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REPORT OF THE BOARD TRUSTEES

B of T Report 02-JUN-2021

Subject: 2020 Grants and Donations

Presented by: Russ Kridel, MD, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2020.

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2020
Amounts in thousands

Funding Institution	Project	Amount Received
Agency for Healthcare Research and Quality (subcontracted through RAND Corporation)	Health Insurance Expansion and Physician Distribution	$ 29
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	257
Centers for Disease Control and Prevention (subcontracted through National Association of Community Health Centers, Inc.)	Preventing Heart Attacks and Strokes in Primary Care	348
Centers for Disease Control and Prevention	Engaging Physicians to Strengthen the Public Health System and Improve the Nation's Public Health	163
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	9
Centers for Disease Control and Prevention	Promoting HIV, Viral Hepatitis, STDs, and LTBI Screening in Hospitals, Health Systems, and Other Healthcare Settings	44
Government Funding		**850**
American Heart Association, Inc.	Release the Pressure Program	200
American Heart Association, Inc.	Target: Blood Pressure Initiative	52
American Medical Association Foundation via contributions from Genentech, Inc.	Accelerating Change in Medical Education Conference	45
American Medical Association Foundation via contributions from Pfizer, Inc.	Accelerating Change in Medical Education Conference	23
Physicians for a Healthy California	Graduate Medical Education Innovations Summit	15
Nonprofit Contributors		**335**
Total Grants and Donations		**$ 1,185**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-JUN-2021

Subject: Update on Corporate Relationships

Presented by: Russ Kridel, MD, Chair

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2020. 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 2020 RESULTS

In 2020, 64 new activities were considered and approved through the Corporate Review process. Of the 64 projects recommended for approval, 31 were conferences or events, nine were educational content or grants, 20 were collaborations or affiliations, two were member programs, one was an American Medical Association Foundation (AMAF) program and one was an AMA Innovations, Inc. program (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), Center for Health Equity, 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 Current Procedural Terminology (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 2020

Project No.	Project Description	Corporations	Approval Date
CONFERENCES/EVENTS			
4648	**Poynter Institute Webinar –** Sponsorship with AMA name and logo.	Poynter Institute	12/1/2020
4694	**National Press Club Webinar –** COVID-19 vaccine focused webinar sponsorship with AMA name and logo.	National Press Club	12/2/2020
4907	**American Bar Association (ABA) Opioid Summit –** Sponsorship with AMA name and logo.	American Bar Association (ABA)	12/16/2020
27981	**Alliance for Health Policy Post Election Symposium –** Updated virtual sponsorship with AMA name and logo.	Alliance for Health Policy	10/5/2020
35268	**AMA/American Health Information Management Association (AHIMA) Outpatient Clinical Documentation Improvement (CDI) Workshop –** Co-branding event with AMA name and logo.	American Health Information Management Association (AHIMA)	8/31/2020
36280	**2021 National Rx Drug Abuse & Heroin Summit Update –** Repeat support of event with AMA name and logo.	University of Kentucky, Northern Kentucky University Deterra Drug Deactivation System	10/7/2020
37286	**Women Business Leaders Annual Sponsorship 2020 –** Sponsorship with AMA name and logo.	Women Business Leaders (WBL) Amgen, Inc. McKesson Corporation MCG (Milliman Care Guidelines) Hearst Health Tivity Health	6/16/2020
37366	**National Lesbian and Gay Journalist Association –** Convention sponsorship with AMA name and logo.	National Lesbian and Gay Journalist Association (NLGJA)	2/4/2020

37455	**Bellin Health Team-Based Care Training Camp –** Sponsorship with AMA name and logo.	Bellin Health Systems	2/14/2020
37486	**HCA Healthcare Event Collaboration –** Updated collaboration with HCA for residents with AMA name and logo use.	HCA (Hospital Corporation of America) Healthcare	2/19/2020
37467	**Erie Neighborhood House 150th Anniversary Dinner Celebrating Inclusion –** Sponsorship with AMA name and logo.	Erie Neighborhood House	2/14/2020
37487	**Fenway Institute's Conference on Minority Health –** Sponsorship with AMA name and logo.	Fenway Health Harvard Medical Massachusetts Medical Society's LGBTQ Issues Committee	2/19/2020
37515	**HIMSS Health 2.0 Kingdom of Saudi Arabia Conference and Exhibition 2020 Sponsorship –** Sponsorship with AMA name and logo for Health Solutions products.	Healthcare Information and Management Systems Society, Inc. (HIMSS) Adaptive Tech Soft Epic Systems Inter Systems NOMD Holding Company Oasis Vocera Communications Ideal Middle East Sapphire Health Management System (HMS) Elsevier	2/24/2020
37561	**National Association of Black Journalist 2020 Convention –** Sponsorship with AMA name and logo.	National Association of Black Journalists (NABJ) National Association of Hispanic Journalists (NAHJ)	3/4/2020
37597	**2020 Joy in Medicine CEO Consortium Summit –** Sponsorship with AMA name and logo.	Stanford University School of Medicine ChristianaCare	3/13/2020
37686	**Howard Brown Health - Midwest LGBTQ Health Symposium 2020 and Webinar –** Sponsorship with AMA name and logo.	Howard Brown Health ConsejoSano	6/15/2020

37980	**NAMSS Town Hall Webinar Sponsorship** – Repeat sponsorship with AMA name and logo use.	National Association of Medical Staff Services (NAMSS)	4/22/2020
38013	**National Medical Fellowships' Champions of Health Awards 2020 –** Sponsorship with AMA name and logo.	National Medical Fellowships (NMF)	4/29/2020
38181	**AHIP Online Institute and Expo Sponsorship –** Repeat sponsorship with AMA name and logo use.	America's Health Insurance Plans (AHIP) 3M (formerly Minnesota Mining and Manufacturing Company) Accenture Amwell (American Well)	5/29/2020
38245	**American Telemedicine Association 2020 Sponsorship –** Sponsorship with AMA name and logo for annual conference of telehealth providers.	American Telemedicine Association (ATA) Bayesian Health Amwell (American Well) Ziegler InTouch Health	6/9/2020
38299	**Rush University Medical Center - 2020 Virtual West Side Walk for Wellness –** Repeat sponsorship with AMA name and logo.	Rush University Medical Center (RUMC)	6/23/2020
38379	**Structural Racism in Health Professions Education: Curriculum, Structural Competency, and Institutional Change –** AMA name and logo use for webinar collaboration.	Beyond Flexner Alliance (BFA)	7/10/2020
38468	**American Academy of Professional Coders Healthcon Regional Conference 2020 –** Sponsorship with AMA name and logo.	American Academy of Professional Coders (AAPC)	7/28/2020
38536	**Women Leaders in Healthcare Conference –** Sponsorship with AMA name and logo of virtual booth and program.	Modern Healthcare Furst Group NuBrick Partners Keck Medicine of USC (University of Southern California) TeamHealth HARTZ Search GetixHealth University of Alabama at Birmingham (UAB)	7/31/2020

38783	**Rock Health Summit –** Repeat sponsorship with AMA name and logo of digital health conference.	Rock Health Vynyl Accenture Fenwick & West LLP J.P. (John Pierpont) Morgan Chase & Co.	9/9/2020
38819	**NAMSS 44th Educational Virtual Conference & Exhibition –** Repeat sponsorship with AMA name and logo.	National Association Medical Staff Services (NAMSS) SkillSurvey Verity Stream MD-Staff (Applied Statistics & Management, Inc.) Verge Health	9/15/2020
38853	**AHIMA 2020 Conference and Assembly on Education –** Repeat sponsorship with AMA name and logo.	American Health Information Management Association (AHIMA)	9/30/2020
39137	**AHIP Consumer Experience and Digital Health Forum Sponsorship** – Sponsorship with AMA name and logo.	America's Health Insurance Plans (AHIP) 3M (formerly Minnesota Mining and Manufacturing Company) Accenture Amwell (previously known as American Well)	11/6/2020
	Managing Your Health and Wellness in the Era of COVID-19 – AMA name and logo use at World Health Day.	Livongo Health Inc. HLTH, LLC American Diabetes Association (ADA) American Heart Association (AHA)	4/7/2020
	Healthcare Administration Alliance's (HAA) Conference – AMA's Health Solutions participation with name and logo use.	Healthcare Administration Alliance (HAA)	9/15/2020
	Consumer Privacy Framework for Health Data – Framework and webinar with AMA name and logo association with these organizations.	eHI (Enable Healthcare, Inc.) Center for Democracy Technology (CDT) Robert Wood Johnson Foundation 23andMe American College of Physicians Ancestry AI Now Institute American Cancer Society American Hospital Association Ascension Change Healthcare Children's National Hospital Ciitizen Corporation CVS (Consumer Value Stores) Health	8/25/2020

		Datavant Electronic Frontier Foundation Elektra Labs Evidation Fitbit, Inc. Future of Privacy Forum Georgetown Institute for Technology Law and Policy Google LLC GW (George Washington University) School of Medicine Hispanic Technology and Telecom Partnership Hogan Lovells Marshfield Clinic Health System Microsoft National Partnership for Women & Families New America's Open Technology Institute Pew Charitable Trusts Salesforce Teladoc Health Under Armour University of Nebraska Governance and Technology Center Waldo Law Offices Wellmark Blue Cross and Blue Shield Yale University	

EDUCATIONAL CONTENT OR GRANTS

36512	**Collaboration with LuCa (Lung Cancer) National Training Network –** The Education Center to host "Lung Cancer and the Primary Care Provider" educational module. AMA name and logo use on program materials.	LuCa (Lung Cancer) National Training Network University of Louisville School of Medicine Bristol-Myers Squibb (BMS) Foundation Cancer Care™ Initiative	1/27/2020
37287	**AMA Mini Z Well-Being Survey –** Technology solution survey with AMA name and logo.	Hennepin Healthcare System, Inc. Hennepin County Medical Center (HCMC)	1/23/2020
37566	**Edge-U-Cate Credentialing School/Certification Study Program –** Sponsorship with AMA name and logo.	Edge-U-Cate LLC ABMS Solutions/Certi-FACTS American Osteopathic Information Association (AOIA) Elsevier	3/3/2020

37718	**Center for Health Equity Curriculum and Content Development with Health Begins –** A content development agreement with AMA name and logo.	HealthBegins, LLC	3/20/2020
37973	**MAVEN Project including Volunteers in Medicine for COVID-19 Emergency Workforce Augmentation** – This guide includes resources to aid health care workforce volunteer process around credential verification.	MAVEN (Medical Alumni Volunteer Expert Network) Project Volunteers in Medicine (VIM)	4/21/2020
38479	**Collaboration with Alzheimer's Association –** AMA name and logo use to announce collaboration for free online educational modules.	Alzheimer's Association (AA) MetLife Foundation	7/28/2020
38582	**CPT® E/M 2021 – Content Development Initiative –** Collaboration to develop educational content with AMA name and logo for branding.	Nordic Consulting Partners, Inc.	8/12/2020
38583	**Collaboration with Stanford Center for Continuing Medical Education** – Hosting set of free online educational modules with AMA name and logo.	Stanford University Stanford Center for Continuing Medical Education Pfizer, Inc.	9/24/2020
	Morehouse School of Medicine Book Quote – AMA Board member quote for "The Morehouse Model – How one school of medicine revolutionized community medicine and health equity" book.	Morehouse School of Medicine ACE (Adverse Childhood Experiences) Consortium	2/10/2020

COLLABORATIONS/AFFILIATIONS

4753	**Cardz for Kidz Sponsorship 2020 –** Repeat sponsorship with AMA name and logo for program supporting hospitalized and traumatized children.	Cardz for Kidz!	12/18/2020

4929	**Manatt Health –** National policy roadmap focused on the nation's drug overdose epidemic with AMA name and logo.	Manatt Health	12/15/2020
4958	**Ad Council –** National communications initiative with use of AMA name and logo, to educate the public and increase the use of the COVID-19 vaccines.	Ad Council (The Advertising Council, Inc.)	12/18/2020
5501	**COVID Collaborative –** Bipartisan coalition with AMA name and logo, focused on the effective response to COVID-19.	COVID Collaborative	12/23/2020
36397	**HL7 Benefactor Membership –** Renewal of membership with AMA name and logo.	Health Level Seven International (HL7)	2/4/2020
37393	**ESSENCE Campaign to Promote Heart Health –** Sponsorship with AMA name and logo in first quarter. Addition of Minority Health Institute (MHI) and WW International Inc. in fourth quarter.	ESSENCE Communications Inc. American Heart Association (AHA) National Medical Association (NMA) Association of Black Cardiologists, Inc., (ABC) Minority Health Institute (MHI) WW International Inc. (formerly Weight Watchers)	10/13/2020
37569	**Physician Innovation Network (PIN) and Telehealth Implementation Playbook Collaborators –** AMA Physician Innovation Network (PIN) and Telehealth Implementation Playbook collaboration agreements with limited AMA name and logo use.	MD++ R&T IMG Health In Her Hue The Rounds IEEE/EMBS (Engineering in Medicine and Biology Society) National Digital Inclusion Alliance (NDIA) Cambia Grove Xealth Medici OhMD, Inc. University of Louisville Texas Medical Association The Physicians Foundation Creekside Endocrine Associates	8/25/2020
38007	**Research Project for High-Performing Physician-Owned Private Practices** – Collaboration with AMA name and logo used in final report.	Mathematica	4/28/2020

38040	**COVID-19 Healthcare Coalition –** Organizational membership and participation in telehealth workgroup and study with AMA name and logo.	COVID-19 Healthcare Coalition	5/4/2020
38168	**Hilton COVID Resident Relocation Support –** Discounted extended Hilton hotel stay rates for residents featured in the COVID resource guides.	Hilton Worldwide Holdings Inc.	6/2/2020
38169	**MAP (Measure, Act, Partner) Dashboards for Health Care Organization (HCO) –** The AMA MAP BP™ Dashboard is an evidence-based quality improvement (QI) program providing sustained improvements in blood pressure (BP) control through monthly reports, tracking data and outcome metrics.	Tandem Health (South Carolina)	12/7/2020
38433	**COVID-19 Writer's Project –** The COVID-19 Writers Project captures a viewpoint from inside a virus's hotspot examining health outcomes that are impacted by socio-economics, education and race. Acknowledgement of AMA's participation with name and logo use.	Brooklyn Community Foundation Pulitzer Center National Geographic BK (Brooklyn) Reader The Original Media Group, LLC	7/18/2020
38662	**ASHP Pharmacogenomics Collaboration on Precision Medicine –** Co-branding with AMA name and logo for jointly developed programming and content.	American Society of Health-System Pharmacists (ASHP)	8/28/2020
38663	**SNOMED Virtual Clinical Terms (CT) Expo 2020 and CPT/SNOMED Demonstration Tool –** Sponsorship with AMA name and logo.	SNOMED International SNOMED CT (Clinical Terms) 3M (formerly Minnesota Mining and Manufacturing Company) Clinical Architecture Goldblatt Systems Vidal Group West Coast Informatics	8/31/2020

38777	**Improving Health Outcomes (IHO) Self-Measured Blood Pressure (SMBP) Monitoring Pilot** – Pilot test for a digital health and remote patient monitoring solution. AMA name and logo on pilot presentations.	MEDITECH (Medical Information Technology, Incorporated) Berkshire Health Systems	10/14/2020
39040	**Medical Alley Webinar Series Sponsorship –** AMA name and logo association with Minnesota based medical technology community.	Medical Alley Association	10/16/2020
39080	**Improving Health Outcomes (IHO) Prevention Strategy Collaboration with Health Care Organizations (HCOs) 2020 –** AMA name and logo use alongside these HCOs for prevention of cardiovascular disease and diabetes.	Aledade - Ashley Clinic, KS, Family Care Center, KS, Anne Arundel Medical Center, MD Cone Health Connected Care, LLC, NC University of Mississippi Medical Center, MS Esperanza Health Centers, IL Loyola University Medical Center, IL University of Illinois at Chicago, Department of Medical Education College of Medicine, IL University of North Dakota, NC Mercy, MO Tandem Health, SC Intermountain Healthcare	11/25/2020
39096	**Health Equity & Advocacy Leadership Fellowship –** Fellowship program collaboration with AMA name and logo.	Morehouse School of Medicine (MSM)	10/27/2020
39541	**Women's Wellness through Equity and Leadership Project (WEL 2.0**) – Collaboration with AMA name and logo.	American Academy of Pediatrics American Academy of Family Physicians American College of Obstetricians and Gynecologists American College of Physicians American Hospital Association American Medical Association American Medical Women's Association American Psychiatric Association National Hispanic Medical Association National Medical Association Physicians Foundation	11/24/2020

	Educational Collaboration with Minority Health Institute / Association of American Medical Colleges – Educational venture with AMA name and logo use.	Association of American Medical Colleges (AAMC) The Minority Health Institute (MHI)	9/3/2020

MEMBER PROGRAMS

37632	**Medical Student Outreach Program (MSOP) 2020 Student Incentives –** Membership marketing with AMA name and logo.	Elsevier McGraw-Hill Education Picmonic, Inc SketchyGroup, LLC Ryan Medical Education LLC	3/25/2020
38316	**AMA Participation in Project N95 Program –** AMA collaboration with Project N95, a not-for-profit Personal Protective Equipment (PPE) clearinghouse, to provide AMA members with access to order quality-certified PPE.	Project N95 American College of Physicians (ACP) American Academy of Family Physicians (AAFP) American College of Emergency Physicians (ACEP) Medical Group Management Association (MGMA) American Medical Group Association (AMGA) American Hospital Association (AHA)	6/29/2020

AMA FOUNDATION

	American Medical Association Foundation (AMAF) Corporate Donors 2020 – Corporate donors for 2020.	AbbVie, Inc. Amgen, Inc. Bristol-Myers Squibb (BMS) Eli Lilly and Company Esperion Therapeutics Genentech, Inc. GlaxoSmithKline Merck & Co., Inc. Novartis International AG Pfizer, Inc. Pharmaceutical Research and Manufacturers of America (PhRMA) Sanofi S.A.	11/20/2020

AMA INNOVATIONS INC.

39438	**AMA Innovations Inc. & Onyx Technology –** Collaboration to pursue the ACL's Social Care Referrals Challenge grant and associated promotion.	Onyx Technology LLC NewWave Telecom & Technologies	11/30/2020

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-JUN-21

Subject: AMA Performance, Activities, and Status in 2020

Presented by: Russ Kridel, MD, Chair

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

INTRODUCTION

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

Representing physicians with a unified voice

AMA worked closely with the White House, Congress, state lawmakers and a range of federal and state agencies to ease the public health and economic consequences of COVID-19. We secured nearly $180 billion in emergency funding for physician practices and health systems to help recover from the financial devastation of COVID-19 and continue to provide critical care to patients.

AMA pushed the federal government to accelerate production of life-saving PPE for physicians and frontline workers, improve and expand testing capabilities, and revise guidelines for serological and antibody testing.

AMA worked in federal court to protect international medical graduates, as well as physicians and medical students with Deferred Action for Childhood Arrivals – or DACA -- status. AMA joined 32 other leading health organizations in filing a successful amicus brief to ensure the U.S. Supreme Court upheld the DACA program that has richly benefitted the medical community. AMA now serves as a plaintiff in three federal cases, including one that the U.S. Supreme Court has agreed to review next fall involving the Title X program. In addition, AMA has filed friend of the court briefs in state and federal courts around the country on a wide range of critical issues, from LGBTQ health to tort reform, unfair insurer practices to physician free speech rights, tobacco control to patient access to care, with more than 80 briefs filed in 2020 alone.

Throughout the pandemic, the AMA COVID-19 Resource Center was a trusted source of clear, evidence-based guidance throughout the year. Features included daily video updates, action plans, quick-start telehealth guides, care for caregivers and more.

AMA launched a physician-focused webinar series with federal health officials that explored the COVID-19 vaccine development process and rollout. We also launched a comprehensive campaign

across multiple platforms and channels to build confidence in the safety and efficacy of the new vaccines among physicians, other health care professionals and patients.

AMA supported the year-end omnibus package which avoided major Medicare cuts for most CPT codes, deferred reinstatement of the Medicare sequester, and secured major modifications in surprise billing legislation that originally would have allowed insurers to avoid responsibility to have meaningful networks.

AMA's communications strategy achieved a record 115 billion media impressions in 2020, through nearly 80,000 stories which included 115 national TV interviews and generated $1.1 billion in estimated advertising value equivalent for the AMA.

Removing obstacles that interfere with patient care

AMA worked with the Centers for Medicare & Medicaid Services to reduce physician documentation relating to Evaluation and Management reporting requirements, the first such overhaul of E/M codes in more than 25 years.

AMA continued to work at the state and national levels to push for important prior authorization and step therapy reforms across the U.S., keeping the focus on reducing the volume of prior authorization requirements and its impact on patients care.

AMA introduced a new Coping with COVID-19 for Caregivers assessment survey to help organizations measure and address the unique demands of the pandemic on their staffs. In 2020, over 80 health care systems from 30 states deployed the assessment resulting in more than 50,000 individual responses. The data findings were compiled into a national COVID-19 comparison report for organizations to compare their survey results to national benchmarks. AMA compiled a guide with practical strategies for health system leadership to consider in support of their physicians and care teams and conducted a COVID-19 Roundtable for shared learning among health system leaders.

AMA's STEPS Forward™ portfolio expanded with 12 new and 19 updated toolkits, educational modules, videos, podcasts customizable resources to help physicians and their teams streamline their workflows for improved patient care.

AMA developed a checklist that provided physicians and administrators with guidance and strategies on controlling labor costs and information about stimulus relief considerations and legal compliance during the pandemic.

AMA's guide to Creating a Resilient Organization offered 17 steps to caring for health care workers before, during and after COVID-19, providing practical tips on coping during times of acute stress, lowering the incidence of chronic stress illness and injury.

Supporting physicians' mental health needs, AMA launched a Behavioral Health Integration Collaborative in partnership with leading medical societies to provide practical steps to blend medical and behavioral health services with primary care.

Leading the charge to confront public health crises

AMA's Center for Health Equity helped lead a national conversation about the pandemic's disproportionate impact on communities of color, the importance of accurate, nationwide data

collection, and advanced policies that decrease inequities, supported equitable access to care and research, and improve culturally competent care.

AMA responded to dire shortages of personal protective equipment by helping secure hundreds of thousands of PPE for AMA physician members through a creative new collaboration with Project N95, a non-profit national clearinghouse for medical supplies.

The Current Procedural Terminology (CPT) Team issued 24 new or revised codes supporting COVID-19 care, guides and tools that were the most-downloaded documents from the AMA COVID-19 Resource Center.

The JAMA Network COVID-19 Resource Center provided access to a wealth of scientific resources on COVID-19 diagnosis and treatment, with a focus on information physicians could share with patients and their families. Expanded livestream and podcast portfolios contributed to a 40% surge in online traffic across the JAMA Network in 2020, representing some 190 million engagements.

Rapidly expanded video programming across AMA digital platforms, including 200 episodes of the popular daily AMA COVID-19 Update, resulted in a 900% increase in video minutes viewed in 2020.

More than 6.2 million users consumed nearly 10 million pages of content from the COVID-19 Resource Center, including more than 380,000 downloads of the 60 available guides for health care professions. The record 20 million unique visitors to the AMA website exceeded the combined total for both 2018 and 2019.

AMA partnered with American Heart Association and others on a national campaign to promote better heart health in Black women. The Release the Pressure campaign created culturally relevant resources to help Black women prioritize their blood pressure control and other aspect of self-care.

AMA collaborated with NORC at the University of Chicago to develop criteria for determining validated self-measured blood pressure devices and introduced a MAP blood pressure dashboard. The AMA MAP BP™ program and dashboard provides health care organizations a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race, and gender. The AMA MAP BP™ program and dashboard demonstrates a 10-percentage point increase in BP control in six months with sustained results at one year.

Only in its second year, the AMA's Enterprise Social Responsibility (ESR) program continues to deliver an organized and thoughtful structure to engage AMA employees in public service work aligned with the organization's values and goals. The program has strategically integrated within the OneAMA culture aligning "give back" opportunities at employee events and partnering with employee resource groups. Thirty-nine percent of AMA employees, representing every office location, logged over 2,500 volunteer hours, supported over 90 organizations and fundraised over $60,000.

Driving the future of medicine

AMA built upon strategic efforts to advance telehealth and improve physician well-being and practice sustainability during COVID-19 by developing dozens of free, online resources to help physicians better manage their mental health, keep their practices afloat, and foster widespread

adoption of remote patient care through the Telehealth Initiative, the Telehealth Implementation Playbook and accompanying resource guide.

The AMA successfully launched a new initiative for the AMA Masterfile, which integrates data from over 124 data sources and improves the clarity of race and ethnicity data.

AMA's Integrated Health Model Initiative (IHMII) received recognition within the digital health community for work in developing Social Determinants of Health (SDoH) and data standards and promoting interoperability. Rock Health selected AMA as top non-profit in digital health.

The AMA worked diligently to meet the needs of the medical education community during COVID-19. AMA developed the comprehensive AMA MedED COVID-19 resource guide as a centralized location to assist our educators, residents and students in keeping up with new information and providing resources, links and a community discussion forum. AMA produced a series of webinars addressing COVID-19's impact on medical education and produced guidelines for trainees and others practicing in the pandemic.

The AMA Accelerating Change in Medical Education Consortium and Reimagining Residency Initiative held a highly successful inaugural GME Innovation Summit virtually in October, with more than 400 attendees and over 200 presentations, workshops and posters. It included a shark-tank style Innovations Challenge, which resulted in the award of three new AMA GME Innovations grants.

The JAMA Network launched JAMA Health Forum, an online channel that addresses health policy and health strategy issues affecting medicine and health care, combining curated content from across the JAMA Network with weekly blog posts by leaders in health policy.

Health, Science and Ethics made significant strides in advancing the AMA's precision medicine work in 2020. Accomplishments include convening a cross-business unit collaborative team to align on strategy and implementation, partnering with the American Society of Health-System Pharmacists to develop a virtual summit series focused on the emerging area of pharmacogenomics and gathering data through physician surveys and environmental scans to inform future initiatives.

AMA Journal of Ethics received nearly four million annual visits. To help individuals and organizations navigate ethical challenges wrought by the pandemic, the journal established a COVID ethics resource center with new multimedia CME. While the pandemic disrupted much of normal life including the start of another medical school year, thousands of new students received a pocket edition of the *AMA Code of Medical Ethics* and possibly their first education of AMA's role in advancing the ethics of a profession.

AMA partnered with CDC on Project Firstline, a collaborative of diverse healthcare and public health partners that aims to provide engaging, innovative, and effective infection control training for frontline healthcare workers and members of the public health workforce. Project Firstline's innovative content is designed so that health care personnel can understand and confidently apply the infection control principles and protocols necessary to protect themselves, their facility, their family, and their community from infectious disease threats, such as COVID-19. Project Firstline content will be featured on the AMA Ed Hub™.

AMA Ed Hub™ expanded its offerings to feature courses on COVID-19, infection prevention and control, health equity, and physician burnout and wellness, contributing to a near 65% growth in views over 2019.

AMA's portfolio of education on AMA Ed Hub™ expanded to include more education from JN Learning, the *AMA Journal of Ethics* and *Code of Medical Ethics*, AMA Health Systems Science, AMA Steps Forward and CPT. Sixteen organizations have signed on to highlight their education on AMA Ed Hub with 6 new organizations launched in 2020 – including Obesity Medicine Association, Stanford Center for Continuing Medical Education, Howard Brown Health, Society of Hospital Medicine Education, American Society of Addiction Medicine and The Jackson Laboratory.

The AMA Center for Health Equity (CHE) worked to embed equity across the enterprise and throughout medicine by being among the first to call out the pandemic's missing data through a NY Times OpEd and Oprah-Apple TV. CHE launched the Prioritizing Equity Series, published a COVID-19 Latinx Report and established the Health Equity Resource Center on the AMA Ed Hub. AMA incorporated a diversity, equity and inclusion lens for all convened groups to support our work, including the CPT Editorial Panel, and developed training to better integrate health equity across the organization. AMA began training staff through Racial Equity Institute's phase one program, with plans to broaden the training across all staff in the months ahead.

AMA made a $1 million investment in a Chicago-based collaborative that focuses on addressing social determinants of health in an area of the city where life expectancy is far below the national average. The AMA will invest $2 million total over two years.

Membership

All the ways AMA supported physicians in 2020 contributed to another strong financial performance and a six percent membership surge, the 10th consecutive year of growth.

EVP Compensation

During 2020, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,185,918 in salary and $1,292,221 in incentive compensation, reduced by $2,462 in pre-tax deductions. Other taxable amounts per the contract are as follows: a $182,308 payment of prior years' deferred compensation, $23,484 imputed costs for life insurance, $24,720 imputed costs for executive life insurance, $2,755 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 2020 Annual Report."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-JUN-21

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2020 through February 2021

Presented by: Russ Kridel, MD, Chair

This report summarizes trends and news on tobacco usage, policy implications, and American Medical Association (AMA) tobacco control advocacy activities from March 2020 through February 2021. The report is written pursuant to AMA Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE AND COVID-19

Early studies have linked certain underlying medical conditions with an increased risk for severe illness from the virus that causes COVID-19. The Centers for Disease Control and Prevention (CDC) publish an ongoing list of conditions for which sufficient evidence indicates the conditions are likely to cause or may cause more severe outcomes in adults with COVID-19. CDC includes smoking as a condition likely to increase COVID-19 severity, which has resulted in some states such as Illinois adding current/former smokers to vaccine priority status.

A literature review in *Respiratory Medicine* found that tobacco use in all forms, whether smoking or chewing, is significantly associated with severe COVID-19 outcomes. According to the authors, pre-existing comorbidities in tobacco users such as cardiovascular diseases, diabetes, respiratory diseases, and hypertension were found to further aggravate the virus making the treatment of such COVID-19 patients more challenging due to their rapid clinical deterioration. The authors conducted the literature review from August to September 2020.

TOBACCO USE AND HEALTH EQUITY

Study Looks at Menthol Cigarettes with a Social Justice Lens

Menthol could be exacerbating deep social inequities according to a paper published in *Nicotine & Tobacco Research*. Researchers at Columbia University Mailman School of Public Health and colleagues at CUNY and Rutgers School of Public Health suggest that a ban on menthol cigarettes could have monumental implications for both short- and long-term physical and mental health of communities of color. In 2009 the FDA banned cigarettes with certain flavors that appeal to children and teens such as bubblegum and chocolate. The FDA did not include menthol in that 2009 action stating it would be conducting more research, which FDA completed in 2011. FDA's scientific committee concluded that menthol in cigarettes increases initiation, facilitates progression to regular smoking, increases dependence, and decreases the likelihood of smoking cessation, especially among both youth and adult Black smokers, and as such, the removal of menthol from cigarettes would benefit public health. Overall estimates indicate that if menthol was included in the flavored cigarette ban, over 630,000 deaths would be averted, of which one of three would be a Black life. Despite the committee's conclusions, FDA has not taken action to ban menthol.

Menthol has a cooling and anesthetic (or pain killing) effect. It can decrease the cough reflex and soothe the dry throat feeling that many smokers have. A study in the *American Journal of Public Health* found evidence that the tobacco industry was manipulating levels of menthol by promoting cigarettes with lower menthol content, which were popular with adolescents and young adults, and providing cigarettes with higher menthol content to long-term smokers. Studies have shown that the tobacco industry has targeted Black youth and adult smokers for decades resulting in lower quit rates attributable to menthol. This connection between low quit rates in Black menthol smokers was also confirmed by the FDA's own findings.

AMA Joins in Lawsuit Against FDA

The American Medical Association joined the African American Tobacco Control Leadership Council and Action on Smoking and Health as co-plaintiffs in a lawsuit against the FDA. The complaint, initially filed in June 2020, requests that the court compel the FDA to fulfill its mandate to take action on FDA's own conclusions that it would benefit the public health to add menthol to the list of prohibited characterizing flavors and therefore ban it from sale.

In November 2020, the court denied the FDA's motion to dismiss the complaint, thus allowing the case to proceed to discovery. Following the decision, the National Medical Association was added as a plaintiff, and the FDA is currently working on a response to the citizen petition addressing their inaction on menthol to date.

OTHER EFFORTS TO ADDRESS TOBACCO CONTROL

AMA Supports Increased Funding for Tobacco Control Policy and Programs

The American Medical Association called on the U.S. Senate Subcommittee on Labor, Health and Human Services, Education, and Related Agencies to increase funding for the CDC Office on Smoking and Health by $80 million. In a letter to then-subcommittee chair Senator Roy Blunt and then-ranking member Senator Patty Murray, health care organizations, medical associations and public health groups cited the rising increase in e-cigarette usage by teens and young adults and the continued toll that tobacco takes on the health of the nation.

The letter outlined that the added funds would allow CDC to effectively respond to the youth e-cigarette epidemic, including providing more resources to state and local health departments, expand its Tips from Former Smokers® (Tips®) media campaign and strengthen efforts to assist groups disproportionately harmed by tobacco products.

USPSTF Releases Updated Recommendations for Treating Tobacco Dependence in Adults including Pregnant Women.

To update its 2015 recommendation on smoking cessation, the USPSTF commissioned a review to evaluate the benefits and harms of primary care interventions on tobacco use cessation in adults, including pregnant persons. The updated recommendation reflects newer evidence and language in the field of tobacco cessation and includes a description of the 2019 E-cigarette or Vaping product use Associated Lung Injury, or EVALI, outbreak in the U.S. However, the recommended services that primary care clinicians should provide for tobacco cessation are the same as in 2015. The USPSTF continues to recommend that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and FDA-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco. Pregnant women should be asked about tobacco use, advised to stop using tobacco, and provided behavioral interventions for cessation. There

remains insufficient evidence to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant persons.

The USPSTF concludes that the evidence on the use of e-cigarettes for tobacco smoking cessation in adults, including pregnant persons, is insufficient, and the balance of benefits and harms cannot be determined. The USPSTF identified the lack of well-designed, randomized clinical trials on e-cigarettes that report smoking abstinence or adverse events as a critical gap in the evidence. The 2020 update was published in the January 19, 2021 issue of *JAMA*.

CDC's Tips® Campaign Increases Quit Rates

Findings from a CDC study published in *Preventing Chronic Disease* show that CDC's Tips® campaign led more than 1 million U.S. adults to quit smoking and an estimated 16.4 million U.S. adults to attempt to quit smoking during 2012–2018. To assess the campaign's impact on quit attempts and sustained quits, CDC analyzed data from a nationally representative longitudinal survey of U.S. adults who smoked cigarettes during 2012–2018.

The Tips® campaign was launched in 2012 and shows real people who are living with serious long-term health effects from cigarette smoking and secondhand smoke exposure. Through the campaign, people share compelling stories about their smoking-related diseases and disabilities and the toll these conditions have taken on them. The campaign also features nonsmokers who experienced life-threatening episodes because of exposure to secondhand smoke and family members affected by their loved one's smoking-related illness.

The 2020 U.S. Surgeon General's Report on Smoking Cessation cites studies showing that emotionally evocative, evidence-based campaigns like Tips® are effective in raising awareness about the dangers of smoking and helping people who smoke to quit.

TOBACCO USE SURVEILLANCE

CDC Morbidity and Mortality Weekly Reports (MMWR)

Cigarette smoking is responsible for more than 480,000 deaths per year in the United States, including more than 41,000 deaths resulting from secondhand smoke exposure. From March 2020 through February 2021, the CDC released eight MMWRs related to tobacco use. These reports provide useful data that researchers, health department, 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 including electronic cigarettes.

Monitoring E-cigarette Usage Among Teens to Identify Strategic Control Policies

The September 18, 2020, and October 23, 2020, MMWR both highlighted e-cigarette use among youth, emphasizing the increased popularity of "pod mods," which are products with a prefilled or refillable pod cartridge (pod) and a modifiable (mod) system. According to the report in the September 18 MMWR, e-cigarettes have been the most used tobacco product among U.S. youths since 2014 with 27.5% of high school students reporting current e-cigarette use in 2019. To assess trends in unit sales of e-cigarettes in the U.S. by product and flavor type, the CDC, the CDC Foundation, and Truth Initiative analyzed retail scanner data. By product type, the proportion of total sales that were prefilled cartridge products increased from 47.5% to 89.4% during September 2014–August 2019. The authors of the October 23 MMWR study noticed that the rise in pod mods coincided with the increased usage of e-cigarettes by youth. The popularity of the pod mods is due

in part to the e-cigarette industry marketing the use of nicotine salts instead of freebase nicotine. Freebase nicotine is used in most other e-cigarette cartridges, or vaping, products and conventional tobacco products (e.g., cigarettes). According to the study, nicotine salts, which have a lower pH than freebase nicotine, allow particularly high levels of nicotine to be inhaled more easily and with less irritation to the throat than freebase nicotine. The most commonly sold pod mod brand is JUUL, which accounted for 75% of all U.S. e-cigarettes sales by the end of 2018. A majority (59.1%) of U.S. high school student e-cigarette users report JUUL is their usual brand.

Continued monitoring of e-cigarette sales and use is critical to inform strategies to minimize risks. As part of a comprehensive approach, such strategies could include those that address product innovations and flavors that appeal to youth.

Prevalence and Trends in Cigarette Smoking Among Adults with Epilepsy - United States, 2010–2017.

Studies have shown that cigarette smoking is as common, and sometimes more so, among adults with a history of epilepsy compared with those without a history of epilepsy. According to the prevalence report in the November 27, 2020 MMWR, citing the latest available data, from 2010–2017, one in four adults with active or inactive epilepsy were current smokers, compared with one in six persons without epilepsy. Compared with adults without epilepsy, adults with epilepsy report lower household income, more unemployment and disability, worse psychological health, and reduced health-related quality of life. This report is the first assessment of smoking trends in people with epilepsy. While cigarette smoking declined significantly among adults without a history of epilepsy, from 19.3% in 2010 to 14.0% in 2017, declines in current cigarette smoking among adults with active epilepsy were not statistically significant (from 26.4% to 21.8%). This lack of a significant decrease in people with epilepsy provides an intervention opportunity. Health and social service providers who interact with persons with active epilepsy should ensure that smoking cessation information and resources are available to them.

REPORT 8 OF THE BOARD OF TRUSTEES (June 2021)
Plan for Continued Progress Toward Health Equity
(Center for Health Equity Annual Report)
(Informational)

EXECUTIVE SUMMARY

In accordance with Policy D-180.981, this informational report outlines the equity activities of our AMA from 3rd Quarter 2020 through the 2nd Quarter of 2021, with some projections into the 3rd Quarter of 2021.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-JUN-21

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

Presented by: Russ Kridel, MD, Chair

BACKGROUND

This report is the second of its kind submitted for information to the House of Delegates, following Report 15 from the November 2020 Special Meeting. 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." Since the 2019 establishment of our AMA Center for Health Equity ("the CHE", "the Center"), our AMA continues to make advances in embedding equity in medicine and in public health. This report illustrates those internal activities and strategies, as well as alludes to external events of year 2020 through half of 2021, which deepened and hasten our AMA's commitment to equity across what will assuredly be known as a fateful year in the nation and in the world.

DISCUSSION

Deepening the Case for Strategic Equity

The 2020 Center for Health Equity Annual Report emphasized our AMA's commitment to an enterprise-wide core equity strategy. Within the first year of its inception, the CHE set in motion tremendous efforts and activities that garnered international attention to the equity work of our AMA, particularly considering the impact of the coronavirus SARS-CoV-2, COVID-19. Our membership is at the front lines within clinical spaces, and also in spaces to bolster equity-driven responses as the virus persistently and disproportionately impacts elders and historically racially marginalized and minoritized persons. Additionally, the nation and our AMA now grapple with the equitable distribution of the COVID-19 vaccines; the significant impact of a change in presidential administration; as well as ongoing racially-motivated hatred, tensions, and violence. Each of these factors is external to the activities of the AMA, but clearly impacts how our association positions itself as a national leader in medicine and equity. Simultaneously, our AMA's internal efforts to strengthen staff and membership dexterity and commitments to health equity are in full force. Yet, the fragility of these new efforts is clear, and these efforts are susceptible to any episodic threats that undermine our AMA's work to advance and center equity. The March 2021 *JAMA* podcast titled "Structural Racism for Doctors—What Is It?" is one such harmful episode that caused many to question the core equity commitment of our AMA by rejecting the existence of structural racism. And, while the AMA and *JAMA* are separate entities, that episode has rocked our AMA's public credibility in the equity space, not just the work completed over the two years of the CHE's existence, but across the course of championship for equity within the AMA ranks over the last 20 years. This is not to say there is no space for healthy questioning when there is ignorance about what structural racism is, but there must be no tolerance for stances that perpetuate misinformation and debate the realities of structural racism in medicine and beyond. Thus, in addition to outlining

the equity milestones of the last year, this 2021 report is also staunchly determined to demonstrate our AMA's deepened commitment to uplift health equity, and thwart all threats—external and internal—to that commitment.

THE AMA EQUITY QUARTER SUCCESSES AND MILESTONES

3rd Quarter, 2020

(1) Equity in Advocacy: Internal Impact
Three-Module Immersive Workshop Series

Between summer 2020 and through the end of the year, the CHE embarked on an internal, immersive assessment and subsequent immersive skills building workshop series specifically designed for our AMA Advocacy business unit (BU). This work was a follow up to a November 2019 – February 2020 environmental qualitative assessment primarily of the Washington, D.C. office readiness for embedding equity throughout Advocacy processes. As referenced in last year's report, this assessment led to the *Proposed Health Equity Policy & Advocacy Future State, Goals & Key Deliverables 2020 2025*, referred hereafter as "the Report," which the CHE handed over to the AMA Advocacy leadership for consideration. By summer 2020, the next step was to conduct an *Equity in Advocacy and Policy Needs Assessment*, referred to as "the Assessment," which extended the work of the Report. The Assessment captured the skills that could be strengthened among members of the AMA Advocacy team concerning their knowledge base and application of health equity to all aspects of their policy and advocacy work. Between the Report and the Assessment, CHE staff Mia Keeys, Director of Health Equity Policy and Advocacy, and Joaquin Baca, Senior Health Equity Policy Analyst, developed the Supplemental Health Equity in Advocacy and Policy Immersive Development, Training, & Engagement Curriculum, referred hereafter as "the Curriculum." The purpose of the immersive development, training, and engagement program was to imbue advocacy and policy day-to-day tasks with equity practices. The Curriculum consisted of three, separate full-day or half-day immersive workshops exclusively for Advocacy staff of both the Chicago and Washington, DC offices.

At the end of the workshop series, participants were able to: define health equity in a way that differentiates it from other terms such as health disparities, health inequalities, and health inequity in discussions, written work, and presentations; explain how adopting an equity mindset is essential to all aspects of advocacy work; and apply an equity lens to policy analysis, development, and promotion with proficiency in a normal work environment. Table 1 in the Appendix further outlines the descriptions of each Module.

(2) Equity in Advocacy: External Impact
AMA Congressional Activities

In addition to the internal work that CHE staff executed with the Advocacy BU, Center staff also supported pivotal Congressional activities. In June 2020, AMA Immediate Past President Dr. Patrice A. Harris delivered Congressional testimony to the House Budget Committee Hearing, *Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change*. Her words garnered gratitude from Kentucky Representative John Yarmuth, who is also the Congressional Representative of the slain Breonna Taylor. As we near the year anniversary of her murder by police, we may also reflect on Dr. Harris's testimony, which the CHE was instrumental in crafting and reviewing alongside Advocacy and Enterprise Communications.

In summer 2020, the House Committee on Ways and Means Chairman Richard Neal (D-MA) released to AMA and several other societies/organizations a letter spurred by a *New England Journal of Medicine* (NEJM) article on race and clinical algorithms. The letter called on professional medical societies to push racial health agenda forward and requested information on the misuse of race within clinical care. The Advocacy BU led to response effort, with substantial CHE support under the auspices of one of our driving strategic approaches, embedding equity across health innovations.

As outlined in last year's CHE report, the CHE had written Congressional bill language calling for the collection of equitable data regarding COVID-19 testing, namely race/ethnicity and preferred spoken/written language. Parts of H.R. 6865, the Equitable Data Collection and Disclosure Act were eventually included into the CARES Act, the first COVID-19 relief package. In late Quarter 3, the AMA submitted a "thank you" and an official endorsement letter to the bill's primary sponsor, Rep. Robin Kelly (D-IL). Equitable collection of REI data continues to be a major problem, but now with respect to COVID-19 vaccination distribution. The CHE, alongside Advocacy, continues to ring the alarm about REI data collection, but now with respect to COVID-19 vaccine distribution. (In February 2021, the AMA, American Nurses Association, and the American Pharmacists Association released a letter calling for a bolstering of REI data on COVID-19 vaccine distribution.)

(3) The CHE has also been working with the Office of General Counsel (OGC) to ensure that AMA works to advance equity within judicial settings. For example, the AMA, alongside African American Tobacco Control Leadership Council (AATCLC), Action on Smoking and Health (ASH), and the National Medical Association (NMA), joined a lawsuit against the FDA, mandating action on banning menthol cigarettes. The suit was filed on June 17, 2020 in the United States District Court in Oakland, California and asserts that contrary to the duties imposed by the Family Smoking Prevention and Tobacco Control Act ("Tobacco Control Act"), the FDA failed to act on menthol cigarettes, and requires the FDA to ban menthol cigarettes or, in the alternative, to give a public, cogent explanation of their reasoning. The title of the case is *African American Tobacco Control Leadership Council, Action on Smoking and Health, and American Medical Association v. U.S. Department of Health and Human Services, et al.* Given that addiction to menthol cigarettes has been cited as highest among youth, and associated with higher rates of smoking frequency and death amongst African Americans, the health equity implications of menthol cigarettes are heinous. The CHE and OGC also collaborate in judicial advocacy on other equity issues such as sugar-sweetened beverages, the opioid crisis, LGBTQ protections, reproductive justice, immigration-related issues, and evictions and housing, among others.

(4) Conducted in collaboration with the Environmental Intelligence, Survey and Market Research (EISAMR) BU, the Minoritized & Marginalized Physician Survey captured the barriers that historically marginalized and minoritized physicians face/have faced in delivering care during the pandemic of COVID-19. CHE prioritized sharing these initial insights with internal BUs and workgroups to inform their efforts to support the unique needs of historically marginalized and minoritized physicians. These insights have been shared with the Telehealth Working Group, the Internal LGBTQ+ Working Group and the LGBTQ Advisory Committee. Current efforts include creating a series of external reports illuminating the experiences of racially minoritized physicians and of LGBTQ+ physicians by end of second quarter of 2021. Efforts to highlight the experiences of physicians with disabilities will begin the second quarter of 2021.

(5) In May 2020, the Public Health National Center for Innovations (PHNCI) and the de Beaumont Foundation asked the CHE to review and provide feedback on newly revised 10 Essential

Public Health Services (EPHS) framework. The original 10 Essential Public Health Services (EPHS) framework was developed in 1994 by a federal working group. It serves as the description of the activities that public health systems should undertake in all communities. Health departments and community partners around the nation organize their work around the EPHS framework; schools and programs of public health teach it; and the framework informs descriptions and definitions of practice. The framework is also used as the basis of the Public Health Accreditation Board Domains. The framework has provided a roadmap of goals for carrying out the mission of public health in communities around the nation. However, the public health landscape has shifted dramatically over the past 25 years, and many public health leaders agreed it was time to revisit how the framework can better reflect current and future practice and how it can be used to create communities where people can achieve their best possible health. The CHE contributed significantly to the new framework and submitted its suggestions in August 2020, which may be found here.

(6) The Center for Health Equity. Human Resources, Enterprise Communications, and Environmental Intelligence business units worked together to launch the inaugural All Employee Engagement and Equity Assessment. The objective of the assessment was to understand and enhance employee engagement and satisfaction, ensure an equitable and inclusive workplace for all employees, and advance health equity through the organization's external efforts. The core AMA assessment team worked with outside consultants to design and field a survey that launched in July 2020 and garnered a response rate of 92.35% (1,099 of 1,190 employees). The survey was followed by a series of focus groups to further amplify the voices of demographic groups with the lowest engagement rates based on survey results. A detailed report of the AMA All Employee Engagement and Equity Survey results was published internally and used to engage in dialogue with employees across the organization, including enterprise-wide, within BUs, and with Employee Resource Groups. A roadmap for enterprise-wide and BU action planning was shared.

(7) With the addition of Chelsea Hanson as Director of Health Equity & Innovation to the Center in summer 2020, work began in earnest on internal and external stakeholder discussions and landscape analyses to inform the Center's "Ensure equity in innovation" approach.

4th Quarter, 2020

(1) Historic Passage of Three Anti-Racism HOD Policies

The Center commends the outstanding work of the AMA Medical Student Section (MSS), the Minority Affairs Section (MAS), and the Women Physicians Section for their work in introducing three legacy antiracism policies, which were adopted during the November 2020 Special Meeting of the AMA House of Delegates. The mark of these three outlined policies—H-65.952, "Racism as a Public Health Threat, AMA Health Policy"; H-65.953, "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice, AMA Health Policy"; and D-350.98, Racial Essentialism in Medicine"—is indelible. Following the passage of these policies, the Chief Health Equity Officer published an article in *Essence* magazine to emphasize its significance.

The passage of these policies will facilitate the AMA's stronger support of congressional, federal, and state level antiracist policies. The CHE anticipates working closely with Advocacy to leverage these policies toward the effect.

During this historic HOD session, Dr. Maybank and other CHE staff were invited to present to several sections on health equity topics. This included presentations to the Medical Student Section, the International Medical Graduates Section, and the Senior Physicians Section.

(2) Health Equity Learning Series and Health Equity Spotlight Modules

Under the CHE leadership of Alice Jones, Program Manager, Health Equity Performance and Operations, the AMA is intentionally expanding its focus on inequities associated with disabilities, which was not a strong focus of the CHE until recently. The Access Health Employee Resource Group (ERG) Series were carried out between November and December 2020. Disability 101 focused on basic concepts related to identifying as disabled, including stigma, etiquette, and explanation of Social vs Medical Models of Disability. Disabilities at Work highlighted how to be inclusive, and emphasized hiring and retaining, and reasonable accommodations. The Disability Now and Then workshop gave an overview of social context for people with disabilities (ADA, contemporary issues with accessibility despite the ADA). The work of the ERG draws attention to the spaces our AMA must still address with respect disability equity across the AMA workforce, as well as in medicine, in general. In the future, the CHE looks forward to reviewing, evaluating, and providing feedback on AMA's handling of reasonable accommodations (including ones for electronic accessibility standards) for both new hires and for existing staff. Table 2 in the Appendix lists AMA policies relevant to disabilities and reasonable accommodations.

Also, under co-leadership of CHE and Health Solutions, creation of some educational opportunities around gender identity and non-binary pronouns. The group developed a modules to support staff's developing confidence and ease with sexual orientation and gender identity.

(3) Two critical efforts in support of the "Ensure Equity in Innovation" approach were completed. The first, in October 2020 was the formation and launch of an AMA External Equity & Innovation Advisory Group comprised of 11 experts at the intersection of health equity and innovation, a diverse group of leading physicians, entrepreneurs, investors, and advocates for the health and wellbeing of historically marginalized and minoritized communities. The group held its first quarterly meeting with CHE leadership and began to formulate its collective vision and values. The second effort was the completion and publication of an analysis of twenty-five interviews of internal AMA, Health2047, and Health2047 Capital Partners innovation stakeholders conducted by Center for Health Equity consultant, Braven Solutions, to understand opportunities to support the embedding of equity into existing innovation efforts across our ecosystem.

(4) Toward the end of 2020, CHE, under the planning of Denard Cummings, the CHE Director of Equitable Health Systems Integrations, collaborated with HealthBegins to develop the AMA Upstream Strategy Primer to support the ongoing work of the AMA Social Determinants of Health Workgroup. The CHE is executing the Upstream Strategy with PS2, IHMI, and EISAMR. The role of the Upstream Strategy is to leverage the existing AMA policies on social determinants of health and public health to move AMA's interventions closer to the foundations of avoidable inequities in health.

(5) Our AMA is making strides with respect to written language equity. While there is much room to grow, the CHE's own Dr. Diana Derige and Dr. Diana Lemos led the work with Enterprise Communications on our AMA's Hispanic Heritage Month campaign, one of the first AMA entirely bilingual campaigns. The final product was a multimedia news release and resource for media outlets to consume and report on our AMA content produced in English and Spanish.

Drs. Derige and Lemos were also deeply instrumental in producing The AMA Latinx Health Inequities Report, which reports on Latinx ethnic data and uncovers the true magnitude of COVID-19 on the Latinx community.

(8) Another notable accomplishment has been the creation of the AMA internal Language Access Plan, also led by CHE staff. The Language Access Plan includes best practices and guidance to support an inclusive AMA policy to ensure access under Language Access Obligations Under Executive Order 13166 and meaningful access for limited English proficient persons under the national origin nondiscrimination provisions of Title VI of the 1964 Civil Rights Act. Our AMA Health Equity Initiatives Webpage went live in September 2020. It features content from healthcare, governmental and community organizations across the country that are working to provide resources to minoritized and marginalized populations, dismantling racist systems and improving patient trust in the health care system. The CHE partnered with these organizations to collect their insights to help our AMA better understand the history of the project or initiatives, the overall goals of the projects and initiatives, the expected results and early wins, as well as the key partners involved in the effort.

(9) In November 2020, the CHE hired Gina Hess as Operations Assistant. Amongst other pertinent organizational capacity work, Ms. Hess tracks the CHE team's information for presentations, keynotes, and panels, and co-coordinates the bi-weekly Prioritizing Equity Series with Aziza Taylor, CHE's Communications and Marketing Manager, and with the Digital Strategy and Operations team of Enterprise Communications.

The equity work of the AMA has greatly benefitted from burgeoning health equity leaders, including CHE interns. In six months time (May-November 2020) the first CHE intern, Brian De La Cruz, a graduate student from Wheaton College, was instrumental in the early organization and execution of the Prioritizing Equity series. He built a database for Prioritizing Equity series records, which reflect not only the date and time specifics of the YouTube series but also its episode panelists, viewership statistics and social media impact. Mr. De La Cruz also supported the CHE Performance and Operations, and Marketing and Communications teams to help create a workflow for processing the Prioritizing Equity honoraria for guest speakers, and helped to revamp the CHE Sharepoint site.

The CHE collaborated with the AMA Federation Relations team to engage with the Federation of Medicine on December 2, 2020. Dr. Maybank presented on the mission and goals of the CHE as well reporting on recent activities and plans for 2021. The plans include a deeper and sustained engagement with Federation members through regularly scheduled meetings where Federation members may highlight their health equity activities with each other and potentially collaborate on common efforts.

(10) Starting in 2020 and continuing into 2021, CHE has contributed expertise to the google.org-backed Health Equity Task Force convened by Dr. Daniel Dawes, Satcher Health Institute. The Task Force is guiding the creating of a public-facing health equity tracker, with the goal of providing accessible and impactful data to a wide range of users. CHE staff represented two different subcommittees within the Task Force—the Data Consortium and the Population-Based Strategies Work Group.

(11) As the year came to a close, the CHE continued to expand the equity presence and visibility of the AMA. Since 2020, CHE staff have delivered keynotes and moderated panel conversations close to 160 in number. Table 3 in the Appendix outlines these events.

1st Quarter, 2021

January 2021 brought with it upheaval with the siege of the nation's Capitol building, and ongoing suspicions of threat to the country's symbol of democracy. At the same time, the change in the presidential administration offers opportunities to centering health equity at the national stage. This season of change requires physician-advocate leadership—leadership which the AMA through the CHE and other business units, is creating through various physician-supporting programs.

(1) Referred to in the first CHE BOT Report as the Health Equity Advocacy and Leadership (HEAL) Fellowship, the AMA and Morehouse School of Medicine Satcher Health Leadership Institute's Medical Justice and Advocacy Fellowship is underway. The Medical Justice in Advocacy Fellowship is a collaborative educational initiative to empower physician-led advocacy that advances equity and removes barriers to optimal health for marginalized people and communities. The fellowship will mobilize physicians to be part of the next generation of advocacy leaders, driving meaningful policy and structural changes that produce equity and justice in the communities they serve. By July 2021, it will have selected its first 10-member cohort. Diana Derige, and several other CHE staff, coordinated the internal AMA team—including staff from Advocacy, Ed Hub, Marketing and Member Experience (MMX), Improving Health Outcomes (IHO), Medical Education, Health and Science, and Payment and Quality, to see this vast effort into fruition.

(2) The Women's Equity and Leadership program (WEL) will foster the development of the next wave of female physician leaders to build a healthier, more equitable work experience. WEL is a collaboration of ten health care organizations: the American Academy of Pediatrics (administrator), American Academy of Family Physicians, American College of Physicians, American College of Obstetricians and Gynecologists, American Hospital Association, American Medical Association, American Medical Women's Association, American Psychiatric Association, National Hispanic Medical Association, and National Medical Association, who will each contribute 5 participants to the 2021 cohort (total 50.)

(3) The CHE advances the AMA's commitment and cause to making plain and accessible the significance of equity in health, using myriad multi-media platforms. In continued collaboration with the Marketing and Member Experience (MMX) BU, the CHE commenced Season 2 of "Prioritizing Health Equity," on the AMA's YouTube channel. To date, 26 episodes have been produced, with more than 137,000 views. While the intent of the series remains unchanged since its inception, the co-producing business units vary each episode not only in subject focus, but also by episode length, at either 30 minutes, 45 minutes, or 1-hour. Table 5 reflects the AMA Prioritizing Equity episodes to date, listed from most recent to most dated.

Table 4 of the Appendix lists the books, research papers, and other notable publications produced by CHE staff, over the last year. These include a book, *Unequal Cities: Structural Racism and the Death Gap in America's 30 Largest Cities*, published by the Johns Hopkins University Press as part of its "Health Equity in America" series. CHE members have also co-authored articles in leading scholarly journals, including the *Lancet*, *Health Affairs, JAMA Network Open*, the *American Journal of Preventive Medicine*, and *Public Health*.

In progress are an edited book on structural competency and the COVID-19 pandemic (co-edited by Aletha Maybank, Fernando De Maio, Jonathan Metzl and Uché Blackstock) and an edited theme issue for the *AMA Journal of Ethics* (Fernando De Maio, Diana Derige, and

Diana Lemos) bringing together nine cases/papers from leading scholars of Latinx health equity.

(4) Between January and March 2021, several new members joined the team. Karthik Sivashanker, MD, MPH, CPPS, joined as Vice President of Equitable Health Systems and Innovation. He also serves as the Medical Director of Quality Safety and Equity of Brigham Health. Joni Wheat joined the team as our Program Administrator. Dr. Zain Al Abdeen Qusair and Dr. Iqra Hashwani joined as interns from DePaul University's Master of Public Health program, working under the supervision of Fernando De Maio, PhD, Director of Research and Data Use. The bolstering of the CHE team strengthens the AMA's national position as equity brokers in medicine and public health. CHE secured a memorandum of understanding (MOU) with Northwestern University's Public Health program to increase intern support for the team and to expand opportunities for MPH and MD/MPH students to learn and contribute to the work of the Center.

(5) The AMA External Equity & Innovation Advisory Group reconvened with the Center for Health Equity for its second quarterly meeting in February 2021. The group engaged in interactive breakout discussions that included AMA and Health2047 innovation stakeholder participants.

(6) CHE is working in partnership with Health Solutions and Medical Education on strengthening race and ethnicity data collection in the AMA Masterfile, and with the explicit purpose of building a data foundation toward a more equitable health system. Under the leadership of Fernando De Maio, CHE worked with Kenyetta Jackson of Health Solutions to execute the first ever Physician Data Collaboration Summit in February 2021, a meeting with internal stakeholders across the AMA business units, and with external steering committee, including representatives from the ACGME and AAMC. The group continues to meet in 2021, with the goal of establishing common data standards and definitions and a collaborative research agenda examining diversity of the physician workforce.

The AMA, led by CHE, submitted a proposal for the global challenge address Racial Equity 2030. The RFP called for bold solutions to drive an equitable future for children, their families and communities. Our proposal aims to address medicine's historical production of scientific, cultural, structural, and institutional racism and dismantle its roots; centering restorative and "just" healthcare and meaningfully engages all voices to fundamentally change medicine and the health of our nation.

(7) Working with the American College of Preventive Medicine, CHE responded to an open request for proposals to support solo or small group practices of racial and ethnic minority physicians to accelerate the capacity of implementing COVID-19 prevention, testing, and vaccination strategies within racial or ethnic minority communities. Under the Centers for Disease Control and Prevention (CDC), this is the OT18-1802 Cooperative Agreement, "Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health Improving Minority Physicians' Capacity to Address COVID-19 Disparities". The intent of this work is to increase physicians' ability to capture and collect case studies and to engage patients in impactful conversations about COVID-19 and to make resources available to their patients. For the first time in its 174-year history, our AMA is producing a strategic roadmap that outlines a framework to address inequities in health care. Given the enormity of work that achieving health equity entails, it is critical for the American Medical Association to outline, define and chart a path to success to allow us to not only monitor our progress but to also facilitate transparency, accountability, and continuous quality

improvement in the process. The plan is aligned with the Center for Health Equity's five strategic approaches: embed equity; build alliances and share power; ensure equity in innovation; push upstream; and create pathways for truth, racial healing, reconciliation, and transformation.

2nd Quarter, 2021 and 3rd Quarter 2021 Projections

(1) The Board's first report to the House of Delegates on the CHE gave the early outline for what will henceforth be referred to as the Centering Equity in Emergency Preparedness and Response Recovery Initiative for Healthcare (the CEEPRR). The CEEPRR is created in partnership between our AMA and confirmed partners, including the Planned Parenthood Federation of America (PPFA), American College of Preventive Medicine (ACPM), American Public Health Association (APHA), National Medical Association (NMA), National Hispanic Medical Association (NHMA), GLMA, American Association of Public Health Physicians, America's Essential Hospitals, American Academy of Family Physicians, and the National Birth Equity Collaborative. The CEEPRR will serve as a resource for healthcare professionals and for healthcare organizations to embed and implement equity strategies and tactics to prepare and respond to emergencies. There is a dearth of guidance and community in healthcare in this domain. The initial product will include a guide/playbook with guiding principles, critical shared terminology, and illustrative case studies. There will be opportunities to extend this asset via other amplifying opportunities such as the Ed Hub. The CHE is using a collaborative approach to inform product development, innovation, and amplification. This initiative will be the first of its kind and a unique opportunity to promote and establish more equitable policies, practices and service behaviors across healthcare. The anticipated release date is for May 2021.

(2) The "Ensure equity in innovation" strategy will continue to be developed with the guidance of the AMA External Equity & Innovation Advisory Group and through market research and stakeholder engagement that centers the voices of patients, innovators, and investors from historically marginalized and minoritized communities. This research and stakeholder engagement will inform collaborative strategic initiatives and policies, internal training and tools, and external industry-facing content and resources to be launched in 2021 and beyond.

APPENDIX

TABLE 1: Health Equity in Advocacy and Policy Immersive Development, Training, & Engagement Curriculum Modular Description

Training at a Glance

Module 1: Why an Equity Mindset is Essential to Work in Policy and Advocacy

- History – how policy decisions have created and reinforce inequity
- Examples of Unintended/Unrecognized/Ignored Consequences of policy
- Implicit and Explicit Bias
- Business and Productivity Case for Equity in Policy/policy and Advocacy

Module 2: Foundational Concepts in Health Equity, the Medical Justice in Advocacy Fellowship, and equity in advocacy agenda-setting

- Definitions of SDOH, Health Equity, Anti-racism, etc…
- Review of social, structural, political determinants of health
- The Medical Justice in Advocacy Fellowship overview
- Equity agenda-setting in bi-partisan arenas

Module 3: Review of Equity-based Policy Analysis/Decision Support Tools

- Health Equity Impact Assessment (HEIA)
- Intersectional Policy Analysis
- Applying an Equity Lens: Recognizing Equity Issues in sample policy-evaluations, testimonies, letters, etc…

TABLE 2: DISABILITIES RELEVANT AMA POLICY

POLICY DISTINCTION	TITLE	DESCRIPTION
D-90.991	"Advocacy for Physicians with Disabilities,"	1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including but not limited to: (a) enhancing representation of physicians with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA. 2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration. 3. Our AMA supports physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.
H-65.965	"Support of Human Rights and Freedom,"	Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; 3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
D-180.991	"Work Plan for Maintaining Privacy of Physician Medical Information"	The AMA shall recommend that medical staffs, managed care organizations and other credentialing and licensing bodies adopt credentialing processes that are compliant with the Americans with Disabilities Act and communicate this recommendation to all appropriate entities.

H-90.987	“Equal Access for Physically Challenged Physicians,”	Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act.
H-200.951	“Strategies for Enhancing Diversity in the Physician Workforce,”	Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
9.5.4	Civil Rights & Medical Professionals	Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.
	AMA Principles of Medical Ethics: IV: Balance with patient safety	

TABLE 3: CHE Keynotes, Panels, and Other Speaking Engagements

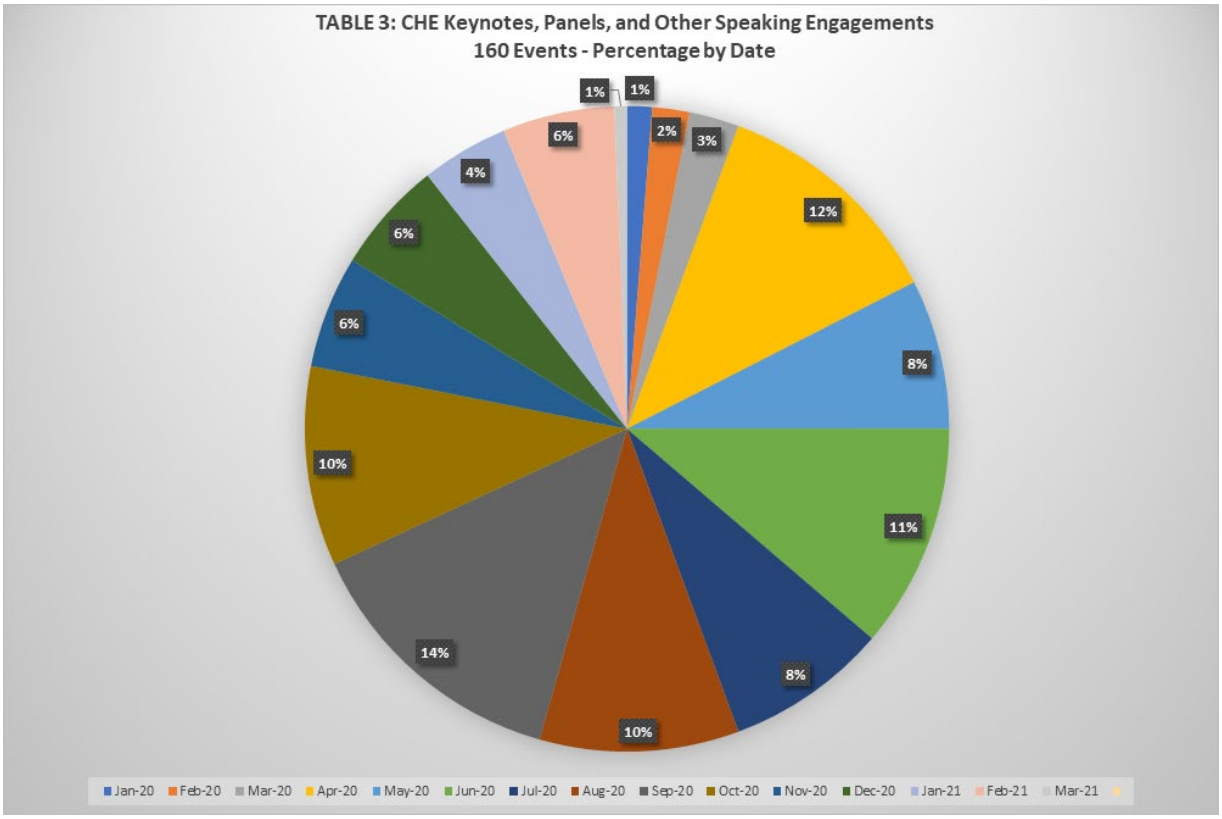

TABLE 4: CHE Peer-Reviewed Publications

AUTHORS	YEAR	TITLE	JOURNAL
Metzl, **Maybank**, and **De Maio**	2020	Responding to the COVID-19 Pandemic: The Need for a Structurally Competent Health Care System	JAMA
Crear-Perry, **Maybank**, **Keeys**, Mitchell, and Godbolt	2020	Moving towards anti-racist praxis in medicine	Lancet
Schober, Hunt, Benjamins, Silva, Saiyed, **De Maio**, and Homan	2020	Homicide Mortality Inequities Across the 30 Biggest Cities in the United States	American Journal of Preventive Medicine
Bishop-Royse, Lange-Maia, Murray, Shah, and **De Maio**	2021	Structural racism, socio-economic marginalization, and infant mortality	Public Health
Benjamins, Silva, Saiyed, and **De Maio**	2021	Comparison of All-Cause Mortality Rates and Inequities Between Black and White Populations Across the 30 Most Populous US Cities	JAMA Network Open
Liao and **De Maio**	2021	Social Inequality, Political Factors, and COVID-19 Infections and Deaths Across US Counties	JAMA Network Open
Richardson, Malik, Darity, Mullen, Morse, Malik, **Maybank**, Bassett, Farmer, Worden, and Jones	2021	Reparations for American Descendants of Persons Enslaved in the U.S. and their Potential Impact on SARS-CoV-2 Transmission	Social Science and Medicine
Khazanchi, Crittenden, Heffron, Manchanda, **Sivashanker, and Maybank**	2021	Beyond Declarative Advocacy: Moving Organized Medicine And Policy Makers From Position Statements To Anti-Racist Praxis	Health Affairs Blog
Keeys, Baca, and Maybank	in press	Race, Racism, and the Policy of 21st Century Medicine	Yale Journal of Biology and Medicine

Note: CHE authors in bold

TABLE 5: Prioritizing Equity Series

Table 5: Prioritizing Equity Series	DATE
COVID-19 & Minoritized Physicians	3/11/2021
COVID-19 & Trauma Informed Approaches	2/25/2021
COVID-19 & Disability	2/11/2021
COVID-19 Vaccine & Equitable Distribution	1/28/2021
After Show: Trustworthiness and Vaccines	12/10/2021
Trustworthiness and Vaccines	12/10/2020
Research and Data for Health Equity	11/19/2020
2020 Election - Moving Forward	11/12/2020
Examining Race-Based Medicine	10/29/2020
Structural Racism and the Latinx Community	10/15/2020
Chicago's Response to COVID-19	10/1/2020
Voting During the COVID-19 Pandemic	9/17/2020
Lessons NYC has learned from COVID-19	9/3/2020
Political Determinants of Health	8/20/2020
Mental Health & COVID-19	8/6/2020
Asian American & Pacific Islander Voices	7/16/2020
Moving Upstream	7/7/2020
LGBTQ Voices	6/18/2020
Root Cause & Considerations for Healthcare Professionals	6/11/2020
Police Brutality & COVID-19	6/4/2020
The Root Cause	5/28/2020
COVID-19 & Native in the Field	5/21/2020
Latinx Voices in the Field	5/14/2020
COVID-19 & the Experiences of Medical Students	5/7/2020
Strengthening the Public Health Infrastructure to Battle Crises	4/23/2020
The Experience of Physicians of Color and COVID-19	4/2/2020

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-JUN-21

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

Presented by: Russ Kridel, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on several specific issues related to the Affordable Care Act (ACA) as well as repealing the SGR and the Independent Payment Advisory Board (IPAB). 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 "2021 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 also is 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.

<u>Cover Uninsured Eligible for Medicaid or Children's Health Insurance Program</u>

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or Children's 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.

<u>Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits</u>

Before the COVID-19 pandemic, 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 advocates 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 also is 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

Before the COVID-19 pandemic, 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 were presented on November 10, 2020 and a decision is expected 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. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the Department of Justice under the new Biden Administration submitted a letter to the Supreme Court arguing that the ACA's individual mandate remains valid, and, even if the court determines it is not, the rest of the law can remain intact.

This action reversed the Trump Administration's brief it filed with the Court asking the justices to overturn the ACA in its entirety. The Trump Administration had 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.

AMERICAN RESCUE PLAN OF 2021

On March 11, 2021, President Biden signed into law the American Rescue Plan of 2021. This legislation included the following ACA-related provisions that will:

- Provide a temporary (two-year) 5 percent increase in the Medicaid FMAP to states that enact the Affordable Care Act's (ACA) Medicaid expansion and covers the new enrollment period per requirements of the ACA.
- Invest nearly $35 billion in premium subsidy increases for those who buy coverage on the ACA marketplace.
- Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose income is above 400 percent of the federal poverty line (FPL) for 2021 and 2022; and
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ACA SPECIAL ENROLLMENT PERIOD

President Biden, during his first weeks in office, opened a new ACA special enrollment period, citing an increased need for coverage during the current economic and health crises. On March 23, 2021, the Biden administration announced its decision to lengthen the ACA special enrollment period from May 15 to August 15.

SGR REPEAL

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing the SGR was signed into law by President Obama on April 16, 2015.

INDEPENDENT PAYMENT ADVISORY BOARD (IPAB) REPEAL

The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018 included provisions repealing the Independent Payment Advisory Board (IPAB). Currently, there are not any legislative efforts in Congress to replace the IPAB.

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165. 938 and other directives of the House of Delegates.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-JUN-21

Subject: Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients"

Presented by: Monique A. Spillman, MD, Chair

INTRODUCTION

At the November 2020 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1, November 2020, "Amendment to Opinion 1.2.2, 'Disruptive Behavior and Discrimination by Patients.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-1.2.2 – Disruptive Behavior and Discrimination by Patients'

The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting the dignity and rights of both patients and physicians.

Disrespectful, derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship. It can make individuals who themselves experience (or are members of populations that have experienced) prejudice reluctant to seek care as patients or to provide care as health care professionals, and create an environment that strains relationships among patients, physicians, and the health care team.

Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:

(a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those who are targeted.

(b) Always treat patients with compassion and respect.

(c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways insofar as possible. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence

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

patient behavior. Regardless of cause, when a patient's behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.

(d) Prioritize the goals of care when deciding whether to decline or accommodate a patient's request for an alternative physician. Physicians should recognize that some requests for a concordant physician may be clinically useful or promote improved outcomes.

(e) Within the limits of ethics guidance, trainees should not be expected to forgo valuable learning opportunities solely to accommodate prejudiced requests.

(f) Make patients aware that they are able to seek care from other sources if they persist in opposing treatment from the physician assigned. If patients require immediate care, inform them that, unless they exercise their right to leave, care will be provided by appropriately qualified staff independent of their expressed preference.

(g) Terminate the patient-physician relationship only when the patient will not modify disrespectful, derogatory or prejudiced behavior that is within the patient's control, in keeping with ethics guidance.

Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to:

(h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.

(i) Educate staff, patients, and the community about the institution's expectations for behavior.

(j) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.

(k) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients, including allowing physicians, trainees, and facility personnel to decline to care for those patients, without penalty, who have exhibited discriminatory behavior specifically toward them.

(l) Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community. (I, II, VI, IX)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 2-JUN-21

Subject: Amendment to Opinion 8.7, "Routine Universal Immunization of Physicians"

Presented by: Monique A. Spillman, MD, Chair

INTRODUCTION

At the November 2020 Special Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 2, November 2020, "Amendment to Opinion 8.7, 'Routine Universal Immunization of Physicians.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-8.7 – Routine Universal Immunization of Physicians

As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers.

In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians have a responsibility to accept immunization absent a recognized medical contraindication or when a specific vaccine would pose a significant risk to the physician's patients.

Physicians who are not or cannot be immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and others. They must adjust their practice activities in keeping with decisions of the medical staff, institutional policy, or public health policy, including refraining from direct patient contact when appropriate.

Physician practices and health care institutions have a responsibility to proactively develop policies and procedures for responding to epidemic or pandemic disease with input from

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practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedures should include robust infection control practices, provision and required use of appropriate protective equipment, and a process for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of staff. Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact. (I, II)

REPORT 4 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (June 2021)
Augmented Intelligence & the Ethics of Innovation in Medicine
(Informational)

EXECUTIVE SUMMARY

AI systems represent the latest in a long history of innovations in medicine. Like many new technologies before them, AI-based innovations challenge how physicians practice and how they interact with patients at the same time that these innovations offer promises to promote medicine's Quadruple Aim of enhancing patient experience, improving population health, reducing cost, and improving the work life of health care professionals.

Ethically appropriate use of augmented intelligence in health care must support, not subvert, the goals and values that define medicine as a profession. Design and implementation of systems for clinical use must take account of:

- risks to privacy;
- the potential for bias to be built into models and their outputs;
- the fact that the most powerful and useful models have the capacity to evolve autonomously, outside of human observation and independent of human control; and
- the challenge of devising mechanisms to ensure appropriate oversight across multiple stakeholders.

That these challenges are well recognized is evidenced by multiple published frameworks for an "ethics of AI," and, importantly, the convergence on key principles among them—for example, Harvard University's Berkman Klein Center for Internet & Society and the High Level Expert Group on AI of the European Commission.

The introduction of AI systems in medicine touches on multiple issues of ethics that are currently addressed in the AMA Code of Medical Ethics. This, combined with the rapid pace of evolution in health care AI, leads the Council to conclude that new guidance directed solely toward AI will not best serve the profession. Therefore, the Council proposes to review existing guidance in the areas of relevance to AI and to share its deliberations with the House of Delegates in this report as well future reports.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 4-JUN-21

Subject: Augmented Intelligence & the Ethics of Innovation in Medicine

Presented by: Monique A. Spillman, MD, Chair

AUGMENTED INTELLIGENCE & THE ETHICS OF INNOVATION IN MEDICINE

AI systems represent the latest in a long history of innovations in medicine. Like many new technologies before them, AI-based innovations challenge how physicians practice and how they interact with patients at the same time that these innovations offer promises to promote medicine's Quadruple Aim of enhancing patient experience, improving population health, reducing cost, and improving the work life of health care professionals [1,2,3,4].

The AMA Council on Ethical and Judicial Affairs (CEJA) recognizes that AI-based tools can serve a variety of ends in health care, from supporting administrative functions and streamlining institutional operations to enhancing clinical decision making for individual patients [see, e.g., 2,5]. AI systems have strengths and weaknesses across all these areas; in the council's view, the characteristics of systems that are intended to inform diagnosis, predict a patient's clinical course, and support clinical decision making, highlight the risks AI-enabled care can pose to patients and are therefore the primary focus of the present analysis.

CHALLENGES OF AI-ENABLED HEALTH CARE

Several features distinguish the data-driven machine-learning algorithms in clinical prediction models and decision support tools from other innovations in medicine that ethics guidance must take account of: the potential for bias to be built into a model and its outputs; the fact that the most powerful and useful models are both opaque and plastic, that is, they have the capacity to evolve autonomously, outside of human observation and independent of human control. It also requires recognizing that not only do these AI systems involve multiple stakeholders, but that they also "transform the modes of interaction between different agents" [6], creating challenges for devising mechanisms to govern complex AI systems and appropriately hold multiple stakeholders accountable for the performance of those systems.

A Word About Privacy

Protecting the privacy of data subjects and the confidentiality of personal information is frequently cited as a central concern in the use of AI systems [7]. However, such risks are hardly unique to AI. They are common to all activities that collect and store personal information, especially activities that rely on data stored in central repositories—electronic health records, clinical registries, DNA databanks, or tissue banks intended for research use [see, e.g. 8]. The potential for benefit is great but risks that identifiable personal information will be inadvertently disclosed or worse, intentionally misused, are high in all activities that rely on sharing access to data sets that contain such information. For these reasons, the present analysis focuses more narrowly on other features unique to characteristic especially of predictive models and decision support tools that utilize machine-learning algorithms.

Bias

Data-driven machine-learning algorithms are subject to the familiar problem of "garbage in, garbage out." The utility and value of such algorithms is hostage to the quality of the data on which they are trained and with which they are validated. Data drawn from electronic health records (EHRs), on which most such algorithms are currently trained, build into the model itself whatever biases already characterize the data in the record, whether statistical or social [9].

As data sets, EHRs have serious weaknesses. Insofar as they include only information from individuals who have access to the health care system in the first place, and in settings that employ electronic records, they are not representative. Information about individuals who have no or irregular access to care, or whose records exist only in paper form is not available to train or validate an algorithm. Nor are EHR data "pristine"—with rare exceptions, electronic records capture information "downstream" of human judgments, in effect training the algorithm to replicate human cognitive errors as well as any design flaws in the record system itself [9,10].

Even well-intended efforts to correct for possible bias can have unintended consequences. For example, race-adjusted assessments for clinical conditions are often based on the misconception that "race" is a reliable proxy for genetic difference and fail to recognize that "race and health reflect enmeshed social and biologic pathways" [11]. Rather than correct for inequity, these algorithms may direct resources away from patients who are members of minoritized populations and inappropriately propagate race-based medicine instead of the equitable personalized care intended [11]. Moreover, algorithms that are fair out of the box can become biased over time once implemented, affected by characteristics of the contexts, goals, and ways they are deployed [12].

Technical solutions are being explored to mitigate bias before, during, or after an algorithm processes data [9,13].

Opacity & Plasticity

The operation of a machine-learning algorithm can be opaque for any of several reasons. In some cases, this is intentional, such as interest in protecting proprietary information; in others it reflects the fact that being able to read and interpret computer code remains a specialized skill not yet widely shared. A more fundamental challenge, however, lies in understanding highly complex algorithms as they operate on data [14]. The most powerful—and useful—algorithms are "black boxes." As a machine-learning algorithm operates on data its internal decision logic "is altered as the algorithm 'learns'" [14]. Such algorithms have the capacity to evolve in ways that may be impenetrable to human understanding – even to their developers. Because the algorithm's operations "do not naturally accord with human semantic explanations," attempts to provide humanly understandable explanations are "at best incomplete and at worst falsely reassuring" [14]. In this, data-driven AI systems are qualitatively different from other innovations in medicine.

Validation

Robust validation lags the development of AI systems in health care. For example, of some 1366 cardiovascular clinical prediction models (CPM) in the Tufts PACE Clinical Prediction Model registry, fewer than 600 reported at least one validation [15]. Current practice generally assesses only a single model at a time and thus cannot provide "reliable ranking of the comparative performance of the many CPMs available for the same application," which allows a small number of models to dominate clinical practice "based on tradition and herding behavior, rather than high-quality evidence" [15]. Randomized clinical trials that assess the clinical utility of CPMs are rare.

Physicians need to be critical consumers of published reports about new AI models, and take into account not only where a report was published, but the source and size of the dataset on which the algorithm was based, whether it was tested on real clinical data, whether its performance was compared to existing solutions, whether it was evaluated for how readily it can be implemented, and whether its results were interpretable to the intended end users [5].

In response to the "current lack of best practice guidance specific to machine learning and artificial intelligence," researchers have proposed 20 key questions to address issues of transparency, reproducibility, ethics, and effectiveness in research involving machine learning and AI [16]. These questions probe issues of inception (e.g., "What is the health question relating to patient benefit"), study design ("Are the data suitable to answer the clinical question…?"), statistical methods, reproducibility, impact (e.g., "Are the results generalizable to settings beyond where the system was developed…?"), and implementation (e.g., "How is the model being regularly reassessed and updated as data quality and clinical practice changes…?").

Oversight & Accountability

Debate continues about whether or to what extent existing models for oversight of medical technologies can be adapted to provide adequate oversight of AI systems in health care. Models for human subjects protections are poorly suited to the evolving "cyber social experiment" [17] represented by machine-learning algorithms, for essentially the same reasons these protections are problematic in contexts of quality improvement activities, or other research that involves the use of personal health or genetic data or stored biological materials [8]. Nor do machine-learning algorithms fit comfortably within current paradigms for oversight of medical devices, even the Food and Drug Administration's new regulatory framework created under the 21st Century Cures Act [8,18].

Beyond regulatory oversight, the increasing complexity and power of AI systems have prompted calls for the health care organizations that deploy such systems to implement programs of "algorithmic stewardship," analogous to antimicrobial stewardship, "to ensure that algorithms are used safely, effectively, and fairly" [19]. On this model, a designated body within the institution would be tasked with creating and maintaining an inventory of the algorithms deployed within the institution and monitoring the performance of AI systems.

Importantly, inserting AI systems into the process of clinical decision making distributes agency among multiple entities—the patient, the physician, the AI system, its designers, the data set on which it was trained, the institution that deployed it—raising questions about "who is guiding clinical decision-making, in which ways, and on what grounds" [6]. This in turn

> "raises a problem of many hands for ascriptions of responsibility: since a plurality of agents contributes to decision-making guided by AI-DSS [decision support systems], it becomes less clear who is morally and legally answerable in which ways. With the involvement of autonomous, adaptive and learning systems, it becomes harder to ascribe individual responsibility and liability for singular decisions, especially those with adverse outcomes" [6].

FRAMEWORKS FOR ETHICAL AI

That these challenges are well recognized is evidenced by multiple published frameworks for an "ethics of AI," and, importantly, the convergence on key principles among them. Thus, a review prepared by Harvard University's Berkman Klein Center for Internet & Society identified the following as common themes among 36 discussions of "how AI generally *ought* to be developed,

deployed, and governed" from governmental agencies, corporations, and private sector organizations [7]:

- Privacy—data subjects have some degree of influence over how and why information about them is used
- Accountability—AI systems should be subject to appropriate oversight during development and deployment, and that appropriate remedies be provided if harm occurs
- Safety and security—AI systems should be reliable and perform as intended, and that systems are appropriately protected against external threats
- Transparency and explainability—it is clear when AI systems are being used and for what task, and that justifications for decision outputs be intelligible
- Fairness and nondiscrimination—steps are taken to prevent and mitigate against discrimination risks in the design, development and application of AI systems
- Human control of technology—important decisions remain subject to human control
- Professional responsibility—individuals and teams involved in the design, development and deployment of AI systems take responsibility for the performance and effects of those systems
- Promotion of human values—the ends to which AI systems are devoted and the means by which they are implemented should correspond with core social norms

The High Level Expert Group on AI of the European Commission identifies five fundamental ethical principles to govern the design and deployment of AI systems [20]:

- Beneficence ("do good")—AI systems should be designed and developed to improve individual and collective well-being.
- Non-maleficence ("do no harm"—By design, AI systems should protect the dignity, integrity, liberty, privacy, safety, and security of human beings … . At the very least, AI systems should not be designed in a way that enhances existing harms or creates new harms for individuals.
- Autonomy ("preserve human agency")—Autonomy of human beings in the context of AI means freedom from subordination to, or coercion by, AI systems. Human beings interacting with AI systems must keep full and effective self-determination over themselves.
- Justice ("be fair")—The principle of justice imparts that the development, use, and regulation of AI systems must be fair. Developers and implementers need to ensure that individuals and minoritized groups maintain freedom from bias, stigmatization, and discrimination.
- Explicability ("operate transparently")—Technological transparency implies that AI systems be auditable, comprehensible and intelligible by human beings at varying levels of comprehension and expertise. Business model transparency means that human beings are knowingly informed of the intention of developers and technology implementers of AI systems.

A report by the Digital Health Learning Collaborative of the National Academy of Medicine similarly identifies beneficence, non-maleficence, autonomy, and justice as fundamental principles for ethical AI in medicine [4].

MOVING FROM PRINCIPLES TO PRACTICE

Recognizing the distinctive challenges AI systems can pose and agreeing on key values and principles that should inform AI systems is essential, but is not enough to guarantee the design, development, and deployment of "ethical AI" in health care or any other domain. As a report by the Gradient Institute has observed, AI systems "possess no intrinsic moral awareness or social context with which to understand the consequences of their actions. To build ethical AI systems, designers must meet the technical challenge of explicitly integrating moral considerations into the objectives, data and constraints that govern how AI systems make decisions" [21].

Algorithms consider only the objectives and constraints supplied by their designers. To embed fundamental ethical considerations into AI systems requires that governing ethical objectives and constraints—for example, "fairness"—be expressed mathematically, as "precise, measurable quantities." For an algorithm to approximate the ethical reasoning a human would bring to bear in making a given decision, its designers must also specify acceptable balances among competing objectives [21]. Further, as some researchers have noted, "analyses of algorithmic fairness in healthcare lack the contextual grounding and causal awareness necessary to reason about the mechanisms that lead to health disparities, as well as about the potential of algorithmic fairness methods to counteract those mechanisms" [22].

Moreover, AI systems must be designed so that the consequences of a system's actions "align with the ethical intent motivating the deployment of the system" [21]. That is, systems must not only be designed in ways that account for bias in training data, but in ways that enable them to apply causal reasoning to model the consequences of its actions and assess the relative likelihood of those consequences occurring. Mathematically representing the kind of multidisciplinary expertise and sensitivity to context that characterize human moral is extremely difficult.

Given these realities, human oversight of AI systems is essential. If overseers are to be able to "anticipate, detect, and correct problems," an AI system must be transparent and interpretable. To reduce the risk that an AI system "will be motivated, designed, or operated in a socially unacceptable way," decisions first must be made about what information needs to be made transparent to whom. The system must further be interpretable in ways that enable people "to understand [a system's] reasoning processes, explain how mistakes occurred, or inform users how to adapt their behavior to obtain different decisions from systems in the future" [21]. Yet, like "fairness," interpretability, often comes at the cost of accuracy, and "determining what attainable compromise between predictive power and effective human oversight results in the best ethical outcomes" will remain a challenge for the foreseeable future.

Finally, Gradient's analysis proposes, oversight and accountability for ethical AI should be sensitive to the complex nature of AI systems and to the multiple contexts in which those systems are used, noting that "labelling requirements, special taxation or regulatory approval processes for 'AI systems' broadly construed" are "unlikely to be helpful" [21]. They propose, instead, sector-specific oversight of the contexts in which AI systems are applied, to permit evidence-based, technically informed regulation that is able to keep pace with rapid, ongoing evolution in the technology.

GUIDANCE IN THE AMA CODE OF MEDICAL ETHICS

The *AMA Code of Medical Ethics* defines fidelity to patients and physicians' corresponding responsibility to promote patients' well-being as the core value of medicine as a profession. Opinion 1.1.1, "Patient-Physician Relationships," holds that

> The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for patients' welfare.

Innovations in health care should sustain this fundamental commitment of fidelity to patients. Those who design and deploy new interventions or technologies, particularly interventions or technologies intended to directly interface with decisions about patient care, have a responsibility to ensure that their work serves the goals of medicine as a priority. Thus Opinion 1.2.11, "Ethically sound innovation in medical practice," provides that any given innovation must be scientifically well grounded and focus on the interests of patients, not those of innovators or health care institutions.

Guidance in Opinion 1.2.11 further recognizes that introducing new technologies or other innovation into medical practice poses challenges at the systemic level as well as for individual physicians. Strong practice requires attention not only to individual clinical interactions "at the bedside," but equally to the organizational policies, practices, and infrastructure of health care institutions that deploy a medical innovation. Innovators have a responsibility to engage stakeholders early in the process and must consciously design innovations to minimize risks to individual patients and maximize the likelihood they will be adopted and will benefit populations of patients. Innovators also have an ethical obligation to be sensitive to the cost implications of innovation and aware of influences that may drive the creation and adoption of innovations for reasons other than patient or public benefit. Institutions and physician practices that adopt innovations have a responsibility to ensure that appropriate infrastructure is in place to support effective implementation and oversight.

Guidance in Opinion 11.2.1,"Professionalism in Health Care Systems," sets out the responsibilities of physician-leaders to create conditions that support physician professionalism within their organizations, including responsibilities to ensure that institutional arrangements that govern care are transparent and that decisions reflect input from key stakeholders. It defines leaders' responsibilities to ensure that mechanisms adopted to influence physician decision making are "designed in keeping with sound principles and solid scientific evidence," deployed fairly so that they "do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities." It further holds physician-leaders responsible to ensure the institution provides avenues "for meaningful appeal and advocacy on behalf of patients" and for monitoring deployment of new practices and tools to identify and respond to their effects on patient care.

ASKING THE RIGHT QUESTIONS

The majority of physicians will be consumers of AI systems developed by others—including even those physicians who are affiliated with institutions that are actively engaged in developing AI for health care. As individual end users, physicians cannot reasonably be expected to have the requisite skills or opportunity to evaluate AI systems, and should not be, any more than they are expected to make firsthand assessment of other diagnostic or therapeutic innovations. They must rely on their institutions—or the vendors from whom they purchase AI systems for their practices—to ensure that those systems are trustworthy.

Ethically appropriate use of AI in health care must support, not subvert, the goals and values that define medicine as a profession. Physicians should be thoughtful consumers of AI and recognize

that they have a responsibility to use their voice as professionals and their knowledge of their patients' needs to help inform decisions about what AI systems will be implemented in the care settings in which they practice. They should be able to expect that health care institutions with which they are affiliated can answer the following questions when deploying an AI system that will affect clinical practice:

- What recognized clinical need among our patient population is this tool intended to address?
- Has it been rigorously demonstrated to successfully meet that need among patients relevantly similar to ours in comparable clinical settings?
    - By whom?
- What is the worst that could happen to the person who is most adversely affected if we deploy this system?
    - Are those who are most likely to be adversely affected already disadvantaged compared to others?
    - How will the institution minimize the possibility of a "worst case" scenario occurring?
- Through what process and by whom was the decision made to acquire and deploy this technology at this time?
- What resources, in both personnel and infrastructure, are needed to deploy this technology successfully?
    - How will the institution ensure that these resources are available?
- How will the institution monitor the performance of this system once it is deployed?
    - Are there clear protocols for clinicians to contribute to performance assessment? To regularly receive information about the system's impact on patient care/outcomes?
- How will the institution support my exercise of professional clinical judgment and expertise with respect to clinical predictions or treatment recommendations generated by this AI system?

CONCLUSION

As the foregoing analysis indicates, the introduction of augmented intelligence systems in medicine touches on multiple issues of ethics that are currently addressed in the AMA Code of Medical Ethics. This, combined with the rapid pace of evolution in health care AI, leads the Council to conclude that new guidance directed solely toward AI will not best serve the profession. Therefore, the Council proposes to review existing guidance in the areas of relevance to AI and to share its deliberations with the House of Delegates in future reports.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 5-JUN-21

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: Monique A. Spillman, MD, Chair

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2020 – MARCH 31, 2021

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
10	Determinations of no probable cause
22	Determinations following a plenary hearing
7	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
10	No sanction or other type of action
5	Monitoring
6	Probation
1	Revocation
7	Suspension
1	Denied
1	Suspension lifted
3	Censure
2	Reprimand
3	Admonish

Physicians Reviewed	PROBATION/MONITORING STATUS
6	Members placed on Probation/Monitoring during reporting interval
6	Members placed on Probation without reporting to Data Bank
6	Probation/Monitoring concluded satisfactorily during reporting interval
1	Memberships suspended due to non-compliance with the terms of probation
48	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
18	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-JUN-21

Subject: Demographic Characteristics of the House of Delegates and AMA Leadership

Presented by: Shannon P. Pryor, MD, Chair

This informational report is prepared in odd numbered years by the Council on Long Range Planning and Development (CLRPD, pursuant to AMA Policy G-600.035, "The Demographics of the House of Delegates." This policy states:

> (1) A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. (2) As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. (3) Future reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote diversity within state and specialty society delegations.

This report will survey the current demographic makeup of AMA leadership in accordance with AMA Policy G-600.030, "Diversity of AMA Delegations," which states that, "Our AMA encourages…state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity..." and AMA Policy G-610.010, "Nominations," which states in part:

> Guidelines for nominations for AMA elected offices include the following... (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity…

Like previous reports, this document compares AMA leadership with the entire AMA membership and with the overall U.S. physician population. Medical students are included in all references to the total physician population, which is consistent with past practice. For the purposes of this report, AMA leadership includes delegates; alternate delegates; the Board of Trustees (BOT); and councils and leadership of sections and special groups (hereafter referred to as CSSG; see detailed listing in Appendix A).

Additionally, this report includes information on successful initiatives and best practices to promote diversity of state and specialty society delegations, pursuant to part 3 of Policy G-600.035.

DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of House of Delegates (HOD) Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect year-end 2020 delegation rosters. AMA council rosters as well as listings for the governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of U.S. medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2020 Masterfile after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee (AMPAC) and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the number allotted at the 2020 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. Race and ethnicity information, which is provided directly by physicians, is missing for slightly over one-fifth of AMA members (21.8%) and the total U.S. physician population (22.7%), limiting the ability to draw firm conclusions.

Readers are reminded that most AMA leadership groups considered herein designate seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of age-related groups, namely the student, resident, and young physician sections.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 displays the basic characteristics of AMA leadership, AMA members, and all physicians and medical students. Raw counts for Tables 1 and 2 can be found in Appendix A. Upward- and downward-pointing arrows indicate an increase or decrease of at least two percentage points compared to CLRPD 1-A-19, "Demographic Characteristics of the House of Delegates and AMA Leadership"; the following observations refer to changes since CLRPD Report 1-A-19. Changes are not highlighted for the BOT due to the small number of Board members. Between year-end 2018 and year-end 2020, AMA membership increased by 21,402 members, an 8.6% increase.

- Younger age groups saw increases in representation among the delegates to the HOD, with the percentage of delegates under age 40 increasing from 14.1% in 2018 to 16.2% in 2020, and delegates age 40-49 increasing from 10.4% to 13.3%. Concurrent with these increases, the percentage of delegates age 50-59 decreased from 22.2% in 2018 to 18.8% in 2020, while the percentage of delegates age 60-69 decreased from 34.5% to 32.2%.

- An increase was also observed among alternate delegates under age 40, from 22.7% in 2018 to 28.5% in 2020. The percentage of alternate delegates age 60-69 decreased from 26.2% to 22.7% during the same period.

- An increase was observed among female delegates, alternate delegates, and AMA members. The percentage of female members of the AMA increased from 35.7% to 38.0% from 2018 to 2020. During the same period, the percentage of female delegates to the HOD

increased from 26.4% to 30.7%, and the percentage of female alternate delegates increased from 33.2% to 38.3%.

- Increased percentages were observed among Asian/Asian American delegates, alternate delegates and CSSG from 2018 to 2020. During that time, the percentage of Asian/Asian American delegates increased from 9.1% to 11.5%, alternate delegates increased from 13.5% to 15.9%, and CSSG increased from 15.3% to 19.9%. Simultaneous decreases were observed among white, non-Hispanic alternate delegates (from 66.6% to 63.4%) and CSSG (from 59.4% to 55.4%).

Table 1. Basic Demographic Characteristics of AMA Leadership, December 2020

	Delegates[2]	Alternate Delegates[2]	Board of Trustees[3]	Councils and Leadership of Sections and Special Groups[4]	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Mean age (years)[5]	56.8	50.2	55.8	52.5	47.0	52.6
Age Distribution						
Under age 40	16.2%↑	28.5%↑	10.0%	27.7%↓	51.3%	29.3%
40-49 years	13.3%↑	18.1%	15.0%	16.3%↑	10.8%	18.0%
50-59 years	18.8%↓	22.4%	30.0%	15.7%	9.9%	16.9%
60-69 years	32.2%↓	22.7%↓	40.0%	25.9%	10.3%	16.8%
70 or more	19.5%	8.3%	5.0%	14.5%	17.7%	19.0%
Gender						
Male	69.2%↓	61.7%↓	65.0%	52.4%	61.4%↓	63.8%
Female	30.7%↑	38.3%↑	35.0%	47.6%	38.0%↑	35.5%
Unknown	0.1%	0.0%	0.0%	0.0%	0.6%	0.7%
Race/Ethnicity						
White non-Hispanic	68.3%	63.4%↓	60.0%	55.4%↓	49.9%↓	50.1%
Black non-Hispanic	4.6%	5.0%	15.0%	7.2%	5.0%	4.3%
Hispanic	3.1%	3.1%	0.0%	4.8%	6.0%	5.7%
Asian/Asian American	11.5%↑	15.9%↑	10.0%	19.9%↑	15.5%	15.4%
Native American	0.1%	0.2%	0.0%	0.0%	0.4%	0.3%
Other[6]	1.3%	2.2%	0.0%	1.2%	1.4%	1.4%
Unknown	11.0%	10.2%	15.0%	11.4%	21.8%	22.7%
Education						
US or Canada	92.0%	92.2%	100.0%	86.7%↑	82.4%	77.6%
IMG	8.0%	7.8%	0.0%	13.3%	17.6%	22.4%

[2] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[3] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[4] Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[5] Age as of December 31. Mean age is the arithmetic average.
[6] Includes other self-reported racial and ethnic groups.

Table 2 displays life stage, present employment, and self-designated specialty of AMA leadership.

- The life stage, employment, and specialty characteristics of delegates to the HOD saw few changes from 2018 to 2020, with decreases observed among established physicians (from 49.8% in 2018 to 45.8% in 2020) and self-employed solo practice physicians (from 15.0% to 13.0%).

- Among alternate delegates, increased proportional representation was observed among students (6.2% to 9.4%) and residents (5.7% to 8.5%), while decreases were observed among established physicians (52.4% to 49.7%) and senior physicians (21.9% to 19.4%). The percentage of alternate delegates employed in group practice settings (39.9% to 37.7%), state or local government hospitals (11.5% to 8.7%) and medical schools (11.5% to 8.7%) declined, as did physicians whose self-designated specialty was surgery (20.4% to 17.9%) and other (17.7% to 15.0%).

- Among CSSG, the percentages of students (11.8% to 8.4%) and young physicians (15.9% to 9.6%) decreased, while the percentage of established physicians increased from 34.1% to 41.0%. Decreases in representation were also observed among physicians working in self-employed solo practice (12.4% to 10.2%) and medical schools (8.8% to 5.4%), while representation of physicians in group practices increased from 27.6% to 33.7%. Among specialties, increases were observed in family medicine (6.5% to 9.6%), internal medicine (14.7% to 18.7%), and obstetrics and gynecology (9.4% to 13.3%), and decreases were observed in surgery (19.4% to 16.9%) and psychiatry (8.2% to 6.0%).

Table 2. Life Stage, Present Employment and Self-Designated Specialty1 of AMA Leadership, December 2020

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of AMA Sections and Special Groups	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Life Stage						
Student[2]	4.8%	9.4%↑	5.0%	8.4%↓	21.0%	7.9%
Resident[2]	6.1%	8.5%↑	5.0%	12.0%	24.5%	9.9%
Young (Under age 40 or first eight years of practice) ^	7.0%	13.1%	0.0%	9.6%↓	9.6%	15.7%
Established (Age 40-64) ^	45.8%↓	49.7%↓	60.0%	41.0%↑	22.1%	39.3%
Senior (Age 65 or more)^	36.4%	19.4%↓	30.0%	28.9%	22.8%	27.2%
Present Employment						
Self-employed solo practice	13.0%↓	9.6%	20.0%	10.2%↓	6.7%	8.3%
Two physician practice	1.5%	2.0%	10.0%	1.8%	1.4%	1.8%
Group practice	41.7%	37.7%↓	40.0%	33.7%↑	24.0%	40.2%
Non-government hospital	6.1%	6.5%	5.0%	4.2%	3.1%	4.3%
State or local government hospital	10.3%	8.7%↓	5.0%	10.8%	3.9%	6.3%
HMO	0.7%	1.3%	0.0%	0.6%	0.2%	0.2%

^ Reflects section/group definition of its membership.

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of AMA Sections and Special Groups	Members	All Physicians and Medical Students
Medical School	3.7%	2.8%↓	10.0%	5.4%↓	1.0%	1.5%
U.S. Government	3.3%	4.1%	0.0%	2.4%	0.9%	1.7%
Locum Tenens	0.4%	0.0%	0.0%	0.0%	0.2%	0.2%
Retired/Inactive	6.9%	5.7%	0.0%	8.4%	11.1%	12.1%
Resident/Intern/Fellow	6.1%	8.5%↑	5.0%	12.0%	24.5%	9.9%
Student	4.8%	9.4%↑	5.0%	8.4%↓	21.0%	7.9%
Other/Unknown	1.5%	3.7%	0.0%	1.8%	1.9%	5.7%
Self-designated specialty[3]						
Family Medicine	10.6%	10.0%	5.0%	9.6%↑	8.5%	11.4%
Internal Medicine	22.7%	19.2%	30.0%	18.7%↑	19.7%	22.7%
Surgery	22.1%	17.9%↓	40.0%	16.9%↓	13.4%	13.4%
Pediatrics	3.3%	5.2%	0.0%	5.4%	5.2%	8.7%
OB/GYN	6.6%	6.1%	5.0%	13.3%↑	5.0%	4.6%
Radiology	5.4%	5.7%	0.0%	4.2%	3.5%	4.5%
Psychiatry	4.2%	4.4%	5.0%	6.0%↓	4.2%	5.2%
Anesthesiology	3.4%	3.9%	5.0%	3.6%	3.9%	5.0%
Pathology	1.9%	3.3%	0.0%	0.0%	1.8%	2.2%
Other specialty	15.2%	15.0%↓	5.0%	13.9%	13.9%	14.4%
Student	4.8%	9.4%	5.0%	8.4%↓	21.0%	8.0%

[2] Students and residents are so categorized without regard to age.
[3] See Appendix B for a listing of specialty classifications.

For further data, including information on state medical associations and national medical specialty societies, please see Appendix A.

PROMOTING DIVERSITY AMONG DELEGATIONS

Pursuant to Part 3 of AMA Policy G-600.035, CLRPD queried state and specialty societies on initiatives they have instituted to encourage diversity among their delegations, and the outcomes of these initiatives.

- Nominating committees: As has been noted in previous editions of this report, nominating committees act as a primary mechanism with which delegations attempt to promote diversity among their leadership and AMA representatives. Associations noted that their nominating committees are encouraged to consider the demographic makeup of their members, as well as those of leadership, including boards of trustees, delegations, etc. In addition to demographic characteristics previously listed, other elements of diversity considered by nominating committees included specialty, practice setting and geographic region.

- Task forces and committees on diversity, equity, and inclusion: An increasing number of associations have formed task forces and/or committees with the goals of increasing and promoting diversity, equity, and inclusion among their ranks. Among the goals of such groups are to develop strategies to encourage cultures of diversity, equity and inclusion across membership, leadership and educational activities; identify specific and actionable steps to advocate for and foster diverse and inclusive environments within their

associations and representatives to other organizations such as the AMA; review diversity and inclusion among their boards of trustees, committee chairs, committee members, annual meeting program participants, presenters and award recipients; and develop initiatives to ensure open access to leadership positions and other opportunities throughout their organizations. Associations that have implemented task forces and committees have noted that they have implemented many or all of the groups' recommendations, and that the efforts have led to increased diversity among their leaderships.

- Improved data collection: Several associations noted the need for baseline data to measure the effectiveness of diversity and inclusion initiatives and undertook efforts to collect necessary data. Such efforts included evaluating and updating questions in membership surveys, automated diversity data collection from volunteers for workgroups and representative positions, and the development of dashboards and other reporting mechanisms that help understand the demographic makeup of the various groups and representative positions within their associations. Lack of adequate demographic data, as well as hesitance to request data that some individuals may be uncomfortable providing, was routinely cited as a barrier to implementing and measuring the efficacy of diversity, equity, and inclusion initiatives.

- Educational and outreach efforts: Associations mentioned a variety of events and initiatives aimed to educate their members and the public on diversity and inclusion, as well as outreach efforts to demonstrate the value of associations to more diverse populations. Among those efforts were town halls on race, equality, and justice; social media campaigns featuring issues related to physician diversity, underserved communities, and disparities; expanding educational opportunities for students from underrepresented social groups at the undergraduate and graduate levels; implementation of a "diversity day" as part of annual awareness events (e.g., National Physicians Week); and collaborating with professional associations with similar foci to increase awareness of their efforts to underrepresented social groups. These efforts demonstrate that attempts to increase diversity among leadership within associations can also include efforts to recruit members from more diverse social groups to participate as members, which in turn lead to more diverse and representative leaders.

- Efforts to advance younger members: Delegations have made efforts to encourage more participation by previously underrepresented groups, particularly by engaging residents, medical students, and young physicians as active participants in delegation activities, including as delegates. The groups expressed hope that these younger members would continue participation in the future and participate as members of specialty and state delegations. These associations noted that in addition to increasing age diversity among leadership, younger members tend to be more diverse in terms of other demographic characteristics.

CLRPD hopes that these initiatives may act as useful examples for those societies considering strategies by which to promote diversity among their own memberships and leaders.

For raw counts of the above tables, as well as detailed state and specialty society data, please see the appendices.

APPENDIX A

Table 3. Basic Demographic Characteristics of AMA Leadership

	Delegates[2]	Alternate Delegates[2]	Board of Trustees[3]	Councils and Leadership of Sections and Special Groups[4]	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Mean age (years)[5]	56.8	50.2	55.8	52.5	47.0	52.6
Age Distribution						
Under age 40	109	131	2	46	139,355	407,345
40-49 years	89	83	3	27	29,271	250,268
50-59 years	126	103	6	26	26,992	235,857
60-69 years	216	104	8	43	28,081	233,980
70 or more	131	38	1	24	47,956	264,140
Gender						
Male	464	283	13	87	166,793	887,425
Female	206	176	7	79	103,274	494,657
Unknown	1	0	0	0	1,588	9,508
Race/Ethnicity						
White non-Hispanic	458	291	12	92	135,523	697,801
Black non-Hispanic	31	23	3	12	13,562	59,965
Hispanic	21	14	0	8	16,394	78,855
Asian/Asian American	77	73	2	33	42,101	214,602
Native American	1	1	0	0	974	3,764
Other[6]	9	10	0	2	3,804	20,031
Unknown	74	47	3	19	59,297	316,572
Education						
US or Canada	617	423	20	144	223,820	1,079,301
IMG	54	36	0	22	47,835	312,289

[2] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[3] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[4] Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[5] Age as of December 31. Mean age is the arithmetic average.
[6] Includes other self-reported racial and ethnic groups.

Table 4. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of AMA Sections and Special Groups	Members	All Physicians and Medical Students
Count	671	459	20	166	271,655	1,391,590
Life Stage						
Student[2]	32	43	1	14	56,959	110,305
Resident[2]	41	39	1	20	66,648	137,332
Young (Under age 40 or first eight years of practice) ^	47	60	0	16	26,156	217,953
Established (Age 40-64) ^	307	228	12	68	60,070	547,156
Senior (Age 65 or more)^	244	89	6	48	61,822	378,844
Present Employment						
Self-employed solo practice	87	44	4	17	18,275	114,866
Two physician practice	10	9	2	3	3,822	24,890
Group practice	280	173	8	56	65,113	558,755
Non-government hospital	41	30	1	7	8,478	59,952
State or local government hospital	69	40	1	18	10,605	87,872
HMO	5	6	0	1	613	2,301
Medical School	25	13	2	9	2,743	20,951
U.S. Government	22	19	0	4	2,508	24,069
Locum Tenens	3	0	0	0	430	2,786
Retired/Inactive	46	26	0	14	30,228	168,331
Resident/Intern/Fellow	41	39	1	20	66,648	137,332
Student	32	43	1	14	56,959	110,305
Other/Unknown	10	17	0	3	5,233	79,180
Self-designated specialty[3]						
Family Medicine	71	46	1	16	23,140	158,727
Internal Medicine	152	88	6	31	53,524	316,032
Surgery	148	82	8	28	36,344	186,535
Pediatrics	22	24	0	9	14,203	120,915
OB/GYN	44	28	1	22	13,636	64,059
Radiology	36	26	0	7	9,558	62,156
Psychiatry	28	20	1	10	11,301	72,180
Anesthesiology	23	18	1	6	10,521	69,030
Pathology	13	15	0	0	4,754	30,997
Other specialty	102	69	1	23	37,676	200,103
Student	32	43	1	14	56,998	110,856

[2] Students and residents are so categorized without regard to age.
[3] See Appendix B for a listing of specialty classifications.

^ Reflects section/group definition of its membership.

Table 5. Characteristics of Specialty Society Delegations[1]

	Mean Age	% Female	% IMG	% Resident
AMA Members (n =271,655)	47.0	38.0%	17.6%	24.5%
Specialty Society Delegates and Alternates (n =452)	54.4	35.0%	6.9%	4.0%
Family Medicine Delegations (n =31)	53.4	38.7%	9.7%	6.5%
Internal Medicine Delegations (n =100)	54.5	35.0%	11.0%	7.0%
Surgery Delegations (n =101)	57.6	15.8%	5.0%	1.0%
Pediatrics Delegations (n =14)	54.5	78.6%	0.0%	7.1%
OB/GYN Delegations (n =26)	57.3	65.4%	3.8%	0.0%
Radiology Delegations (n = 34)	53.7	29.4%	5.9%	8.8%
Psychiatry Delegations (n =23)	52.7	39.1%	4.3%	0.0%
Anesthesiology Delegations (n =16)	54.1	31.3%	12.5%	0.0%
Pathology Delegations (n =22)	53.7	36.4%	9.1%	0.0%
Other specialty Delegations (n =85)	51.2	41.2%	4.7%	4.7%

[1] See Appendix B for a listing of specialty classifications.

Table 6. Mean Age of AMA Members and Delegations by State

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Alabama	2,988	51.4	8	61.8
Alaska	368	55.2	3	*
Arizona	4,473	54.4	11	61.5
Arkansas	2,036	52.2	5	61.4
California	31,805	54.6	60	53.9
Colorado	4,306	52.7	9	55.6
Connecticut	3,246	52.9	8	67.4
Delaware	610	55.6	2	*
District of Columbia	2,020	45.6	4	55.3
Florida	15,328	55.9	31	59.3
Georgia	5,811	52.1	11	60.5
Guam	25	58.5	1	*
Hawaii	1,086	56.0	3	*
Idaho	602	55.8	2	*
Illinois	11,391	51.4	23	60.5
Indiana	4,826	51.8	10	60.2
Iowa	3,233	52.0	7	53.0
Kansas	1,834	52.5	7	63.7
Kentucky	3,797	51.3	11	57.6
Louisiana	5,597	49.9	8	53.8
Maine	1,237	54.3	3	*
Maryland	5,330	53.8	10	54.6
Massachusetts	12,209	50.7	20	56.5
Michigan	12,013	50.2	27	56.4
Minnesota	4,708	52.1	11	62.0
Mississippi	2,357	52.0	6	54.8
Missouri	5,187	48.4	10	60.2
Montana	705	56.3	2	*
Nebraska	1,736	48.7	4	49.0
Nevada	1,523	53.6	5	70.2
New Hampshire	871	54.3	2	*
New Jersey	7,934	54.4	17	64.3
New Mexico	1,112	55.3	4	58.0
New York	20,229	52.0	35	60.6
North Carolina	5,140	51.9	8	59.8
North Dakota	780	50.1	1	*
Ohio	10,697	50.6	22	53.4
Oklahoma	3,501	52.3	8	65.0
Oregon	2,385	54.3	5	59.2
Other	1,140	62.4	N/A	N/A
Pennsylvania	12,136	51.4	27	58.1
Puerto Rico	1,523	54.9	2	*
Rhode Island	985	50.4	5	59.0
South Carolina	4,111	51.3	10	61.5

* To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall total.

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
South Dakota	985	51.5	3	*
Tennessee	4,804	52.0	9	62.9
Texas	20,342	50.5	31	61.5
Utah	1,785	51.6	4	61.5
Vermont	424	52.8	2	*
Virgin Islands	33	64.8	0	N/A
Virginia	7,495	52.9	14	62.9
Washington	4,295	54.3	9	53.2
West Virginia	1,837	50.8	4	67.5
Wisconsin	4,511	52.4	9	63.2
Wyoming	213	58.2	2	*
TOTAL	271,655	53.1	555	59.1

Table 7. Women and International Medical Graduates on State Association Delegations

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	2,988	8	29.5%	0	11.5%	0
Alaska	368	3	37.2%	2	8.4%	0
Arizona	4,473	11	35.2%	2	15.0%	0
Arkansas	2,036	5	36.0%	1	12.1%	1
California	31,805	60	39.9%	15	17.8%	2
Colorado	4,306	9	40.2%	6	5.5%	0
Connecticut	3,246	8	39.6%	3	19.9%	1
Delaware	610	2	31.1%	2	22.1%	0
District of Columbia	2,020	4	50.4%	0	11.8%	0
Florida	15,328	31	33.3%	8	26.2%	4
Georgia	5,811	11	39.2%	2	16.6%	1
Guam	25	1	16.0%	0	44.0%	0
Hawaii	1,086	3	35.5%	1	12.8%	0
Idaho	602	2	23.3%	1	5.3%	0
Illinois	11,391	23	38.0%	7	23.0%	6
Indiana	4,826	10	33.2%	3	14.7%	2
Iowa	3,233	7	35.2%	2	18.1%	0
Kansas	1,834	7	30.8%	3	14.6%	1
Kentucky	3,797	11	35.4%	2	14.1%	0
Louisiana	5,597	8	40.8%	2	14.3%	1
Maine	1,237	3	43.9%	1	8.8%	0
Maryland	5,330	10	42.8%	6	22.0%	4
Massachusetts	12,209	20	46.6%	6	15.4%	1
Michigan	12,013	27	37.1%	8	20.4%	4
Minnesota	4,708	11	37.8%	4	12.6%	0
Mississippi	2,357	6	31.3%	3	7.7%	0
Missouri	5,187	10	36.8%	3	10.7%	2
Montana	705	2	38.6%	1	4.1%	0
Nebraska	1,736	4	38.0%	2	7.5%	0
Nevada	1,523	5	35.3%	1	17.5%	2
New Hampshire	871	2	35.2%	0	17.5%	0
New Jersey	7,934	17	36.9%	5	28.7%	3
New Mexico	1,112	4	37.9%	1	15.2%	0
New York	20,229	35	39.7%	5	27.4%	5
North Carolina	5,140	8	34.6%	4	12.4%	0
North Dakota	780	1	37.9%	1	17.3%	0
Ohio	10,697	22	38.3%	9	16.1%	1
Oklahoma	3,501	8	33.9%	1	11.2%	1
Oregon	2,385	5	35.8%	1	7.6%	0
Other	1,140	0	25.1%	0	41.4%	0
Pennsylvania	12,136	27	36.5%	6	16.2%	3
Puerto Rico	1,523	2	42.7%	0	20.3%	1
Rhode Island	985	5	41.9%	3	15.5%	0

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
South Carolina	4,111	10	40.0%	1	7.3%	0
South Dakota	985	3	34.5%	1	12.2%	0
Tennessee	4,804	9	34.1%	2	11.4%	2
Texas	20,342	31	39.4%	7	17.1%	2
Utah	1,785	4	27.7%	1	5.7%	0
Vermont	424	2	39.6%	1	6.6%	0
Virgin Islands	33	0	30.3%	0	42.4%	0
Virginia	7,495	14	41.2%	4	15.8%	1
Washington	4,295	9	36.8%	3	12.9%	1
West Virginia	1,837	4	36.1%	0	21.6%	0
Wisconsin	4,511	9	36.3%	3	16.0%	1
Wyoming	213	2	26.8%	0	10.3%	0
TOTAL	271,655	555	36.1%	156	16.0%	53

American Medical Association Councils, Sections and Special Groups

COUNCILS

- American Medical Political Action Committee
- Council on Constitution and Bylaws
- Council on Ethical and Judicial Affairs
- Council on Legislation
- Council on Long Range Planning and Development
- Council on Medical Education
- Council on Medical Service
- Council on Science and Public Health

SECTIONS

- Academic Physicians Section
- Integrated Physician Practice Section
- International Medical Graduates Section
- Medical Student Section
- Minority Affairs Section
- Organized Medical Staff Section
- Private Practice Physicians Section[2]
- Resident and Fellow Section
- Senior Physicians Section
- Young Physicians Section
- Women Physicians Section

SPECIAL GROUPS

- Advisory Committee on LGBTQ Issues

[2] The Private Practice Physicians Section was established during the Special Meeting of the House of Delegates in November 2020. Data for section leaders was therefore not included in this report.

APPENDIX B

Specialty classification using physicians' self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

REPORT OF THE SPEAKERS

Speakers' Report 1-JUN-21

Subject: Recommendations for Policy Reconciliation

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

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Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete."

Your Speakers present this report to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken at recent meetings of the House of Delegates. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to policy language will be made, additions are shown with underscore and deletions are shown with strikethrough.

RECOMMENDED RECONCILIATIONS

Policies to be rescinded in their entirety

The following directives will be rescinded in full, as the requested activity has been completed, with reports presented to the House of Delegates when required.

- D-65.988, "TIME'S UP Healthcare"
  Our AMA will evaluate the TIME'S UP Healthcare program and consider participation as a TIME'S UP partner in support of our mutual objectives to eliminate harassment and discrimination in medicine with report back at the 2019 Interim Meeting.

  Board of Trustees Report 16-I-19 provided the report, which concluded that "your Board of Trustees will work with the leadership of TIME'S UP Healthcare to specify the terms of a formal partnership that will enable our organizations to work together to advance gender equity in medicine." The policy will be rescinded.

- D-165.936, "Updated Study on Health Care Payment Models"
  Our AMA will research and analyze the benefits and difficulties of a variety of health care financing models, with consideration of the impact on economic and health outcomes and on health disparities and including information from domestic and international experiences.

  The Council on Medical Service authored Report 2-A-17, "Health Care Financing Models," fulfilling this directive, which will be rescinded.

- D-215.989, "Studying Hospital Incentives for Admission, Testing and Procedures"
  Our AMA will study the extent to which US hospitals interfere in physicians' independent exercise of medical judgment, including but not limited to the use of incentives for admissions, testing, and procedures.

  This policy will be rescinded, having been studied in Council on Medical Service Report 5-A-15, "Hospital Incentives for Admission, Testing and Procedures."

- D-230.984, "Hospital Closures and Physician Credentialing"
  1. Our AMA will develop model state legislation and regulations that would require hospitals to: (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files. 2. Our AMA will: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations, including tracking hospital closures, as well as how and where these closed hospitals are storing physician credentialing information; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information, and report back to the House of Delegates at the 2019 Interim Meeting.

  The model legislation called for in paragraph 1 has been prepared and is available from the Advocacy Resource Center, and your Board of Trustees presented Report 13-I-19 in fulfillment of paragraph 2 of the policy. The policy will be rescinded.

- D-285.964, "Physician Payment by Medicare"
  Our AMA will study the impact of hospital acquisition of physician practices on health care costs, patient access to health care and physician practice.

  This should be rescinded as the study was accomplished with Council on Medical Service Report 2-A-15, "Physician Payment by Medicare."

- D-305.954, "For-Profit Medical Schools or Colleges"
  Our AMA will study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (a) attrition rate of students; (b) financial burden of non-graduates versus graduates; (c) success of graduates in obtaining a residency position; and (d) level of support for graduate medical education; and report back at the 2019 Annual Meeting.

  This policy will be rescinded as the Council on Medical Education issued Report 1-I-19 in fulfillment of this directive.

- D-410.991, "Re-establishment of National Guideline Clearinghouse"
  Our AMA will research possible and existing alternatives for the functions of the National Guidelines Clearinghouse with a report back to the House of Delegates.

  The Board of Trustees presented report 11-I-19 in fulfillment of this request. The policy will be rescinded.

Policies to be rescinded in part

- H-85.952, "Advance Directives During Pregnancy"
  1. Our AMA vigorously affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship.
  2. Our AMA will promote awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics.
  3. Our AMA recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.
  ~~4. The Council on Ethical and Judicial Affairs will consider examining the issue of advance directives in pregnancy through an informational report.~~

  The Council on Ethical and Judicial Affairs reviewed ethics policy on advance care planning (Opinion 5.1), surrogate decision making (Opinion 2.1.2), and treatment at the end of life (Opinions 5.2, 5.3, 5.4, 5.5, and 5.6) and concluded that existing guidance is clear with respect to strong ethics practice regarding advance care planning and treatment decisions at the end of life. For this reason, Paragraph 4 of the policy will be rescinded.

- H-285.902, "Ban on Medicare Advantage "No Cause" Network Terminations"
  1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by: a. Requiring Medicare Advantage (MA) plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network; b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies; c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder; d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following: (i) civil monetary penalties; (ii) enrollment sanctions; or (iii) incorporating the accuracy score into the Stars rating for each plan; e. ~~Offering plans the option of using AMA/Lexis-Nexis VerifyHCP system to update provider directory information; f.~~ Requiring MA plans immediately remove from provider directories providers who no longer participate in their network.
  2. Our AMA urges CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by: a. Requiring plans to report the percentage of the physicians, broken down by specialty and subspecialty, in the network who actually provided services to plan members during the prior year; b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy; c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; d. Evaluating alternative/additional measures of adequacy.
  3. Our AMA urges CMS to ensure lists of contracted physicians are made more easily accessible by: a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form; b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. Our AMA urges CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: (i) the number of contracted physicians in each specialty and county; (ii) the extent to which a plan's network exceeds minimum standards in each specialty,

subspecialty, and county; and (iii) the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network.
4. Our AMA urges CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty and subspecialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder.
5. Our AMA urges CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website.
6. Our AMA urges CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force that includes multiple stakeholders including patients.
7. Our AMA urges CMS to ban "no cause" terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract with a MA plan.

Although the VerifyHCP product still exists, our AMA is no longer a partner, and AMA is no longer offering the product. For this reason, paragraph 1(e) of the policy will be rescinded, with any necessary renumbering accomplished editorially.

- D-383.978, "Restrictive Covenants of Large Health Care Systems"
  ~~1.~~ Our AMA, through its Organized Medical Staff Section, will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.
  ~~2. Our AMA will study the impact that restrictive covenants have across all practice settings, including but not limited to the effect on patient access to health care, the patient-physician relationship, and physician autonomy, with report back at the 2019 Interim Meeting.~~

  Board of Trustees Report 5-I-19 provided the study requested by paragraph 2 of the policy, so that portion of the policy will be rescinded.

Changes effected by the Speakers' Report do not reset the sunset clock for those items rescinded in part, and the changes are implemented upon filing of this report.

Fiscal Note: $500 to edit PolicyFinder