efficient models of care delivery and provide relief to physician practices confronting the COVID-19 pandemic.

Extend APM Payments

In addition to providing positive physician payment updates, Congress and the Administration must work to provide physicians with adequate resources to move into new payment models. One goal of MACRA, in addition to the MIPS program, was to provide physicians with a path to transition into new, innovative APMs that could allow physicians to be paid for services that add value to patient care.

To help facilitate this transition, Congress provided a five percent incentive payment for physicians who participate in Advanced APMs during the first six years of the program. Unfortunately, through the first three participation years, very few physicians had the opportunity to earn this incentive payment due to the small number of Advanced APMs approved by CMS. While our AMA is working closely with numerous physician groups, as well as the Center for Medicare & Medicaid Innovation (CMMI), to develop and test physician-led APMs, it will take time to implement the number of APMs needed to allow most physicians a realistic opportunity to participate in these models. Therefore, our AMA is urging Congress to extend the Advanced APM incentive payments to provide support to physicians as they transition to new payment models. The Board strongly supports efforts to ensure there are voluntary APMs available for physicians in all specialties and practices of all sizes.

Impact of Budget Neutrality

The Board strongly supports providing physicians with the resources necessary to improve quality and patient care. The Board is therefore concerned about reports from numerous physicians who have worked diligently to comply with the numerous MIPS requirements, yet have ended up investing more in health information technology and care management processes than they received through their resulting MIPS incentive payment. The negative return on investment from MIPS participation is a serious problem. Also, several witnesses have testified in reference committee that funding positive MIPS incentive payments with penalties imposed on practices that do not score above the MIPS performance threshold exacerbates this problem for smaller practices. The Board supports language in Resolution 243-A-19 noting that physicians need dedicated funding for MIPS incentive payments in order to ensure physicians have the capital they need to move into models that provide patients with the utmost value. Basing positive payment adjustments on penalties also creates uncertainty in the program, which further discourages practices from making the up-front investments needed to transition to value-based payment and care delivery models.

MIPS incentive payments for performance years 2019 through 2022 are based on a combination of budget neutrality and dedicated annual funding. Congress provided \$500 million for each of the first six years of MIPS to fund additional adjustments for exceptional performance. The first two years of MIPS payment adjustments (2019 and 2020) were funded largely by the \$500 million annual allocation due to the gradual implementation of MIPS which resulted in very few penalties. One option for supplementing budget neutral incentive payments is to seek an extension of the \$500 million pool, which expires after year six of MIPS.

While supporting the elimination of budget neutrality in the MIPS program, the Board also understands that this is a complex issue that would involve some difficult trade-offs. It would be extremely difficult to secure funding from Congress both for positive MIPS incentive payments, which would help practices that participate in MIPS and exceed the MIPS performance threshold, and funding for positive conversion factor updates, which would help all practices that care for fee-for-service Medicare patients, including small practices that are excluded from MIPS, because they are below the low-volume threshold. In addition, physicians in large practices have generally obtained higher MIPS scores than those in smaller practices, so this policy is more likely to help large practices than smaller practices. Partially or fully eliminating MIPS budget neutrality may also make it more difficult to achieve adoption of AMA recommendations to improve the MIPS program, because Congress and the Administration would view any increase in the number of physicians able to succeed in MIPS as increasing federal spending.

Despite these concerns, the Board determined that replacing or supplementing the budget neutrality requirements in MIPS with incentive payments would help support physicians as they continue to work to comply with the program. Therefore, the Board supports MIPS incentive payments not limited by budget neutrality requirements to provide physicians a margin to transition into more efficient models of care delivery.

Simplifying and Streamlining MIPS

Our AMA has repeatedly urged CMS to reduce burden and complexity and make MIPS more clinically relevant for physicians and patients. As noted in Resolution 243, many physicians must report MIPS measures that are not linked to improved clinical care for their patients. Studies suggest the cost of reporting quality metrics is considerable.¹ Our AMA is engaged in a research study to determine the cost to physician practices of creating the infrastructure needed to participate in MIPS and of collecting and reporting data. Through interviews with practice leaders and administrators, our AMA aims to understand the costs (e.g., software, staff, practice leaders, and consultants) associated with MIPS participation for practices of different sizes and specialties and in different regions of the country, as well as practice leader views about MIPS.

Our AMA's MIPS workgroup has developed detailed recommendations that would make the MIPS program more cohesive and allow physicians to select more relevant measures to report. Our AMA has urged CMS to streamline the MIPS program by allowing physicians to focus their participation around a specific episode of care, clinical condition, or public health priority. By allowing physicians to focus on activities that fit into their workflow and address their patient populations' needs, rather than segregated measures divided into four disparate MIPS categories, the program would be more likely to improve quality of care for patients and be more meaningful for physicians.

In the 2020 Medicare Physician Payment Schedule final rule, CMS outlined the MIPS Value Pathways (MVPs) approach, which responds to some of the recommendations made to CMS by the AMA after significant consultation with specialty and state medical societies. Physicians in MVPs would focus their MIPS participation on a set of measures tailored to an episode of care or condition starting in the 2021 performance period. The MVPs framework would also provide enhanced data and feedback to physicians. Our AMA and specialty societies are working with CMS to develop MVPs that are relevant to physicians and their patients and expect more details to be included in future rulemaking. Our AMA continues to work with CMS to ensure MVP participation is voluntary, less burdensome, and incentivizes physicians to opt into this new framework.

Our AMA has also urged Congress to allow CMS the flexibility to base scoring on multi-category measures to make MIPS more clinically meaningful, reduce silos between each of the four MIPS categories, and create a more unified program. Our AMA's goal is to help the Administration develop an approach that allows physicians to spend less time on reporting and more time with patients and on improving care. The Board strongly supports the efforts to unify MIPS reporting while also making it more meaningful for physicians.

Support for Small and Rural Practices

As noted in Resolution 231, our AMA agrees that small physician practices could be disproportionately impacted by penalties under MIPS. In 2017, the national mean and median scores for all MIPS eligible clinicians were 74.01 and 88.97 points. However, the mean and median scores for small practices were 43.46 and 37.67. In 2018, small practice scores increased, although they remain lower than the national mean and median, which were 86.96 and 99.63. The 2018 mean and median scores for small practices were 65.69 and 81.16. Our AMA agrees that the lower scores achieved by small practices illustrate the need for our AMA to continue advocating for changes to MACRA that will help small practices and solo practitioners.

In order to help small practices become more successful in the MIPS program, our AMA has engaged in advocacy efforts in multiple areas. First, our AMA has been a strong supporter of the low-volume threshold exemption which was increased and now excludes physicians with allowed charges of \$90,000 or less, 200 or fewer unique Medicare patients, or 200 or fewer covered professional services to Medicare Part B beneficiaries from the MIPS program. Our AMA has also supported MIPS policies including reduced reporting requirements for small practices in the Quality performance category, hardship exemptions from the Promoting Interoperability performance category for qualifying small practices, bonus points for small practices, and technical assistance grants to help small and rural practices succeed in the program. Finally, our AMA is advocating for a legislative change that would allow CMS to develop separate thresholds for small and large practices, so that small physician practices are compared to practices with

similar resources. The Board agrees that additional changes are needed to ensure small and rural practices have the opportunity to succeed in the MIPS program.

Flexibility During the COVID-19 Public Health Emergency

Since the HHS Secretary declared a public health emergency (PHE) due to the 2019 novel coronavirus on Jan. 27, 2020, our AMA has worked constantly with CMS to identify issues and make recommendations to ensure physicians are able to continue to meet the needs of patients while confronting and slowing the spread of the virus. In response to our concerns about relieving MIPS reporting burdens, CMS automatically held harmless from penalties every eligible clinician who did not submit any MIPS data for 2019 and extended the deadline for physicians and groups who wished to opt into MIPS.

CMS recently announced expanded hardship exceptions due to COVID-19 for the 2020 MIPS performance period. Physicians will have the option to opt-out completely or partially from MIPS by completing a hardship exception application through the end of the year. For example, a practice may submit a hardship application and indicate that they do not want to be scored on Cost and Quality and have their score calculated based on just Promoting Interoperability and Improvement Activities. Alternatively, practices may submit a hardship application and opt-out of all four performance categories and be held harmless from a 2022 payment adjustment.

Our AMA is pleased CMS took our recommendation to create flexible reporting options in 2020 with the option to reweight any or all of the MIPS performance categories. The flexibilities should assist with allowing practices to focus their attention on caring for patients during the pandemic and reduce administrative burden. Our AMA continues to monitor the impact COVID-19 is having on practices and advocate to CMS for the appropriate relief and to ensure CMS liberally grants hardship requests due to the COVID-19 PHE. It is also our understanding that CMS QPP.CMS.GOV website is in the process of being updated with the 2020 policy and should reflect the announcement along with additional educational materials in late summer. The information currently posted on the website is regarding the 2019 MIPS COVID-19 policy. CMS has also indicated that additional information on MIPS COVID-19 policy will be included in upcoming rulemaking. The Board strongly supports efforts to minimize MIPS reporting burdens and allow greater flexibility during this pandemic.

Other Advocacy Efforts

In addition to these major program changes, our AMA also continues to urge CMS and Congress to address more nuanced issues in the QPP such as:

- Stabilizing the performance threshold until program improvements are tested and implemented;
- Revamping the Virtual Group option to encourage small practices to participate;
- Improving risk adjustment methodologies to account for social risk factors;
- Reducing the number of quality measures a physician must report under the Quality performance category;
- Maintaining a minimum point floor for physicians reporting on quality measures that meet the data completeness threshold, regardless of performance on the measure;
- Eliminating the requirement that physicians must report on an outcome or high priority measure and eliminating the requirement to report on all-payer data;
- Developing a phased approach for removing “topped-out” measures from MIPS and improving the benchmark methodology;
- Aligning the MIPS and Physician Compare calculation methodologies;
- Maintaining the Cost performance category weight while new episode-based cost measures are developed and piloted;
- Modifying the threshold levels of APM participation required to be eligible for the APM incentive payments;
- Securing adoption of physician-focused payment models with realistic targets for improving patient health outcomes and generating savings;
- Eliminating the Total Cost of Care and Medicare Spending Per Beneficiary measures within the Cost performance category as improved episode-based cost measures are developed;
- Allowing physicians to attest to their use of Certified Electronic Health Record Technology (CEHRT) in the Promoting Interoperability performance category;
- Reducing the number of measures physicians are required to report in the Promoting Interoperability performance category; and

- Providing credit for the use of health information technology beyond CEHRT.

As illustrated by the list above, our AMA has spent significant staff time working with both Congress and CMS to improve the QPP. Our AMA has specifically been advocating persistently for MIPS to be more meaningful to physicians and less administratively burdensome, and to increase the number of available APMs. Our AMA advocacy team meets regularly with both CMS officials and Congressional staff to work to improve MIPS and the APM pathway for physicians and will continue to do so going forward.

Among the concerns raised with seeking repeal of the MIPS penalties at this time is that the cost would need to be offset and would potentially come at the expense of bonuses or across the board cuts in physician payments, which would impact physicians who are currently exempt from MIPS, such as small practices. Another concern is that repealing penalties associated with MIPS or repealing the entire program at this time could result in an alternative quality payment program that may be less desirable. Furthermore, such a shift in our AMA's advocacy position would effectively preclude our AMA from continuing our advocacy efforts with state and specialty medical societies in support of the Administration's and Congress' efforts to advance successful, innovative payment models as well as the technologies needed to support such models.

AMA POLICY

Our AMA has numerous existing policies on MACRA including Policies D-395.999, D-395.998, H-390.838, D-390.950, and D-390.949. Together, these policies direct our AMA to work with CMS to advocate for improvements to MIPS, a reduction in MIPS requirements for all physicians, an exemption to MIPS for small practices, a period of stability in the MIPS program to allow for testing and stability and additional flexibilities for fragile practices. AMA policy also supports our advocacy to increase the number and variety of APMs available to physicians, extend the Advanced APM incentive payments to provide support to physicians as they transition to new payment models, and modify the threshold levels of APM participation required to be eligible for the APM incentive payments (Policies H-385.913, H-450.931, and H-385.908).

CONCLUSION

Our AMA understands that there is significant frustration with the MIPS program and continues to vigorously advocate that both CMS and Congress make needed changes. In addition to urging CMS to make additional improvements to the MIPS program, our AMA is joined with many state and specialty medical societies making it a priority to advocate that Congress provide physicians with positive Medicare payment updates, extend the \$500 million positive payment adjustment for exceptional performance in MIPS that is not subject to budget neutrality, and extend APM payments to provide physicians with additional resources to help transition to APMs. The Board believes that the lack of positive updates from 2020 to 2025 severely threatens physicians' ability to sustain their practices, especially while at the same time implementing quality improvements. Our AMA will work with due purpose to seek positive updates as we continue to reduce MIPS burdens.

While the Board recognizes that the QPP needs improvement, we also acknowledge that the MIPS program continues to be refined. Detailed results from the 2017 and 2018 performance years reflect MIPS' gradual implementation as most physicians were able to achieve high scores and earn a positive payment adjustment. Results from at least the 2019 and 2020 performance periods will be impacted by the COVID-19 pandemic and hardship exceptions will be in place to provide relief. Implementation of a new quality and payment program is a significant undertaking and requires an iterative process with constant evaluation and improvement.

In addition to our current policy, the Board believes that our AMA should have the ability to support legislation that would provide physicians with positive payment updates that could shift the budget neutrality dynamic of the current MIPS program. The Board understands that eliminating the budget neutrality requirements of the MIPS program is a complex issue and that there are many ways to achieve that goal. Therefore, we offer a recommendation to support replacing or supplementing budget neutrality, which will allow us flexibility to review and consider legislation without being too narrowly defined that we overlook an opportunity to improve the MIPS program in another way.

Therefore, the Board recommends, consistent with existing AMA policy, that our AMA continue its work with CMS and Congress to improve the MIPS program, increase APM opportunities for physicians, and provide additional resources for physician practices through positive updates and APM payments. Given that the repeal of MACRA

could result in a more burdensome quality program with no opportunity to earn incentives and lower payment updates for physicians, we recommend not advocating for the repeal of MIPS penalties or the MIPS program at this time. However, the Board will continue to monitor the QPP's impact and burden on physicians, and if improvements to the program are not sufficient, we will reevaluate our advocacy policies and position in the future.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 206-I-18, 231-I-18, and 243-A-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.
2. That our AMA reaffirm Policy D-395.999, "Reducing MIPS Reporting Burden," Policy D-395.998, "Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program," Policy H-390.838, "MIPS and MACRA Exemption," Policy D-390.950, "Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA)," Policy D-390.949, "Preserving Patient Access to Small Practices Under MACRA," Policy H-385.913, "Physician-Focused Alternative Payment Models," Policy H-450.931, "Moving to Alternative Payment Models," and Policy H-385.908, "Physician-Focused Alternative Payment Models: Reducing Barriers."

REFERENCE

1. Casalino LP, Gans D, Weber R, Cea M, Tuchovsky A, Bishop TF, Miranda Y, Frankel BA, Ziehler KB, Wong MM, Evenson TB. U.S. Physician Practices Spend More than \$15.4 Billion Annually to Report Quality Measures (March 2016). *Health Affairs* 35:3 <https://doi.org/10.1377/hlthaff.2015.1258>

EXISTING AMA POLICY

Policy D-395.999, "Reducing MIPS Reporting Burden"

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician's choosing) within the calendar year.

Policy D-395.998, "Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program"

1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.

Policy H-390.838, "MIPS and MACRA Exemption"

Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Policy D-390.950, "Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA)"

1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.

3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.

Policy D-390.949, “Preserving Patient Access to Small Practices Under MACRA”

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.
2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Policy H-385.913, “Physician-Focused Alternative Payment Models”

1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
2. Our AMA supports that the following goals be pursued as part of an APM:
 - A. Be designed by physicians or with significant input and involvement by physicians;
 - B. Provide flexibility to physicians to deliver the care their patients need;
 - C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
 - D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
 - E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
 - F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
 - G. Avoid placing physician practices at substantial financial risk;
 - H. Minimize administrative burdens on physician practices; and
 - I. Be feasible for physicians in every specialty and for practices of every size to participate in.
3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
 - A. Identify leading health conditions or procedures in a practice;
 - B. Identify barriers in the current payment system;
 - C. Identify potential solutions to reduce spending through improved care;
 - D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
 - E. Define services to be covered under an APM;
 - F. Identify measures of the aspects of utilization and spending that physicians can control;
 - G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
 - H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
 - I. Identify mechanisms for ensuring adequacy of payment; and
 - J. Seek support from other physicians, physician groups, and patients.
4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:
 - A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
 - B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
 - C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
 - D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
 - E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.
5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models.

Policy H-450.931, “Moving to Alternative Payment Models”

1. As physician payment moves to pay-for-value, our American Medical Association will help physician practices with the following: (a) physician practices need support and guidance to optimize the quantity and content of physician work under alternative payment models; (b) address physicians' concerns about the operational details of alternative payment models to improve their effectiveness; (c) to succeed in alternative payment models, physician practices need data and resources for data management and analysis; and (d) harmonize key components of alternative payment models across multiple payers, especially performance measures to help physician practices respond constructively.

2. Our AMA will, in partnership with other appropriate physician organizations, work with the Centers for Medicare & Medicaid Services to establish an appropriate timetable for implementation of pay-for-value models that takes into account the physician community's readiness to assume two-sided risk (up-side and down-side risk).

Policy H-385.908, "Physician-Focused Alternative Payment Models: Reducing Barriers"

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.
3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.
4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
 - a. Continue to expand technical assistance;
 - b. Develop IT systems that support and streamline clinical participation;
 - c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;
 - d. Identify methods to reduce the data collection burden; and
 - e. Begin implementing the 21st Century Cures Act.
5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:
 - a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors;
 - b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and
 - c. Explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.
6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
 - a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;
 - b. Distinguish between services ordered by a physician and those delivered by a physician;
 - c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;
 - d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patient's and physician's responsibility for managing the condition; and
 - e. Provide physicians with lists of attributed patients to improve care coordination.
7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
 - a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;
 - b. Account for costs that are not currently billable but that cost the practice to provide; and
 - c. Account for lost revenue for providing fewer or less expensive services.

14. ENHANCED FUNDING FOR AND ACCESS TO OUTPATIENT ADDICTION REHABILITATION

Reference committee hearing: see report of Reference Committee B.

**HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 201-I-19
REMAINDER OF REPORT FILED
TITLE CHANGED**
See Policies H-95.922, H-95.981, D-95.962 and D-95.981

INTRODUCTION

At the American Medical Association’s (AMA) 2019 Interim Meeting, the House of Delegates (HOD) referred Resolution 201-I-19, “Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities,” introduced by the Medical Student Section, which asks: “That our American Medical Association advocate for the expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection in line with evidence-based care.” Testimony on Resolution 201 was mixed. Testimony was provided that raised significant concerns related to additional federal regulations proffered by Resolution 201. Additional testimony offered several amendments and substitute language proposals to strengthen the resolution. Believing that further study was warranted, the HOD referred Resolution 201. This report recommends new policy and reaffirms existing policy in lieu of the adoption of Resolution 201.

DISCUSSION

Background

Despite sharp reductions in opioid prescriptions, increases in the use of state prescription drug monitoring programs, increases in naloxone, and other signs of progress, the nation is now experiencing a more deadly and complicated drug overdose epidemic. According to the AMA’s [Opioid Task Force 2020 Progress Report](#), released July 21, 2020, while physicians have reduced opioid prescriptions by 37 percent between 2014 and 2019, illicitly manufactured fentanyl, fentanyl analogues, and stimulants (e.g., methamphetamine, cocaine) are now killing more Americans than ever. The use of these illicit drugs has surged, and their overdose rate increased by 10.1 percent and 10.8 percent, respectively. The changing landscape of the epidemic poses challenges for the health care system, which must pivot to treat people in danger of overdose from all drugs.

One of the primary challenges in ending the nation’s drug overdose epidemic remains the inability of most patients to obtain evidence-based care for a substance use disorder. While the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) in combination have addressed some of the coverage and access gaps, the [National Survey on Drug Use and Health](#) for 2017 and 2018, conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), has found that over 90 percent of those 12 and older with an illicit drug use disorder did not receive treatment. The number of drug overdoses will continue to rise unless more is done to help the more than two million Americans with an untreated substance use disorder.

Resolving the issue of capacity to treat all patients who require it, however, faces several barriers. While network adequacy laws require a sufficient number of addiction medicine and psychiatric physicians in a patient’s network, health insurance companies are falling far short of their obligation, and enforcement of these requirements often is lacking. Moreover, many payers are failing to comply with state and federal mental health and substance use disorder parity laws.

Removing the barriers for patients to receive evidence-based treatment is critical to helping end the epidemic. AMA advocacy in this area has been substantial and multipronged, focusing on removing barriers to evidence-based care, encouraging more physicians to become trained to provide buprenorphine in-office to help treat opioid use disorder, and advocating for payers to increase network capacity and demonstrate compliance with mental health and substance use disorder parity laws. The AMA is working at the state and federal levels to strengthen network adequacy requirements and enforcement and promote meaningful oversight and enforcement of mental health and substance use disorder parity laws. In addition, the AMA has advocated against health insurance company tactics to delay and deny access to evidence-based treatment for opioid use disorder through the use of prior authorization requirements and

other barriers for medications to treat opioid use disorder (MOUD), the gold standard for treating opioid use disorder. Barriers include the reluctance among some providers and individuals to use MOUD, stigma, administrative obstacles, and lack of sufficient treatment facilities and addiction medicine specialists or physicians who treat patients with an OUD. The AMA has partnered with the American Psychiatric Association, American Society of Addiction Medicine (ASAM), and many other organizations in the Federation to simultaneously address these issues.

Congressional Action

According to SAMHSA, due to the increased demand for opioid treatment, substance use treatment centers are a multi-billion-dollar industry. As noted in Resolution 201, media outlets have reported cases of fraud and abuse in this industry. Multiple federal law enforcement agencies, including the Federal Trade Commission (FTC), the Federal Bureau of Investigation (FBI), and the Department of Labor's Employee Benefits Security Administration (EBSA), have conducted investigations uncovering fraudulent acts regarding substance use treatment services and products, especially involving insurance fraud. Under the Federal Trade Commission Act (15 U.S.C. §§41 et seq.), the FTC has the authority to prohibit false or deceptive claims and may seek a judicial order levying civil penalties on violators. The FDA and FTC have sent joint warning letters to companies illegally marketing unapproved opioid cessation products claiming to treat opioid addiction and withdrawal. In addition, several states, including New York, have cracked down on fraudulent operators and federal prosecutors have brought lawsuits in California and Florida.

In 2018, as part of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271—the SUPPORT for Patients and Communities Act, or the SUPPORT Act), Congress took action against fraudulent treatment centers. Sections 8021-8023 of the SUPPORT Act include the Opioid Addiction Recovery Fraud Prevention Act, which prohibits any unfair or deceptive acts regarding substance use disorder treatment services or products. The provision makes these practices unlawful under section 18 of the Federal Trade Commission Act (15 U.S.C. §57a). [The provision](#) effectively authorizes the FTC to seek civil penalties against opioid treatment programs and products that make false or deceptive claims regarding their cost, price, efficacy, performance, benefit, risk, or safety. The bill also authorizes state attorneys general, or other state officials, to bring civil actions for violations. The AMA supported these provisions.

The Board commends the laudable goal underlying Resolution 201. However, in considering the many comments received on this resolution, we find most compelling the many comments by those who testified before the reference committee that the problem is not lack of regulation but lack of enforcement of laws. As noted above, state and federal laws already govern outpatient treatment facilities. Federal regulations can often interfere with evidence-based medicine—e.g., the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain issued by the CDC—and the Board agrees that standardized evidence-based federal regulations are not the right approach. The Board also notes that medical specialties, such as ASAM and the American Psychiatric Association, have guidelines and standards to help ensure the provision of evidence-based care in treatment facilities for in-patient and out-patient care.

The Board has determined that more evaluation of existing programs and outcomes is needed. Billions of dollars have been spent by the federal government in support of state-level grant programs to provide care for those with a substance use disorder or co-occurring mental disorder. Many of these programs are certainly saving lives, but there may be others that are not as effective. The SUPPORT Act took an important step toward ensuring such evaluation in section 7171, which requires the Secretary to review entities that receive federal funding to provide SUD treatment services. The review is required to include certain specified elements about the entity's history, population served, and treatment capacity. The Secretary is required, within two years of enactment, to develop and submit a plan to Congress to direct appropriate resources to entities that provide SUD treatment services in order to address inadequacies in services or funding identified through the required review. When released, this report will help in determining which of the many federally funded programs are working and should be continued and which should either be improved or denied future funding. The AMA looks forward to highlighting those evidence-based, best practices demonstrated to help increase access to treatment for those with an OUD.

Moreover, we remain concerned that relying on short-term grants that depend on the annual appropriations process in Congress does not provide long-term certainty for states in terms of planning for programs and resources or accessibility to treatment and continuity of care for individuals seeking substance use disorder treatment. A short-term grant would not allow most states to recruit, for example, addiction medicine specialists or psychiatrists to underserved areas if there is only a short-term commitment for that medical professional. Recruiting a physician (and his or her

family) to relocate with a promise of only a 6- or 12-month commitment is problematic, to say the least. Sustained funding and a comprehensive framework to prevent and treat all substance use disorders is necessary as the epidemic evolves and overdose fatalities involving illicit opioids, stimulants (e.g., methamphetamine), heroin, and cocaine increase.

One such proposal, which the AMA supports, is the “Comprehensive Addiction Resources Emergency (CARE) Act” (S. 1365/H.R. 2569), introduced by Senator Elizabeth Warren (D-MA) and the late Representative Elijah E. Cummings (D-MD). The CARE Act is modeled directly on the Ryan White Comprehensive AIDS Resources Emergency Act, which was passed by Congress in 1990 to provide significant new funding to help state and local governments combat the HIV/AIDS epidemic. The CARE Act is designed to support local decision making and federal research and programs to prevent drug use while funding evidence-based treatments and recovery support services. The bill would provide \$100 billion over 10 years, the type of long-term funding that could really help to turn-around the substance-use epidemic. While this bill has not moved forward during this Congressional session, your Board believes it serves as an excellent model for a framework in the future.

AMA POLICY

Our AMA has longstanding and extensive policy on addiction and substance use disorder treatment. Policy D-95.981, “Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction,” which was reaffirmed by the HOD at the 2019 Interim Meeting, provides in part that our AMA “will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.”

Likewise, AMA policy provides that “our AMA (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders; (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.” (Policy H-95.922, “Substance Use and Substance Use Disorders”).

Current AMA policy also broadly covers parity issues, including support for “health care reform that meets the needs of all Americans, including people with mental illness and substance use/addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use/addiction disorders in all national health care reform legislation.” (Policy H-165.888, “Evaluating Health System Reform Proposals”) (Also see Policy D-180.998, “Insurance Parity for Mental Health and Psychiatry” and Policy H-185.974, “Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs”).

With respect to third-party payers, our AMA opposes federal, state, third-party and other laws, policies, rules and procedures, including those imposed by pharmacy benefit managers working for Medicaid, Medicare, TRICARE, and commercial health plans, that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federal regulated Opioid Treatment Program, by imposing limitations on the duration of treatment, medication dosage or level of care. (Policy H-95.944, “Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy”).

More generally, with regard to federal drug policy, “our AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective; (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the

employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.” (Policy H-95.981, “Federal Drug Policy in the United States”).

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 201-I-19, and that the remainder of the report be filed.

1. That our AMA advocate for the expansion of federal grants in support of treatment for a substance use disorder to states that are conditioned on that state’s adoption of law and/or regulation that prohibit drug courts, recovery homes, sober houses, correctional settings, and other similar programs from denying entry or ongoing care if a patient is receiving medication for an opioid use disorder or other chronic medical condition.
2. That our AMA advocate for sustained funding to states in support of evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder, such as that put forward by the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and other professional medical organizations.
3. That our AMA reaffirm Policy D-95.981, “Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction.”
4. That our AMA reaffirm Policy H-95.922, “Substance Use and Substance Use Disorders.”
5. That our AMA reaffirm H-95.981, “Policy Federal Drug Policy in the United States.”

15. PLAN FOR CONTINUED PROGRESS TOWARD HEALTH EQUITY (CENTER FOR HEALTH EQUITY ANNUAL REPORT)

Informational report; no reference committee hearing.

HOD ACTION: FILED

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.

3rd Quarter, 2019

- (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, summararily, 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 existing 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)

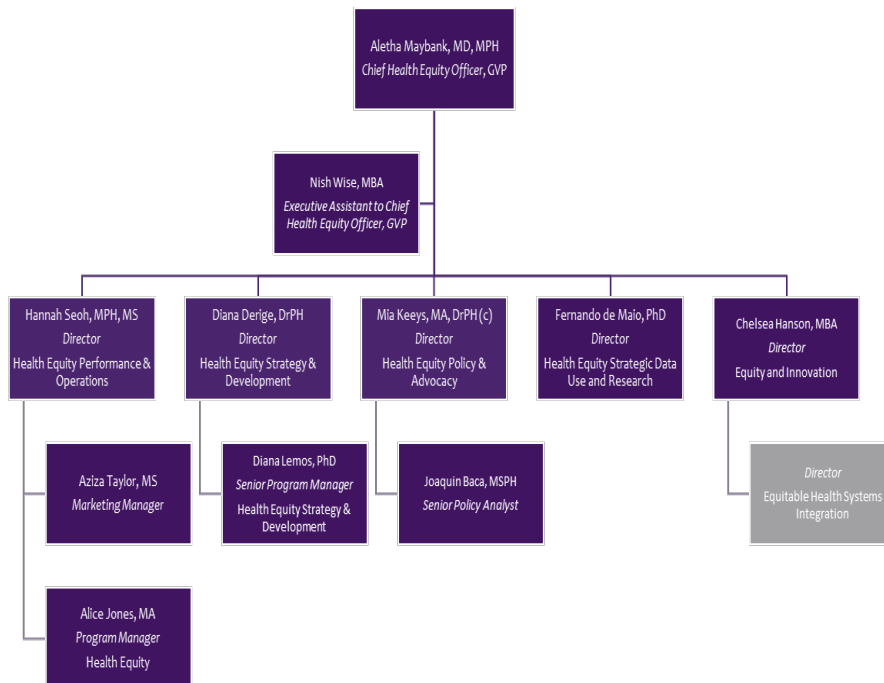


Table 1. AMA Center for Health Equity Supports & Partners (2020-2025)

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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> IHMI EISAMR Health and Science MedEd PS2 Ed Hub MMX 	<ul style="list-style-type: none"> EISAMR PS2 Health Solutions Health & Science IHMI Health 2047 	<ul style="list-style-type: none"> AMA Archives Health & Science [Ethics] MMX
External Partnerships		<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> West Side United MEDICC APHA (American Public Health Association) American College of Preventive Medicine (ACPM) NAACP Academy of Nutrition & Dietetics 	<ul style="list-style-type: none"> AfroTech – Blavity Landmark Ventures (Sponsorship) HealthTech 4 Medicaid 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Race Forward Morten Group Racial Equity Institute Interaction Institute for Social Change OnBoard Health Brandstage 		<ul style="list-style-type: none"> Health Begins Advancing Health Equity (Uche Blackstock) Jonathan Metz (Vanderbilt) 	<ul style="list-style-type: none"> Onboard Health 	<ul style="list-style-type: none"> 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

Table 2: American Medical Association Center for Health Equity National Speaking Engagements (Nov 2019-Present)				
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 Obob 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

16. ENABLING METHADONE TREATMENT OF OPIOID USE DISORDER IN PRIMARY CARE SETTINGS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy D-95.961

INTRODUCTION

At the 2019 Interim Meeting of the AMA House of Delegates, Board of Trustees (BOT) Report 2, “Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings,” was considered for adoption.

Board Report 2-I-19 recommended:

That our American Medical Association (AMA) support further research into how primary care practices can implement MAT into their practices and disseminate such research in coordination with primary care specialties;

That our AMA support efforts to expand primary care services to patients receiving methadone maintenance therapy (MMT) for patients receiving care in an Opioid Treatment Program or via office-based therapy; and

That the AMA Opioid Task Force increase its evidence-based educational resources focused on MMT and publicize those resources to the Federation.

Testimony on Board Report 2-I-19 generally supported the recommendations, but there was conflicting testimony related to Recommendation 2. Recommendations 1 and 3 were adopted. This report discusses the issues raised by Recommendation 2 and presents additional recommendations.

DISCUSSION

Background

Board Report 2-I-19 discussed the history and efficacy of methadone maintenance treatment (MMT) in great detail, including the increase in Opioid Treatment Programs (OTPs) offering MMT; the medication’s efficacy in treating opioid use disorder; and the various state and federal requirements regulating the provision of MMT. Board Report 2-I-19 also reviewed examples of clinical research and practice in providing MMT in primary care settings, “that have demonstrated benefits of having MMT provided in a primary care setting outside of a traditional OTP.” BOT Report 2 explained, however, that the examples were, “highly structured and still must comply with state and federal rules (including who can dispense, take-home rules for stable patients, patient monitoring, strict record-keeping, etc.) governing the provision of MMT.” It is worth further highlighting that testimony pointed out the limited nature of the research, and the studies did not involve large groups of patients. The patients in the studies, moreover, were highly selected; with low acuity; without significant untreated psychiatric comorbidity; and had been stable in treatment for at least one year. In addition, the primary care practices in the studies each had a close ongoing relationship with the community OTP, and there was not the option of the physicians in the primary care setting to provide buprenorphine, which was approved by the U.S. Food and Drug Administration (FDA) for use in treating opioid use disorder in 2002.¹

The Board provides this additional context to emphasize both the positive nature of the pilot programs but also to make clear that they were provided as examples rather than suggesting the MMT primary care practice pilot programs should be the rule or able to be replicated in all situations. The Board appreciates the opportunity to clarify the issues and present a discussion and recommendations to further support increased access to evidence-based care.

There are other barriers to MMT, including the fact that MMT remains one of the most highly stigmatized forms of treatment to treat opioid use disorder (OUD). Previous studies make clear how patients who receive MMT, “experience prejudice, stereotypes, and discrimination from friends and family, coworkers and employers, healthcare workers, and others.”² This stigma is one of the root causes why those with an OUD may not seek treatment. In addition, because MMT is highly regulated by multiple layers of state and federal government, patients encounter

multiple additional barriers, including a lack of access in rural areas³ and the common requirement to drive or travel long distances to an OTP.⁴ Dosing restrictions/requirements and other administration and/or legal barriers limit the ability of jails, prisons and Federally Qualified Health Centers (FQHCs) to provide MMT to particularly vulnerable and marginalized populations. It is beyond the scope of this report, but important to note that the AMA, American Society of Addiction Medicine (ASAM) and other medical organizations strongly support removing barriers to treatment for OUD in correctional settings.⁵ Furthermore, some states place additional restrictions on the number of OTPs allowed to operate in a state or have burdensome requirements for an OTP to open.⁶ Each of these barriers—whether stigma, social determinants, statute or rule—potentially limit a patient’s ability to receive MMT and could also hinder that patient from receiving any care, including primary care as discussed above. At the same time, the Board recognizes that there is an appropriate role for clinical and other guidance to ensure the safety of patients. The focus of this report is not to delve into every potential barrier but to point out, broadly, that there are opportunities for further advocacy to identify, evaluate and either support or oppose policies that impede the provision of primary care services in an OTP, as well as the provision of MMT itself.

At a minimum, better coordination with primary care and MMT services would help increase access to evidence-based care for an OUD. Better support and training for family physicians, for example, to assess, diagnose and refer patients with an OUD to an OTP for MMT or other appropriate care, is supported by evidence.⁷ While beyond the scope of this report, clinical research also is widely available to help primary care physicians with dosing and other clinical issues raised by the use of buprenorphine and/or MMT.^{8,9} The AMA also has placed additional resources regarding methadone on the [AMA drug overdose epidemic microsite](#), including information and research from the American Association of Treatment for Opioid Dependence,¹⁰ American Academy of Family Physicians,¹¹ ASAM,¹² American College of Physicians¹³ and the Providers Clinical Support System.¹⁴ The AMA will continue to update the microsite with relevant information as provided by our Federation partners.

Physicians who might be interested to include MMT in primary care practices should be aware, for example, of some of the costs that their practices would incur under current federal requirements to operate an OTP.¹⁵ Practices would need to meet specifications to assure that the stocked methadone and the practice site are secure. Credentialed staff would need to be present to administer medication. Systems would need to be in place to monitor patients for adherence, ensure stock of medication and keep records with accountability to the U.S. Drug Enforcement Administration (DEA). The Board recognizes that these requirements are not insignificant and may be cost prohibitive. In addition, the Board points out the many different therapeutic and patient safety issues raised during the I-19 Interim Meeting concerning dosing, methadone’s narrow therapeutic index, side effects and other issues.¹⁶

The issue at hand, however, is not whether patients currently receiving MMT, or those who might benefit from MMT, should also receive primary care services. The issue is how to best ensure that patients who are receiving MMT, or would benefit from receiving MMT, *also* receive primary care services. As noted in Board Report 2-I-19 and above, this entails multiple aspects, including removing barriers to MMT. There is no question that patients receiving MMT would benefit from receiving primary care services and the AMA remains committed to supporting efforts for patients receiving care in an OTP to also receive primary care services. This must be an evidence-based approach¹⁷ done in compliance with applicable state and federal regulations. If the evidence demonstrates that patients can safely receive MMT in office-based settings, and the provision of such care is done in accordance with the highest standards of medical evidence and clinical research, the AMA wants to ensure that it supports policies that advance patient care.

It follows that the Board recommends further research into evidence-based initiatives to support the integration of primary care services into OTPs. This includes working with our partners at the American Society of Addiction Medicine, American Psychiatric Association, American Academy of Addiction Psychiatry, American Academy of Family Physicians and other medical societies to better understand and identify examples and best practices of how primary care services have been integrated into OTPs and addiction medicine practices. Additional stakeholders, including the American Association for the Treatment of Opioid Dependence, will likely be able to provide helpful information on evidence-based initiatives—as well as barriers—to integrate primary care services in OTPs and practices providing care for substance use disorders.

As stated above, the Board recognizes that the costs, requirements, etc. may make including MMT in primary care practices challenging and as such, the Board understands that not all primary care practices are able to or would be able to provide MMT. Yet, at a time when more Americans than ever are dying from illicitly manufactured fentanyl, fentanyl analogs and heroin—and prescription opioid-involved mortality remains at more than 11,000 deaths per year—the AMA believes all efforts must be made to increase access to evidence-based care. This is in line with

recommendations from the National Academy of Medicine (NAM), which recommends the need for the DEA and U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to “explore methadone delivery models that can increase access to this lifesaving medication.”¹⁸ The NAM authors call for additional use of pilot programs to evaluate best practices as well as the need for health insurance companies, Medicaid, and Medicare to “eliminate policies that disincentivize clinicians from providing medications and limit or delay access to treatment.” The call for further research and removal of administrative and financial barriers are items the AMA strongly supports.

The AMA will continue its work to remove utilization management barriers to patients with an OUD from receiving evidence-based care. This includes AMA advocacy to: (1) urge states to include all medications used to treat OUD on the lowest cost-sharing tier of a health insurer’s or pharmacy benefit management company formulary;¹⁹ (2) support for state Medicaid agencies to include methadone on the state preferred drug list; (3) support for innovative proposals such as mobile units to provide MMT;²⁰ and broad support for increased flexibility for OTPs to provide take-home dosing and other policies during the COVID-19 pandemic.²¹ It bears repeating that the AMA believes the focus must be on increasing access to MMT *and* primary care. The AMA does not see the value in debating the specific mechanisms by which physicians can do this effectively so long as they do so safely and in accordance with best clinical practice and medical evidence. This approach will help remove stigma and increase access to MMT and primary care. AMA policy strongly supports physicians exercising the clinical judgment to care for their patients according to the highest standards that the medical profession brings to all other medical conditions. This is true for MMT and any other type of treatment proven effective for a medical disease.

The Board, therefore, recommends that the AMA provide further support for primary care services and MMT, including continued support for clinical research and other evidence to guide safe clinical practice, as well as new recommendations to remove barriers and increase access to evidence-based care.

AMA POLICY

The AMA opposes “the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.” (Policy D-95.981, “Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction”) The AMA broadly supports MMT, the evolving nature of evidence supporting MMT, education on MMT as well as removing barriers to MMT. (Policy H-95.957, “Methadone Maintenance in Private Practice”) Specifically, Policy H-95.957 “supports the position that ‘medical’ methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed; encourages additional research that includes consideration of the cost of ‘medical’ methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users; supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management.”

The AMA also broadly supports efforts to increase access to OTPs in areas where they are needed most. (Policy H-95.921, “Exclusive State Control of Methadone Clinics”) This includes an ongoing commitment by the AMA to support and promote education relating to MMT. (Policy D-120.985, “Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone”) The policy includes “how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.” (Policy D-95.968, “Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder”) AMA policy also supports how “[f]inancial incentives should enhance the provision of high quality, cost-effective medical care.” (Policy H-285.951, “Financial Incentives Utilized in the Management of Medical Care”) Finally, there is extensive support in current policy for removing administrative

barriers for the provision of evidence-based care. (Policy H-320.939, “Prior Authorization and Utilization Management Reform”)

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of the second recommendation of Board Report 2-I-19, and that the remainder of the report be filed:

1. That our AMA research current best practices and support pilot programs and other evidence-based efforts to expand and integrate primary care services for patients receiving methadone maintenance treatment.\
2. That our AMA support further research to help define the population of patients who may be safely treated with methadone maintenance treatment via office-based treatment, including primary care.
3. That our AMA urge all payers, including health insurance companies, pharmacy benefit management companies, and state and federal agencies, to reduce prior authorization and other administrative burdens and to enhance the provision of primary care, counseling, and other medically necessary services for patients being treated with methadone maintenance treatment.

REFERENCES

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- 2 Earnshaw V, Smith L, Copenhaver M. Drug Addiction Stigma in the Context of Methadone Maintenance Therapy: An Investigation into Understudied Sources of Stigma. *Int J Ment Health Addict*. 2013;11(1):110-122. doi:10.1007/s11469-012-9402-5
- 3 Lack of access in rural areas was cited in testimony by family physician residents at the 2019 meeting of the American Academy of Family Physicians in adopting a resolution to support increased access to MMT. See “Residents Focus Discussions on Training, Patient Care,” July 31, 2019. Available at <https://www.aafp.org/news/education-professional-development/20190731nc-rescongress.html>
- 4 Joudrey PJ, Edelman EJ, Wang EA. Drive Times to Opioid Treatment Programs in Urban and Rural Counties in 5 US States. *JAMA*. 2019;322(13):1310–1312. doi:10.1001/jama.2019.12562
- 5 See, for example AMA and Vermont Medical Society strong support for strong support for Senate Bill 166, An act relating to the provision of medication-assisted treatment for inmates. Feb. 21, 2018. Available at <https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Fstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-2-21-AMA-VMS-Letter-in-support-of-VT-SB-166-FINAL.pdf>. Also see American Society of Addiction Medicine public policy statement on Treatment of OUD in Correctional Settings. Available at https://www.asam.org/docs/default-source/public-policy-statements/2020-statement-on-treatment-of-oud-in-correctional-settings.pdf?sfvrsn=ff156c2_2
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- 12 See https://end-overdose-epidemic.org/resources/?societies_associations=american-society-of-addiction-medicine
- 13 See https://end-overdose-epidemic.org/resources/?societies_associations=american-college-of-physicians
- 14 See https://end-overdose-epidemic.org/resources/?other_organizations=pcss
- 15 See, broadly, the certification and accreditation requirements for Opioid Treatment Programs. U.S. Substance Abuse and Mental Health Services Administration. Available at <https://www.samhsa.gov/medication-assisted-treatment/certification-opioid-treatment-programs>
- 16 National Center for Biotechnology Information. PubChem Database. Methadone, CID=4095, <https://pubchem.ncbi.nlm.nih.gov/compound/Methadone> (accessed on July 23, 2020)
- 17 See, for example, the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. American Society of Addiction Medicine. Available at https://www.asam.org/docs/default-source/quality-science/npq-jam-supplement.pdf?sfvrsn=a00a52c2_2

- 18 Madras, B. K., N. J. Ahmad, J. Wen, J. Sharfstein, and the Prevention, Treatment, and Recovery Working Group of the Action Collaborative on Countering the U.S. Opioid Epidemic. NAM Perspectives. Discussion Paper, Washington, DC. <https://doi.org/10.31478/202004b>
- 19 This is one of several recommendations contained in the AMA-Manatt Health publication, *National Roadmap on State-Level Efforts to End the Opioid Epidemic: Leading-edge Practices and Next Steps*. September 2019. Available at <https://end-overdose-epidemic.org/wp-content/uploads/2020/05/AMA-Manatt-National-Roadmap-September-2019-FINAL.pdf>
- 20 AMA letter to Uttam Dhillon, Acting Administrator, Drug Enforcement Administration, U.S. Department of Justice. RE: RIN 1117-AB43/Docket No. DEA-459 Registration Requirements for Narcotic Treatment Programs with Mobile Components. April 27, 2020. Available at <https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-4-27-Letter-to-Dhillon-re-NTP-Mobile.pdf>
- 21 AMA letter to Elinore F. McCance-Katz, MD, PhD, Assistant Secretary for Mental Health and Substance Use, U.S. Department of Health and Human Services. April 13, 2020. Available at <https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-4-13-Letter-to-McCance-Katz-at-SAMHSA-re-OTP-Telemed-.pdf>

17. HOSPITAL WEBSITE VOLUNTARY PHYSICIAN INCLUSION

Reference committee hearing: see report of Reference Committee G.

**HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 819-I-19
REMAINDER OF REPORT FILED
See Policy D-215.985**

At the 2019 Interim Meeting, the House of Delegates (HOD) referred Alternate Resolution 819-I-19, “Hospital Website Voluntary Physician Inclusion.” Resolution 819 was sponsored by the Organized Medical Staff Section and asked the AMA to:

advocate for regulation and/or legislation requiring that all credentialed physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally included on the websites and physician search engines, such as Find a Doctor sites...

The resolution further asked the AMA to:

study a requirement that all credentialed physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally included on the websites and physician search engines, such as Find a Doctor sites with a report back at the 2020 Annual Meeting.

Testimony around Resolution 819 was supportive of having all credentialed physicians included in hospital and healthcare facility websites and search functions. Speakers recalled anecdotes of hospitals that only advertised employed physicians with the suggestion that this practice may be part of a plan to encourage voluntary physicians to consolidate with larger healthcare facilities. Additional testimony noted the practice of omitting non-employed physicians from websites and search functions was not transparent, making it hard to ascertain why a facility engaged in the practice. Testimony also reflected that omissions of physicians in this way could lead to a more confusing experience for patients who may have a more difficult time locating a physician for the first time or returning to one later.

Original iterations of Resolution 819 called more forcefully for the AMA to engage in the policymaking and regulatory process at the state and federal level to ensure that all credentialed physicians are included on healthcare facilities’ websites. Some believed, however, that a fully engaged legislative and advocacy campaign was an inappropriate remedy for the problem and encouraged that the AMA do more to understand physician inclusion on websites first before committing to more involved action.

This report addresses the request to study requirements and practices around physician inclusion in hospital and healthcare facility websites and search functions with attention paid to recommendations for future action. For the

purposes of this report, a “voluntary physician” can be understood to be any physician who is credentialed and privileged to practice at a hospital or health facility for any period of time but who is not employed or is otherwise financially independent on that hospital or health system.

DISCUSSION

Resolution 819 follows the experiences of several voluntary physicians in New York who found that their names were not included in the “Find a Doctor” search functions of at least one, and in some cases more than one, healthcare facility they practiced in. By contrast, names and information for physicians who were employed by the facilities were listed. When the voluntary physicians reached out to understand why, they heard a variety of reasons, including that the website was being updated. In each of the anecdotal cases, the issue was resolved, and voluntary physicians were eventually also included in the web search function.

These incidents raised a few concerns: first, that credentialed physicians were being, intentionally or otherwise, deprived of potential new patients because they were harder to find online. Second, that patients themselves may lose out on needed care due to the difficulties of locating a physician or returning to one in the future. Third, that excluding voluntary physicians from facility websites may put undue pressure on voluntary physicians to consolidate their practices into larger systems or facilities.

To better understand this issue, we reached out to the ten largest hospitals in the United States by number of beds according to Becker’s Hospital Review¹. These hospitals were chosen simply as a sample of the kinds of facilities that could potentially have a wide variety of employed and voluntary physicians working in them and not due to any suspected bad policies or inappropriate actions. (In point of fact, the healthcare facilities that were mentioned in the New York physicians’ anecdotes all tended to be much smaller facilities.) All ten had “Find a Doctor” search functions on their websites. We attempted to speak with someone who could explain how these hospitals make determinations about management of their web search functions; however, we did not receive responses.

In examining the current regulatory landscape, we again were unable to identify any significant body of work that directly governed how physicians were listed on websites from state, local, or federal sources. While some guidance exists for certain standards, such as listing credentials, disclosures, or conflicts of interest in a public forum, very little is codified as to when and in what manner physicians’ general information should be included or presented. Likewise, the AMA itself has not, prior to the Interim Meeting in 2019, established any guiding principles or policy on the subject.

While it does not relate directly to web searches and “Find a Doctor” sites, it is worth mentioning that one area of public reporting that is seeing a significant amount of attention involves reporting of quality metrics and performance measures. Federal and state mandates about how physicians and health systems may rank against each other are increasingly becoming more searchable and easier to find. Voluntary physicians should pay special attention to how they are listed on hospital websites to ensure that they are presented with the same contact information and quality measures as all other providers.

CONCLUSION

With few standards and almost no regulation from professional bodies, or state, local, or federal governments, it is difficult to fully grasp the effect of listing physicians’ names in search functions. It is a potentially fruitful area for further academic research, as it is currently difficult to fully articulate how hospital and healthcare facilities’ internal practices could affect not only physicians but patients seeking care as well. Additionally, none of the hospitals examined during this research responded to any requests to better understand how physicians are included in their websites and search functions. This gap in policy and practice uniquely positions the AMA to provide leadership and establish best practices for all medical staff in healthcare facilities. In the absence of public regulations and policy, the AMA can proactively establish standards for medical staff inclusion in public-facing promotional efforts like websites.

Because it is difficult to demonstrate how widespread the practice of limiting voluntary physicians on hospital websites is, it is also difficult to draw conclusions about the harm or benefit. Regardless, promoting access to practicing physicians, whether they are employed by a facility or voluntary, should be considered a best practice by the AMA. Any actions the AMA can take to promote the availability of credentialed and practicing physicians in any practice setting should ultimately be considered for the benefit of all physicians and their patients.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 819-I-19 and that the remainder of the report be filed:

1. That our AMA (1) work with relevant stakeholders to encourage decision-makers at all appropriate levels that all credentialed physicians be included in healthcare organizations' website listings and search functions in a fair, equal, and unbiased fashion; and (2) support efforts to ensure that physicians, through their medical staffs, are able to provide input on what information is published.
2. That our AMA work with relevant stakeholders to encourage healthcare organizations to notify credentialed physicians when a website is about to be changed if there is reason to believe that such a change could affect how physicians are listed or if they are listed at all.
3. That our AMA, through its Organized Medical Staff Section, produce and promote educational materials, trainings, and any other relevant components to help physicians advocate for their own inclusion on facilities' websites and search functions.

REFERENCE

1. 50 Largest Hospitals in America. *Becker's Hospital Review*. Accessed June 25, 2020: <https://www.beckershospitalreview.com/lists/50-largest-hospitals-in-america.html>

18. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES: FIVE-YEAR REVIEW

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOD ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy D-600.984

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) scheduled to submit information and materials for the 2020 American Medical Association (AMA) Annual Meeting and the 2020 Interim Meeting in compliance with the five-year review process established by the HOD in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed in anticipation of the 2020 Annual Meeting:

- American Academy of Otolaryngic Allergy
- American Association for Geriatric Psychiatry
- American College of Legal Medicine
- American College of Mohs Surgery
- American College of Obstetricians and Gynecologists
- American College of Physicians
- American College of Preventive Medicine
- American College of Radiology
- American College of Surgeons
- American Society of Breast Surgeons
- American Society of Retina Specialists
- American Vein and Lymphatic Society

Heart Rhythm Society
 International Academy of Independent Medical Evaluators
 Society of Hospital Medicine
 Undersea and Hyperbaric Medical Society

The following organizations were also reviewed in anticipation of the 2020 Annual Meeting, having failed to meet the requirements at the 2019 Annual Meeting:

American Society for Aesthetic Plastic Surgery
 American Society of Interventional Pain Physicians
 Association of University Radiologists
 Infectious Diseases Society of America
 International Society for the Advancement of Spine Surgery

The following organizations were reviewed in anticipation of the 2020 Interim Meeting:

American College of Occupational and Environmental Medicine
 American Gastroenterological Association
 American Geriatrics Society
 American Orthopaedic Association
 American Psychiatric Association
 American Roentgen Ray Society
 American Society of Abdominal Surgeons
 The Triological Society

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American Academy of Otolaryngic Allergy, American Association of Geriatric Psychiatry, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Occupational and Environmental Medicine, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Breast Surgeons, American Society of Interventional Pain Physicians, American Society of Retina Specialists, American Vein and Lymphatic Society, Association of University Radiologists, Heart Rhythm Society, Infectious Disease Society of America, International Society for the Advancement of Spine Surgery, Society of Hospital Medicine, The Triological Society and the Undersea and Hyperbaric Medical Society meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicated that the American Society for Aesthetic Plastic Surgery and the International Academy of Independent Medical Examiners did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The American Society of Abdominal Surgeons did not submit materials and is therefore not in compliance.

RECOMMENDATIONS

In light of the cancellation of the 2020 Annual and Interim Meetings and with an intention to continue compliance with the five-year review process, the Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. That the American Academy of Otolaryngic Allergy, American Association of Geriatric Psychiatry, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Occupational and Environmental Medicine, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Breast Surgeons, American Society of Interventional Pain Physicians, American Society of Retina Specialists, American Vein and Lymphatic Society, Association of University Radiologists, Heart Rhythm Society, Infectious Disease Society of America, International Society for the Advancement of Spine Surgery, Society of Hospital Medicine, The Triological Society and the Undersea and Hyperbaric Medical Society retain representation in the American Medical Association House of Delegates. (Directive to Take Action)
2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the International Academy of Independent Medical Evaluators and the American Society of Abdominal Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year's grace period to increase membership, the American Society for Aesthetic Plastic Surgery not retain representation in the House of Delegates. (Directive to Take Action)

APPENDIX

Exhibit A - Summary Membership Information

Organization	AMA Membership of Organization's <u>Total Eligible Membership</u>
American Academy of Otolaryngic Allergy	259 of 997 (26%)
American Association for Geriatric Psychiatry	233 of 829 (28%)
American College of Legal Medicine	52 of 176 (30%)
American College of Mohs Surgery	306 of 1,088 (28%)
American College of Obstetrician and Gynecologists	13,123 of 43,410 (30%)
American College of Occupational and Environmental Medicine	646 of 2,633 (25%)
American College of Physicians	33,190 of 102,042 (32%)
American College of Preventive Medicine	326 of 1,193 (27%)
American College of Radiology	7,370 of 34,011 (22%)
American College of Surgeons	5,869 of 29,938 (20%)
American Gastroenterological Association	1,273 of 7,791 (16%)
American Geriatrics Society	724 of 2,750 (26%)
American Orthopaedic Association	387 of 1,665 (23%)
American Psychiatric Association	6,837 of 25,719 (27%)
American Roentgen Ray Society	2,533 of 13,859 (18%)
American Society for Aesthetic Plastic Surgery	330 of 1,888 (17%)
American Society of Abdominal Surgeons	no data
American Society of Breast Surgeons	609 of 2,473 (25%)
American Society of Interventional Pain Physicians	652 of 2,587 (25%)
American Society of Retina Specialists	575 of 2,154 (26%)
American Vein and Lymphatic Society	238 of 957 (25%)
Association of University Radiologists	179 of 861 (20%)
Heart Rhythm Society	656 of 3,040 (22%)
Infectious Disease Society of America	1062 of 3,515 (30%)
International Academy of Independent Medical Evaluators	61 of 139 (44%)
International Society for the Advancement of Spine Surgery	109 of 369 (29%)
Society of Hospital Medicine	2,389 of 12,827 (19%)
The Triological Society	123 of 534 (23%)
Undersea and Hyperbaric Medical Society	123 of 586 (21%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C - AMA Bylaws on Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations

- 8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:
 - 8.2.1 To cooperate with the AMA in increasing its AMA membership.
 - 8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
 - 8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
 - 8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
 - 8.2.5 To provide information and data to the AMA when requested.

Exhibit D - AMA Bylaws on Specialty Society Periodic Review

- 8 Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates
 - 8.5 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.
 - 8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.
 - 8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the

responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

- 8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.
 - 8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.
 - 8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:
 - 8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.
 - 8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.