

## REPORTS OF THE BOARD OF TRUSTEES

The following reports were presented by Sandra Fryhofer, MD, Chair:

### 1. ANNUAL REPORT

*Reference committee hearing: see report of Reference Committee F.*

#### HOUSE ACTION: FILED

The Consolidated Financial Statements for the years ended December 31, 2022 and 2021 and the Independent Auditor's report have been included in a separate booklet, titled "2022 Annual Report." This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

### 2. NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

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

#### HOD ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

*See Policy 600.984*

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Academy of Addiction Psychiatry, American Society for Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion three. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by each organization's explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. These organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the November 2022 Interim Meeting indicated that the American Academy of Addiction Psychiatry, American Society for Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance meet the criteria for representation in the HOD.

#### RECOMMENDATION

Therefore, the Board of Trustees recommend that the American Academy of Addiction Psychiatry, American Society for Aesthetic Plastic Surgery, and the Society for Cardiovascular Magnetic Resonance be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

## APPENDIX

## Exhibit A - GUIDELINES FOR REPRESENTATION IN &amp; ADMISSION TO THE HOUSE OF DELEGATES:

National Medical Specialty Societies

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

## RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

1. To cooperate with the AMA in increasing its AMA membership.
2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.
3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.
4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.
5. To provide information and data to the AMA when requested.

*Exhibit B - Summary Membership Information*

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Addiction Psychiatry	384 of 1,127 (34%)
American Society for Aesthetic Plastic Surgery	359 of 1,691 (21%)
Society for Cardiovascular Magnetic Resonance	254 of 866 (30%)

### 3. 2022 GRANTS AND DONATIONS

*Informational report; no reference committee hearing.*

#### HOD ACTION: FILED

This informational financial report details all grants or donations received by the American Medical Association during 2022.

<b>American Medical Association Grants &amp; Donations Received by the AMA For the Year Ended December 31, 2022 Amounts in thousands</b>		
Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	\$ 202
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	314
Centers for Disease Control and Prevention	Improving Health Outcomes through Partnerships with Physicians to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats	477
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	897
Centers for Disease Control and Prevention	Promoting HIV, Viral Hepatitis, STDs, and LTBI Screening in Hospitals, Health Systems, and Other Healthcare Settings	246
Health Resources and Services Administration (subcontracted to AMA through American Heart Association, Inc.)	National Hypertension Control Initiative: Addressing Disparities Among Racial and Ethnic Minority Populations	549
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medicated Assisted Treatment	24
<b>Government Funding</b>		<b><u>2,709</u></b>
American Academy of Dermatology	2022 Annual Meeting of House of Delegates - Presidential Inauguration	15
American Association for the Advancement of Science	International Congress on Peer Review and Scientific Publication	3
American College of Physicians	International Congress on Peer Review and Scientific Publication	10
American Medical Association Foundation (via contribution from Daiichi Sankyo)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	9
American Medical Association Foundation (via contribution from Genentech)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	45
American Medical Association Foundation (via contribution from Pfizer Inc.)	Accelerating Change in Medical Education Conference co-sponsored by AMA and AMA Foundation	23
Massachusetts Medical Society	International Congress on Peer Review and Scientific Publication	20
The Physicians Foundation, Inc.	Practice Transformation Initiative: Solutions to Increase Joy in Medicine	3
<b>Nonprofit Contributors</b>		<b><u>128</u></b>

**American Medical Association  
Grants & Donations Received by the AMA  
For the Year Ended December 31, 2022  
Amounts in thousands**

Funding Institution	Project	Amount Received
Cabell Publishing Company	International Congress on Peer Review and Scientific Publication	10
Elsevier	International Congress on Peer Review and Scientific Publication	10
John Wiley & Sons, Inc.	International Congress on Peer Review and Scientific Publication	30
MPS Limited (formerly Highwire Press)	International Congress on Peer Review and Scientific Publication	10
Silverchair Science + Communications, Inc.	International Congress on Peer Review and Scientific Publication	10
Wolters Kluwer Health	International Congress on Peer Review and Scientific Publication	30
<b>Other Contributors</b>		<u><b>100</b></u>
<b>Total Grants and Donations</b>		<b>\$ <u>2,937</u></b>

#### 4. AMA 2024 DUES

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:      RECOMMENDATIONS ADOPTED  
REMAINDER OF REPORT FILED**

*See Policy G-635.130*

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

#### RECOMMENDATION

##### 2024 Membership Year

The Board of Trustees recommends no change to the dues levels for 2024, that the following be adopted and that the remainder of this report be filed:

Regular Members	\$ 420
Physicians in Their Fourth Year of Practice	\$ 315
Physicians in Their Third year of Practice	\$ 210
Physicians in Their Second Year of Practice	\$ 105
Physicians in Their First Year of Practice	\$ 60
Physicians in Military Service	\$ 280
Semi-Retired Physicians	\$ 210
Fully Retired Physicians	\$ 84
Physicians in Residency/Fellow Training	\$ 45
Medical Students	\$ 20

## 5. UPDATE ON CORPORATE RELATIONSHIPS

*Informational report; no reference committee hearing.*

**HOD ACTION: FILED**

### PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2022. 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 and 2022 Annual Meeting. AMA managers are responsible for reviewing AMA projects to ensure they fit within these guidelines.

### YEAR 2022 RESULTS

In 2022, 92 activities were considered and approved through the Corporate Review process. Of the 92 projects recommended for approval, 48 were conferences or events, 11 were educational content or grants, 27 were collaborations or affiliations, five were member programs, and one was an American Medical Association Foundation (AMAF) program. See Appendix B for details.

### 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 - Corporate Review Process Overview

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

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 in cases where 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 2022

##### CONFERENCE/EVENTS

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
18477	IAIME Annual Event 2022 - Exhibit – Sponsorship with AMA name and logo.	International Academy of Independent Medical Evaluators Veritas Association Management Axis Administration Services Independent Medical Transcription, Inc ABCDisability, Inc	01/11/2022
18380	WBL Annual Summit 2022 and 2023 - Repeat sponsorship with AMA name and logo.	Women Business Leaders Foundation AMGEN Anthem, Inc McKesson Tivity Health Epstein Becker Green MEDecision AMN Healthcare Aveus, LLC Johnson & Johnson West Monroe Common Spirit Newport Healthcare Progeny Health United Health Group AArete Consulting Healthcare Leadership Council Hello Heart MCG Health Mintz NTT Data	01/13/2022

		Tabula Rasa Healthcare Trustmark VillageMD	
18538	NHMA Virtual COVID-19 Briefing – Sponsorship of virtual event with AMA name and logo.	National Hispanic Medical Association George Mason University George Washington University Howard University Elizabeth Dole Foundation	01/14/2022
18470	March of Dimes Gala - Repeat sponsorship with AMA name and logo.	March of Dimes Samsung General Motors NACDS Foundation Proctor and Gamble Pampers Aflac American Beverage Association Volkswagen BNSF Railway Rocket Mortgage	01/19/2022
18460	ViVE 2022 Conference - Sponsorship with AMA name and logo.	ViVE College of Healthcare Information Management Executives HLTH	01/26/2022
18698	National Press Club Event featuring Dr. Harmon – Sponsorship with AMA name and logo.	National Press Club	02/03/2022
18691	HIMSS Annual Conference – Repeat sponsorship with AMA and CPT name and logo.	Health Information and Management Systems Society Premier, Inc Seal Shield Athenahealth Symplr ZS Consulting Guidehouse Vyaire Coding Services Group Masimo Red Hat	02/09/2022
18980	Third Horizon Strategies International Women’s Day Forum – Sponsorship with AMA name and logo.	Third Horizon Strategies MATTER Chicago Alight Solutions	03/02/2022
18987	NHIT Summit – Sponsorship with AMA name and logo.	National Health IT Collaborative for the Underserved Sanitas Medical Center hims&hers DocuSign Health Innovation Alliance	03/04/2022
18968	NHMA Conference – Sponsorship with AMA name and logo.	National Hispanic Medical Association Centene Corporation Abbott Laboratories Davita Pfizer Johnson & Johnson Genentech	03/11/2022

		Eli Lilly and Company Vertex PhRMA Sanofi Travere NovoNordisk Orasure Technologies, Inc. Orlando Health Med Group Planned Parenthood Action Fund Sentara Healthcare Penn State Health	
19058	National Rx Drug Abuse and Heroin Summit – Repeat sponsorship with AMA name and logo.	HMP Global Psychiatry and Behavioral Health Learning Network Operation Unite University of Kentucky Northern Kentucky University Bamboo Health Detera RTI International Advantage EMS World Georgia Department of Behavioral and Development Disabilities NASA DAD – National Association of State Alcohol and Drug Abuse Directors SAM – Smart Approaches to Marijuana PROUD – Peers in Recovery from Opioid Use and Dependence PTACC – Police, Treatment and Community Collaborative R2ISE Recovery	03/21/2022
19112	AAPC HEALTHCON 2022 – US and International – Repeat sponsorship with AMA name and logo.	American Academy of Professional Coders AHA Coding Clinic HC Pro Charter Oak State College Foresee Medical GHR RevCycle Workforce MidOcean Partners MediCodio OS2 Healthcare Solutions Unify Healthcare Services	03/23/2022
19202	Credentialing State Shows – Repeat sponsorship with AMA name and logo.	Illinois Association of Medical Staff Services Texas Society for Medical Services Specialists Florida Association of Medical Staff Services California Association of Medical Services Specialists MD Staff ABMS Solutions Hardenbergh Group MD Review AMN Healthcare/Silversheet VerityStream PreCheck NAMSS PASS Edge-U-Cate SkillSurvey	04/01/2022



19263	AMA 20 <sup>th</sup> Annual Research Challenge – AMA branded competition repeat event with Laurel Road sponsored prize.	Laurel Road Bank	04/13/2022
19267	AMA Release the Pressure (RTP) and AKA Derby Day Scholarship Brunch – Sponsorship of AKA -hosted event.	AKA Sorority Eta Omega Chapter Weight Watchers Ad Council Ebony iHeartRadio Hortense B. Perry Foundation Weight Watchers Fashion Fair Tgin Auda.B Henry Schein	04/14/2022
19259	ATA Conference and Expo – Repeat sponsorship with AMA name and logo.	American Telemedicine Association AliveCor BioIntelliSense Pexip Health Northeast Telehealth Resource Center Optum eDevice ATA Action	04/15/2022
19247	AHCJ Conference – Sponsorship with AMA name and logo.	Association of Healthcare Journalists Nixon Peabody InterSystems HCA Healthcare Meadows Mental Health Policy Institute St. David’s Foundation Arnold Ventures Robert Wood Johnson Foundation Leona and Harry Helmsley Trust Gordon and Betty Moore Foundation The Commonwealth Fund Episcopal Health Foundation The Kresge Foundation Pcori The Pew Charitable Trust John A. Hartford Foundation Mayo Clinic NYS Health Foundation Health Foundation for Western and Central New York California Health Care Foundation The Colorado Health Foundation Milbank Memorial Fund Missouri Foundation for Health Rhode Island Foundation Burroughs Wellcome Fund	04/19/2022
19428	Rush University Medical Center – West Side Walk for Wellness – Repeat sponsorship with AMA name and logo.	Rush Health Blue Cross and Blue Shield of Illinois	05/02/2022

19250	Social Innovation Summit – Presenting sponsorship with AMA and AMAF names and logos.	Landmark Ventures	05/10/2022
19647	NLGJA Annual Convention – Repeat sponsorship with AMA name and logo.	National Lesbian and Gay Journalists Association The Association of LGBTQ Journalists	05/23/2022
19649	Modern Healthcare’s Annual Virtual Briefing – Repeat sponsorship with AMA name and logo.	Crain Communications Modern Healthcare Digital Magazine	06/01/2022
19699	Black Men in White Coats Summit – Repeat sponsorship with AMA name and logo.	Black Men in White Coats American Association of Colleges of Osteopathic Medicine Health & Medicine Policy Research Group Chicago Area Health Education Center	06/02/2022
19647	NABJ/NAHJ Annual Convention – Repeat sponsorship with AMA name and logo.	National Association of Black Journalists National Association of Hispanic Journalists	06/03/2022
19743	Becker’s Collaborations - Repeat sponsorship of CEO and CFO Roundtable, Annual Meeting, and webinar collaboration with Becker’s with AMA name and logo.	Becker’s Hospital Review ASC Communications LLC	06/07/2022
19648	MVJ Annual Convention – Repeat sponsorship with AMA name and logo.	Military Veterans in Journalism CNN The Washington Post Fox News NBC U.S. Veterans Magazine DAV (Disabled American Veterans) The Lenfest Institute John S. Knight Program Facebook With Honor Action Wyncote Foundation Knight Foundation Wall Street Journal Google News Initiative	06/30/2022
19848	NAMSS – Annual Virtual Conference - Repeat sponsorship with AMA name and logo.	National Association of Medical Staff Services ABMS Solutions American Board of Physician Specialties CIMRO Quality Healthcare Solutions DecisionHealth MD-Staff Medallion National Commission on Certification of Physician Assistants PBI Education PreCheck QGenda RLDatix Silversheet Symplr The Greeley Company	06/30/2022

		The Hardenbergh Group UC San Diego PACE Program VerityStream	
19919	SNOMED CT Virtual Expo 2022 – Repeat sponsorship of virtual event with AMA name and logo.	Systemized Nomenclature of Medicine (SNOMED) West Coast Informatics Meridian DLT Unai Software Consultants ERMLEX The Phoenix Partnership PHAST (France) VIDAL Group Conteir.no (Norway)	07/07/2022
19970	Genetic Health Information Network Summit 2022 – Repeat sponsorship of virtual event with AMA name and logo.	Genetic Health Information Network Concert Genetics Illumina Genome Medical	07/12/2022
20075	NMA Annual Convention and Scientific Assembly – Sponsorship with AMA name and logo.	National Medical Association Council on Concerns of Women Physicians (CCWP) American College of Rheumatology The Lupus Initiative	07/19/2022
20209	IAIABC Forum 2022 – Repeat sponsorship with AMA name and logo.	Industrial Association of Industrial Accident Boards and Commissions National Council on Compensation Insurance Optum Sedgwick The Black Car Fund Concentra Aerie EDI Group Safety National Healthsystems ODG by MCG Health Enlyte SFM Mutual Insurance Ebix Insurance Software Verisk HealthTech, Inc Rising Medical Solutions	08/10/2022
20246	SAWCA All Committee Conference – Repeat sponsorship with AMA name and logo.	Southern Association of Workers' Compensation Administrators Verisk National Council on Compensation Insurance Safety National Optum	08/16/2022
19989	Northwestern University Third Coast Augmented Intelligence (AI) Health Bowl – Student competition sponsorship with AMA name and logo.	3rd Coast AI for Health Bowl Vizient Health Highmark Health Leap of Faith Technologies	08/19/2022
20375	CFHA Annual Integrated Care Conference – Sponsorship with AMA name and logo.	Collaborative Family Healthcare Association Cambia Health Solutions Elevance Health	08/30/2022

		Merakey Mid-American Mental Health Technology Transfer Center Mayo Clinic - National Center for Integrated Behavioral Health Comagine Health Health Federation of Philadelphia National Register of Health Service Psychologists	
20400	TeleHealth Academy 2022 – Repeat sponsorship with AMA name and logo.	Nashville Entrepreneur Center eVISIT NTT DATA Best Buy Health Akin Gump LLP LBMC Accounting TeleHealth Solutions Sage Growth Partners North Highland	08/31/2022
20411	Nourishing Hope -Fighting Hunger Feeding Hope Annual Event – Repeat sponsorship with AMA name and logo.	The Feinberg Foundation Northwestern School of Medicine Allstate Donald R. Wilson Jr (DRW) Venture Capital Kovitz Wealth Management Huntington Bank Purposeful Wealth Advisors Barack Ferrazzano LLP Saul Ewing, Arnstein and Lehr	09/01/2022
20431	ATA Telehealth Awareness Week – Repeat co-hosted webinar with AMA name and logo.	The American Telemedicine Association	09/02/2022
20388	West Side United Media Event – Event to announce sponsorship with AMA name and logo.	West Side United City Club of Chicago The Hatchery Allies for Community Business Rush Hospital Lurie Children’s Hospital Northern Trust Lawndale Christian Development Corporation	09/08/2022
20465	GCC eHealth Workforce Development Conference 2022 – Repeat sponsorship with AMA name and logo.	Gulf Cooperation Council UAE Cyber Security Council American Health Information Management Association (AHIMA) Infermedica Orion Health Philips Corporation Malaffi	09/08/2022
20507	NMF Gratitude Gala – Sponsorship with AMA name and logo.	National Medical Fellowships Cedars – Sinai Hospital Dana-Farber Cancer Institute Public Service Electric and Gas CO Association of American Medical Colleges (AAMC) Merck Don Levin Trust Mayo Clinic	09/12/2022

20630	HLTH 2022 Innovation Sponsorship Program – Sponsorship with AMA name and logo.	HLTH LLC	09/28/2022
20703	29 <sup>th</sup> Annual Princeton Conference – Repeat sponsorship with AMA name and logo.	AARP Arnold Ventures Blue Cross Blue Shield of Massachusetts Foundation Blue Shield of California Booz Allen Hamilton California Health Benefits Review Program California Health Care Foundation Jewish Healthcare Foundation MAXIMUS Peterson Center on Healthcare The Health Industry Forum The John A. Hartford Foundation	09/30/2022
20735	Alliance for Health Policy Dinner – Repeat sponsorship with AMA name and logo.	Blue Cross Blue Shield Association Elevance Health Kaiser Permanente Otsuka Pharmaceutical Premier Health Welsh, Carson, Anderson, and Stowe	10/03/2022
20699	Greater Chicago - Leadership Series – Sponsorship of leadership development series with AMA name and logo.	Leadership Greater Chicago Northern Trust Health Care Service Corporation First Midwest Bank Price Waterhouse Cooper William Blair JP Morgan Chase & Company FHLBank Chicago Slalom Blue Cross Blue Shield of Illinois ComED AON BMO Harris Bank Allstate MacArthur Foundation Nicor Gas	10/06/2022
20783	IHI Forum 2022 – Sponsorship with AMA name and logo.	Institute for Healthcare Improvement Ethicon Digital Solutions Johnson & Johnson Exact Science Corporation GOJO Industries Gordon and Betty Moore Foundation Healthgrades Michigan Hospital Association Minitab Statistical Software Novartis Premier Healthcare Alliance Riskconnect, Inc Software John A. Hartford Foundation Vizient	10/27/2022

21140	“The Color of Care” Screening – Co-host screening with AMA name and logo at HLTH conference.	HLTH LLC Cityblock Health Health Tech 4 Medicaid	11/01/2022
21350	Managing the EHR Inbox Conference – Sponsorship with AMA name and logo.	University of California - San Francisco The Doctor’s Company The Women’s College Hospital at University of Toronto	11/21/2022
21400	Primary Care Collaborative: “Better Health: Block by Block” Conference – Sponsorship with AMA name and logo.	University of Pittsburgh Medical Center (UPMC) Blue Shield of California American Psychological Association American Academy of Physician Assistants (AAPA) Elevance Health Johnson & Johnson Blue Cross Blue Shield Michigan GTMRx (Get the Medications Right) Institute American Association of Retired Persons (AARP) CVS	11/23/2022
21693	The ROCS Foundation’s Health Summit at Sundance – Sponsorship with AMA name and logo.	The Jewish Healthcare Foundation Pittsburgh Regional Health Initiative (PRHI) Health Careers Futures (HCF) Women's Health Activist Movement Global (WHAM Global) The John A. Hartford Foundation Center for Health Incentives and Behavioral Economics (CHIBE) - Penn Medicine	12/13/2022

## EDUCATIONAL CONTENT OR GRANT

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
18088	Becker's Whitepaper – AMA co-branding and sponsorship of white paper.	Becker’s Hospital Review	01/20/2022
18667	Clinical Problem Solvers – Educational Series – AMA EdHub hosted podcasts with AMA name and logo.	The Clinical Problem Solvers	02/07/2022
18767	Return on Health Report – Repeat project for co-branded white paper on findings for behavioral health integration.	Manatt Health - Manatt, Phelps & Phillips, LLP	02/10/2022
18850	Mary Ann Liebert Journal Articles – AMA EdHub co-branded collaboration on women’s healthcare.	Mary Ann Liebert Inc	02/28/2022
17629	Abu Dhabi Department of Health – AMA and CPT logos featured in customer case study.	Department of Health – Abu Dhabi Malaffi Health - Information Exchange Muashir	03/11/2022
19206	Edge-U-Cate Credentialing School Sponsorship – Repeat sponsorship with AMA name and logo.	Edge-U-Cate ABMS Solutions Certi-Facts American Osteopathic Information Association Symplr Morisey Associates	04/06/2022

19464	“The Value of Telehealth Amongst Specific Clinical Use Cases” – Co-branded white paper with AMA name and logo.	Laurel Health Advisors LLC	05/05/2022
19643	Medical News Literacy Project – Literacy content for K-12 students with AMA name and logo.	News Literacy Project Checkology	05/25/2022
19950	ScholarRx Proof of Concept (POC) Project – Co-branded AMA content for ScholarRx platform.	ScholarRx	07/15/2022
20245	Future of Health Research – Co-branded white paper on value of virtual healthcare.	Manatt Health - Manatt, Phelps & Phillips, LLP	08/23/2022
21505	Opioid Overdose Epidemic Project – Research on best practice policies to help end overdose epidemic, with AMA name and logo.	Manatt Health - Manatt, Phelps & Phillips, LLP	11/15/2022

## Collaborations/Affiliations

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
18945	Advancing Equity through Quality and Safety Peer Network – Collaboration to advance equity in healthcare organizations with AMA name and logo.	The Joint Commission Brigham and Women’s Hospital Atlantic Health System University of Iowa Hospitals MD Anderson Cancer Center Ochsner Health The Children’s Hospital of Philadelphia Vanderbilt University Medical Center Dana-Farber Cancer Institute University of Wisconsin Hospitals and Clinics	03/01/2022
18482	Telehealth Access for America Campaign – AMA name and logo use for campaign on permanent approval of Medicare coverage for telehealth.	Telehealth Access for America American Hospital Association AARP American Heart Association American Telemedicine Association Adventist Health Policy Association Consumer Technology Association Athena Health, Executives for Health Innovation Teladoc Health Alliance for Connected Care Partnership to Advance Virtual Care Ascension Johns Hopkins Medicine Included Health	01/12/2022 0
18132	Providers Clinical Support System Collaboration – Co-branded materials for healthcare providers on treating Opioid Use Disorder (OUD).	Minnesota Medical Association Providers Clinical Support System	1/17/2022
18552	DirectTrust Membership Program - Membership with AMA name and logo.	DirectTrust Information Exchange for Human Services (IX4HS) Consensus Body	01/18/2022

19912	MAP Dashboards for HCOs – Repeat AMA co-branding with healthcare organizations for MAP blood pressure dashboard project.	LifeCare Value Network LifeCare Oklahoma LifeCare Ascension	07/06/2022
18857	All In Campaign – Repeat healthcare workforce wellbeing campaign with AMA name and logo.	Dr. Lorna Breen Heroes Foundation Thrive Global Foundation CAA Foundation American Association of Colleges of Nursing American College of Emergency Physicians American Hospital Association American Nurse Foundation Collaborative for Health and Renewal in Medicine Johnson & Johnson Center for Health Worker Innovation Medicine Forward National Black Nurses Association Philippines Nurses Association of America Schwartz Center for Compassionate Care The Physicians Foundation	02/22/2022
18934	Collaborative for Health and Renewal in Medicine (CHARM) - Charter committed to reducing healthcare worker burnout with AMA name and logo.	Arnold P. Gold Foundation Associate Ophthalmologists Atlantic Medical Group Cleveland Clinic Florida Edward-Elmhurst Healthcare Gillette Children's Specialty Healthcare Hartford Healthcare Huntington Hospital Lehigh Valley Health Network Mountain Area Health Education Center Moffitt Cancer Center Nemours Children's Health System NYU Langone Hospital Penn Medical Lancaster General Health Saint Francis Hospital Tulane University School of Medicine University of Florida College of Medicine University of Washington School of Medicine VITAL Worklife	03/01/2022
20181	AMA Grand Rounds – Webinar series on health equity supported by collaborators/sponsors with AMA name and logo.	Accreditation Council for Graduate Medical Education National Center for Interprofessional Practice Education American Society of Addiction Medicine Sinai Chicago Boston Medical Center HealthBegins Accreditation Council for Continuing Medical Education Rush University Medical Center RespectAbility American Board of Internal Medicine Foundation The Hastings Center Council of Medical Specialty Societies	08/08/2022



19225	Rise to Health Coalition – Co-branded coalition to embed equity in healthcare including toolkits, webinars and guides for healthcare professionals.	Institute for Healthcare Improvement (IHI) Race Forward Groundwater Institute PolicyLink HealthBegins American Health Insurance Plans (AHIP) Council of Medical Specialty Societies (CMSS) National Association of Community Health Centers (NACHC)	04/14/2022
19102	Axual Credentialing – Credentialing platform partnership with AMA name and logo.	Axual	03/28/2022
19195	Prime Health – Additional collaborator for “In Full Health” equitable innovation project.	Prime Health	03/30/2022
19214	Rock Health – Repeat annual sponsorship with AMA name and logo.	Rock Health Fenwick and West Law Firm Amazon Web Services (AWS) Morgan Stanley Goldman Sachs Myovant Russell Reynolds	04/08/2022
19698	“The Color of Care” Documentary Medical Advisory Board – Participation on advisory board with AMA name and logo.	Dr. Ala Stanford Center for Health Equity Black Doctors COVID-19 Consortium Atlantic Health System	06/07/2022
19964	Joy in Medicine – Repeat AMA recognition program for outstanding healthcare organizations.	Baylor Scott & White – The Heart Hospital Boston Children's Pediatric Physicians' Organization Centura Health Edward-Elmhurst Health Gillette Children's Specialty Healthcare Hartford HealthCare Moffitt Cancer Center MultiCare Health System Nemours Children's Health Samaritan Health Services Sea Mar Community Health Centers The Christ Hospital Health Network The Permanente Medical Group Cleveland Clinic Oak Street Health Cooper University Health Care Johns Hopkins Medicine Medical College of Wisconsin, Froedtert Children's Hospital Northwell Health Physician Partners Penn Medicine Lancaster General Health Temple University Health System Tulane University School of Medicine UMass Memorial Health UCI Health University of Mississippi Medical Center University of New Mexico School of Medicine UW Medicine   Valley Medical Center	07/07/2022

19931	AMA/Ad Council Flu Vaccine Campaign – Co-branded public awareness campaign.	Ad Council	07/11/2022
19695	Frontline Physician and Nurses Documentary Series – Documentary series with AMA name and logo.	Afropunk National Medical Association	07/13/2022
20054	Health IT End User Alliance – Collaboration focusing healthcare IT principles on patient and care team needs with AMA name and logo.	American Health Information Management Association American Academy of Family Physicians American College of Physicians American College of Surgeons American Medical Group Association Federation of American Hospitals Medical Group Management Association Oregon Community Health Information Network Premier, Inc. Sutter Health Wisconsin Hospital Association	07/20/2022
20506	National Health IT Collaborative (NHIT) for the Underserved – Sponsorship with AMA name and logo.	Gordon and Betty Moore Foundation Multicultural Media Telecom and Internet Council Wiley Law Mass General Brigham Puerto Rican Primary Care Association Network Association of Clinics for the Underserved AmeriHealth Visionary Consulting Partners Acacia Network National Association of Community Health Centers MITRE Corporation Infor Software NextGen Alliance Chicago Tyler Technologies Health Choice Network CCI Center for Civic Innovations Visualutions Keralty Tracfone Wireless Summit Health Institute for Research and Education CIMIT Point of Care Technology in Primary Care RCHN Community Health Foundation	09/14/2022
20571	Alternative Payment Models (APMs) White Paper – Tri-branded white paper to advance the adoption of APMs with AMA name and logo.	America’s Health Insurance Plans National Association of Accountable Care Organizations Manatt Health HMA-Leavitt Aurrera Health Bailit Health	09/20/2022

20652	DTA Webinar - AMA-hosted CPT webinar.	Digital Therapeutics Alliance	09/22/2022
20687	National Academy of Medicine (NAM) Well-Being Collaborative – Sponsorship with AMA name and logo.	Alliance of Independent Academic Medical Centers ChristianaCare CRICO LCMC Health National Quality Forum RENEW Patient Advocate Foundation UAB Medicine UnitedHealth Group	09/29/2022
20788	Alternative Payment Models (APMs) Coalition – Advocacy and Awareness program to advance the adoption of APMs with AMA name and logo.	National Association of Accountable Care Organizations Healthcare Transformation Task Force Premier, Inc.	10/11/2022
20976	Chicago Area Public Affairs Group – Repeat sponsorship with AMA name and logo.	Chicago Area Public Affairs Group	11/10/2022
21427	National Academy of Medicine (NAM) Action Collaborative – Sponsorship of stakeholder meeting series.	Joint Commission American Association of Critical-Care Nurses Johns Hopkins Medical College of Wisconsin UnitedHealth Group Cedars-Sinai American Dental Education Association	11/28/2022
21458	SAWCA – Repeat sponsorship with AMA name and logo.	Southern Association of Workers Compensation Administrators National Council on Compensation Insurance Optum Sedgwick	11/30/2022
21660	The Gravity Project – AMA co-hosted CPT webinar with name and logo.	HL7 Fast Healthcare Interoperability Resources HL7 Fast Healthcare Interoperability Resources Foundation US Core Data for Interoperability (USCDI) Logical Observation Identifiers Names and Codes (LOINC) International Classification of Diseases (ICD – 10) SNOMED CT National Library of Medicine	12/05/2022

## MEMBER PROGRAMS

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
18311	Laurel Road Perks Program – Laurel Road Affinity Program with AMA name and logo.	Laurel Road Bank Brooklinen Sakara P.volve Getaway Kidpass The White Coat Investor Task Rabbit Lyft	01/27/2022
20380	UWorld – Medical Student Outreach Program (MSOP) test prep incentive partner with AMA name and logo.	UWorld	08/29/2022
20736	GradFin Affinity Program – Laurel Road Bank subsidiary added to AMA member benefit program with AMA name and logo.	Laurel Road Bank GradFin	10/17/2022
20729	Mercedes-Benz Affinity Program - Automobile member benefit program with AMA name and logo.	Mercedes Benz	10/14/2022
	AMA Insurance Agency Medical Malpractice Insurance Program – Co-branded medical malpractice insurance program with AMAIA name and logo.	Indigo Concert Group	12/02/2022

## AMA FOUNDATION

<u>Project No.</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
	AMA Foundation Corporate Donors – AMAF name and logo association with 2022 corporate donors.	Amgen Bristol Myers Squibb Eli Lilly Genentech GlaxoSmithKline Grail Henry Schein Merck Novartis Pfizer PhRMA Sanofi	08/29/2022

**6. REDEFINING AMA’S POSITION ON ACA AND HEALTHCARE REFORM**

*Informational report; no reference committee hearing.*

**HOUSE ACTION: FILED**

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, “Redefining AMA’s Position on ACA and Healthcare Reform,” which calls 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 also calls 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 [“2022 and Beyond: AMA’s Plan to Cover the Uninsured.”](#) The COVID-19 pandemic initially led to many people losing their employer-based health insurance. This only increased the need for significant improvements to the Affordable Care Act. Recent data indicate that the uninsured rate has decreased during the COVID-19 pandemic, due to the temporary ACA improvements included in the American Rescue Plan Act, continuous Medicaid enrollment, and state Medicaid expansions.

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 for 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 that is inversely related to income, as well as the current 3:1 age rating ratio.
- Our AMA is also advocating for an expansion of the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

### Cover Uninsured Eligible for Medicaid or Children’s Health Insurance Program

Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or the 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, including auto enrollment.
- Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA believes that Medicaid work requirements would negatively affect access to care and lead to significant negative consequences for individuals’ health and well-being.

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

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.
- Our AMA strongly advocated for the Internal Revenue Service (IRS) proposed regulation on April 7, 2022 that would fix the so-called “family glitch” under the ACA, whereby families of workers remain ineligible for subsidized ACA marketplace coverage even though they face unaffordable premiums for health insurance coverage offered through employers. The proposed regulation would fix the family glitch by extending eligibility for ACA financial assistance to only the family members of workers who are not offered affordable job-based family coverage. The Biden Administration finalized the proposed rule on October 13, 2022.

### 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.

New policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist more than two million nonelderly uninsured individuals who fall into the “coverage gap” in states that have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains that coverage should be extended to these individuals at little or no cost, and further specifies that states that have already expanded Medicaid coverage should receive additional incentives to maintain that status going forward.

### AMERICAN RESCUE PLAN OF 2021

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

- Provide a temporary (two-year) 5 percent increase in the Federal Medical Assistance Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act’s 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 FPL for 2021 and 2022.
- Give an option for states to provide 12-month postpartum coverage under State Medicaid and CHIP.

ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA, eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, “Improving Affordability in the Health Insurance Exchanges,” ARPA eliminated ACA’s subsidy “cliff” for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL (\$51,520 for an individual

and \$106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.83 percent of income in 2021.

Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for two years, lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second lowest-cost silver) plan. Premiums of the second lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. Notably, resulting from the changes, eligible individuals and families with incomes between 100 and 150 percent of the FPL (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022.

In addition, 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 reduces their deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts.

#### LEGISLATIVE EXTENSION OF ARPA PROVISIONS

On August 16, 2022, President Biden signed into law the Inflation Reduction Act of 2022 through the highly partisan budget reconciliation process, which allows both the House and Senate to pass the bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to bypass the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of budgetary requirements. The Inflation Reduction Act included provisions that extended for three years to 2025 the aforementioned ACA premium subsidies authorized in ARPA.

The Inflation Reduction Act did not include provisions to close the Medicaid “coverage gap” in the states that have not chosen to expand.

#### ACA ENROLLMENT

According to the U.S. Department of Health and Human Services (HHS), 16.3 million Americans have signed up for or were automatically re-enrolled in the 2023 individual market health insurance coverage through the marketplaces since the start of the 2022 Marketplace Open Enrollment Period (OEP) on November 1, 2022, through January 15, 2023.

#### 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 was expected before June 2021. The AMA filed an amicus brief in support of the Act and the petitioners in this case.

On February 10, 2021, the U.S. 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 pointed 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.

On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the individuals challenging the law have a legal standing to sue. The Court did not touch on the larger issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress eliminated the penalty for failing to obtain health insurance.

With its legal status now affirmed by three Supreme Court decisions, and provisions such as coverage for preventive services and pre-existing conditions woven into the fabric of U.S. health care, the risk of future lawsuits succeeding in overturning the ACA is significantly diminished.

#### *BRAIDWOOD MANAGEMENT VS. BECCERRA* FEDERAL COURT CASE

A case before a federal district court judge in the Northern District of Texas, *Braidwood v. Becerra* (formerly *Kelley v. Becerra*), would eliminate the ACA requirement that most health insurance plans cover preventive services without copayments. Those filing the case object to paying for coverage that they do not want or need, particularly for those items or services that violate their religious beliefs, such as contraception or PrEP drugs. If the case is ultimately successful, health plan enrollees will also lose access to full coverage for dozens of preventive health services, including vaccinations and screenings for breast cancer, colorectal cancer, cervical cancer, heart disease, and other diseases and medical conditions.

The AMA and 61 national physician specialty organizations issued a joint statement on July 25, 2022, sounding the alarm about the millions of privately insured patients who would be affected by an adverse ruling.

On September 7, 2022, Texas federal court judge Reed O'Connor ruled that part of the ACA's requirement that health plans cover preventive services without copayments was unconstitutional. He further held that that one of the plaintiffs, Braidwood Management, a for-profit company, could not be required to cover PrEP through its employer health plan because of Braidwood's religious objections. Judge O'Connor did not immediately issue an order blocking enforcement of the coverage requirements. He also did not specify whether such an order would be nationwide, for his district only, for all the named plaintiffs, or only for Braidwood. These issues were held for further argument before Judge O'Connor.

On November 30, 2022, the Litigation Center of the American Medical Association and State Medical Societies, along with the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Family Physicians, and four other national associations filed an amicus brief warning against the court ordering broad, nationwide relief, arguing that such a decision would imperil access to vital preventive care that keeps patients healthier and lowers overall costs for the health care system.

On March 30, 2023, after supplemental briefing from the parties and *amici*, the federal district court issued its opinion and order addressing the remedies and final judgment. Most notably, the court ordered that all actions taken by HHS to implement or enforce the preventive care coverage requirements in response to an "A" or "B" recommendation by the U.S. Preventive Services Task Force on or after March 23, 2010 are vacated and enjoined going forward. The court also ordered that the named plaintiffs need not comply with the PrEP mandate, based on the court's prior ruling that the PrEP mandate violates the plaintiffs' rights under the Religious Freedom Restoration Act. On March 31, the federal government filed its notice of appeal, and the litigation will continue.

In a statement following the ruling, AMA President Jack Resneck, Jr., M.D., expressed alarm at the ruling and urged employers and insurers to maintain this first dollar coverage while legislative and judicial next steps are considered.

#### 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.

The AMA is now working on unrelated new Medicare payment reduction threats and is currently advocating for a sustainable, inflation-based, automatic positive update system for physicians.

#### INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

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



## CONCLUSION

Our American Medical Association 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. Given that most of the ACA fixes that led to calls in 2013 for this report at every HOD meeting have been accomplished, our primary goal now related to health care reform is stabilization of the broken Medicare physician payment system, including the need for inflation-based positive annual updates and reform of budget neutrality rules.

## 7. AMA PERFORMANCE, ACTIVITIES, AND STATUS IN 2022

*Informational report; no reference committee hearing.*

### HOUSE ACTION: FILED

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

### INTRODUCTION

The AMA’s mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extend across all physicians, as well as policymakers, medical schools, and health care leaders, the AMA uniquely can deliver results and initiatives that enable physicians to improve the health of the nation.

#### *Representing physicians with a unified voice*

In a year that marked the organization’s 175<sup>th</sup> anniversary, the AMA launched the Recovery Plan for America’s Physicians, a five-point strategy to support and strengthen our nation’s physician workforce. The plan was introduced at the Annual Meeting of the AMA House of Delegates in June 2022. The five objectives of the plan focus on prior authorization, Medicare payment reform, scope of practice creep, physician burnout and telehealth.

The AMA has been leading a multiyear effort to bring about Medicare payment models that give physicians greater flexibility in care delivery, minimize administrative burdens that detract from patient care, and improve the financial viability of physician practices. In 2022, we led a robust advocacy campaign that was joined by more than 150 organizations representing more than 1 million physicians that minimized the 8.5% Medicare physician payment cuts slated for 2023. In addition, AMA advocacy efforts helped secure a two-year postponement of the 4% cuts from the pay-as-you-go sequester tied to the American Rescue Plan Act

The AMA scored more than 40 state-level victories by working in partnership with state medical associations and national medical specialty societies. Pressing the fight for patient safety, we stopped bills that would have expanded the scope of practice for nurse practitioners and other APRNs, helped defeat legislation nationwide that would have allowed physician assistants to practice independently without physician oversight, and turned away measures allowing pharmacists to prescribe medications and optometrists to perform surgery.

The AMA continues to aggressively urge the Department of Veterans Affairs to reject the inappropriate scope of practice expansions outlined in the Federal Supremacy Project while advocating as strongly as ever in favor of physician-led teams and against improper scope expansions in all 50 states and the District of Columbia.

In cases ranging from COVID-19 standards of care and firearm regulations to climate change and transgender rights, the AMA continued to fight for physicians and patients in state and federal courts in 2022. The AMA was a plaintiff in *African American Tobacco Control Leadership Council v. HHS*, which forced the federal government to take the first steps toward banning menthol cigarettes. And in the wake of the U.S. Supreme Court’s *Dobbs v. Jackson Women’s Health Organization* decision, the AMA joined numerous briefs outlining the need for access to reproductive care and opposing third-party interference in the patient-physician relationship.

The AMA elevated the voice of physician leadership on critical issues of public health, securing more than 175 billion media impressions representing nearly \$1.6 billion in estimated ad value and achieving a commanding 43 percent share of voice among healthcare entities in the media.

#### *Removing obstacles that interfere with patient care*

The Improving Seniors' Timely Access to Care Act, the bipartisan effort to ease prior authorization burdens under the Medicare Advantage program, garnered 326 co-sponsors before it was passed by the U.S. House of Representatives in September. Its provisions were developed from the consensus statement on prior authorization reform that the AMA helped draft.

The AMA represented the interests of physicians in a federal regulatory task force exploring methods to streamline the prior authorization process. The AMA also played a key role in the successful adoption of prior authorization reform laws in Georgia, Iowa and Michigan, and paved the way for reform efforts in 2023 in nearly a dozen more states.

The AMA authored or co-authored a record 27 peer-reviewed journal articles and research reports in 2022 relating to physician burnout and improving professional satisfaction and practice sustainability. The AMA helped secure the enactment of the Dr. Lorna Breen Health Care Provider Protection Act, which enables a broad range of essential physician wellness resources, including evidence-based programs dedicated to improving mental health and resiliency.

The AMA STEPS Forward® Program exceeded 1.6 million lifetime users with new training programs that included two more playbooks, two new and 17 updated toolkits, 26 podcasts and four videos.

The AMA expanded its work in promoting physician wellness through its Joy in Medicine™ Health System Recognition Program, honoring nearly 30 health care organizations that represented more than 80,000 physicians.

The AMA expanded its national Behavioral Health Collaborative with the launch of the Behavioral Health Integration Immersion Program, a 12-month curriculum that provides enhanced technical assistance to physician practices seeking to deliver integrated care to patients. This effort builds on the success of the Overcoming Obstacles series with several new webinars on topics such as assembling a behavioral health integration care team and addressing physician and patient mental health.

#### *Driving the future of medicine*

The AMA played a key role in securing passage of legislation to extend Medicare telehealth flexibilities through the end of 2024. We launched model legislation that states can use to advance telehealth coverage and policies. The AMA further supported telehealth expansion by expanding our already-impressive library of print and online resources promoting evidence-based telehealth services to now include strategies to advance health equity in virtual care. The launch of the AMA's Telehealth Immersion Program supports practices in the implementation and optimization of telehealth. The program expanded in 2022 with seven webinars, five clinical case studies, two virtual panel discussions and one mini bootcamp.

The industry-leading AMA Ed Hub™ online education portal received 6 million views and continued to expand its programs, affiliations and reach to support live broadcasts and enhance multimedia capabilities. The number of external education providers grew by 10 to encompass 35 organizations with the addition of the American Board of Pediatrics and the American Academy of Allergy, Asthma and Immunology, among others.

The AMA, led by its Center for Health Equity, strengthened its physician engagement with the launch of seven new social justice education modules published on the AMA Ed Hub™ learning platform. These modules focus on strategies to advance equity through quality and safety improvements to the historical foundations of racism in medicine. In addition, the AMA's popular "Prioritizing Equity" webinar series grew to 28 episodes, with new features on voting, health equity and reproductive care as a human right.

The AMA helped launch the "In Full Health Learning and Action Community to Advance Equitable Health in Innovation" initiative, building upon the expertise of 17 external collaborations to create three AMA Ed Hub™ learning modules and the "Equitable Health Innovation Solutions" toolkit.

Building on the AMA's commitment to diversity, equity and inclusion, the AMA Graduate Medical Education Competency Education Program and the AMA Undergraduate Medical Education Curricular Enrichment Program launched a series of health equity educational courses: "Social Determinants of Health," "Basics of Health Equity," and three courses in the "Racism in Medicine" series.

First published in March 2022 as part of the AMA's MedEd Innovation Series, "Coaching in Medical Education" quickly sold out. Now in its second printing, this instructor-focused guide outlines a scientific foundation for coaching competency and has ranked in the top 100 of medical education and training books since its release. The AMA also published "Protecting the Education Mission During Sustained Disruption" in 2022, a report that explores organizational strategies to support educators amid extreme stress and which formed the basis of the Educator Well-Being in Academic Medicine book published in December.

The AMA released a special 175th anniversary edition of its Code of Medical Ethics, and the Journal of the American Medical Association, under the direction of new Editor-in-Chief Kirsten Bibbins-Domingo, MD, PhD, MAS, maintained its place among the world's preeminent medical journals. All 12 specialty publications from the JAMA Network™ ranked among the top 10 in journal Impact Factor, with eight ranking in the top three for their respective specialties.

The launch of the AMA's new Current Procedural Terminology (CPT®) Developer Program helped creators of health technology and services utilize the code set for their transformative innovations. The new self-service portal gives physicians the ability to license CPT code sets through a simple pay model, including new codes introduced in 2022 relating to the mpox outbreak and ongoing releases for specific COVID-19 vaccines.

The AMA relaunched its popular Physician Innovation Network digital platform, which now has more than 18,000 collaborators and 30 industry partners, to improve user experience and more effectively connect physicians with technology innovators.

#### *Leading the charge to confront public health crises*

The AMA expanded its health equity investments with the launch of the Rise to Health: A National Coalition for Equity in Health Care, an effort that unites individuals and organizations in shared solutions for high-impact structural change, and with a \$3 million multi-year investment in Chicago's West Side United, a community-based collaborative that is addressing determinants of health and helping restore economic vitality on the city's West Side.

The AMA developed a mpox resource page to provide physicians with updated information on testing access, vaccines and therapeutics, and worked with the FDA and CDC on a webinar detailing the tecovirimat (TPOXX) antiviral. And the AMA collaborated on the annual "Get My Flu Shot" campaign, with a specific focus on reaching Black and Latinx populations and kept physicians and the public up to date on the latest pandemic developments, including therapeutics and the importance of staying up to date with COVID-19 vaccines.

To close the gap in blood pressure management training within medical schools, the AMA launched a three-part eLearning series, supported by a one-year grant program to monitor the impact of this new training. AMA policy guidance led to four states increasing access to Medicaid programs for self-measured blood pressure by covering home-use devices and clinical support services. Additionally, the AMA also helped train more than 100 community health workers to help Chicago's West Side residents more accurately measure their blood pressure at home.

The AMA's Substance Use and Pain Care Task Force continues to advance evidence-based recommendations for policymakers and physicians to help end the nation's drug-related overdose and death epidemic. The AMA and Manatt Health 2022 State Toolkit identifies more than 400 state laws, regulations, and policy guidance to help end the nation's drug overdose epidemic.

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 with the Center for Health Equity's strategic plan to support healthy, thriving, equitable communities. Thirty percent of AMA employees, representing every business unit and office location, supported nearly 80 organizations and donated \$160,000 to community partners.

### *Membership*

Following 11 consecutive years of membership growth, in 2022 the AMA experienced a small decrease in overall membership (due to a drop in student numbers), but physician membership remained steady. Overall, the organization's advocacy efforts and mission activities were supported by another strong year of financial performance.

### *EVP Compensation*

During 2022, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was \$1,281,270 in salary and \$1,220,904 in incentive compensation, reduced by \$2,632 in pre-tax deductions. Other taxable amounts per the contract are as follows: \$151,198 distribution from a deferred compensation plan; \$23,484 imputed costs for life insurance, \$24,720 imputed costs for executive life insurance, and \$3,650 paid for an executive physical, and \$3,519 paid for parking and other. 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 2022 Annual Report."

## **8. ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2022 THROUGH FEBRUARY 2023**

*Informational report; no reference committee hearing*

### **HOUSE ACTION: FILED**

This report summarizes trends and news on tobacco usage, policies, and tobacco control advocacy activities from March 2022 through February 2023. The report is written pursuant to AMA Policy D-490.983, "Annual Tobacco Report."

### **TOBACCO USE AT A GLANCE**

Tobacco control efforts are often heralded as a roadmap for advocates addressing other health behaviors associated with negative health outcomes. The successes of those efforts to reduce the tobacco-related harms cannot be diminished; however, tobacco remains the leading cause of preventable disease, disability, and death in the United States.<sup>1</sup> According to the Centers for Disease Control and Prevention (CDC) tobacco kills more than 480,000 people annually. Based on 2020 data, an estimated 31 million U.S. adults smoke cigarettes, and each day 1600 youth under 18 years old smoke their first cigarette. More than 16 million people live with at least one disease caused by smoking.<sup>2</sup>

### *Youth Tobacco Use Associated with Social Determinants of Health Inequities*

The National Youth Tobacco Survey (NYTS) is a cross-sectional, voluntary, school-based, self-administered survey of U.S. middle and high school students. In 2022, the survey was conducted using an online survey. A total of 28,291 students from 341 schools participated, yielding an overall response rate of 45.2%.<sup>3</sup>

An analysis of the 2022 NYTS estimates 3 million (4.5% of middle school students and 16.5% of high school students) currently use any tobacco product including electronic cigarettes (e-cigarettes). E-cigarettes are the most commonly used tobacco product by students. Three percent of middle school students and 14% of high school students reported current use of e-cigarettes. NYTS defines current tobacco use as one or more of any commercial tobacco product on  $\geq 1$  day during the past 30 days.<sup>3</sup>

For the first time since the initial survey in 1999, estimates for Asian, American Indian or Alaska Native (AI/AN), Native Hawaiian or Other Pacific Islander (NH/OPI), and multiracial population groups were provided. The report states, "Whereas AI/AN students reported the highest prevalence of current use of any tobacco product, current use of any combustible tobacco product, specifically cigar and hookah use, was highest among Black students. In addition, current use of any tobacco product was higher among those students identifying as LGB [lesbian, gay,

bisexual] or transgender, those reporting severe psychological distress, those with low family affluence, and those with low academic achievement.”<sup>3</sup>

The inequities suggest the impact of the continued aggressive marketing by tobacco companies and e-cigarette manufacturers to specific populations.

Because of changes in methodology, including differences in survey administration and data collection procedures, the ability to compare estimates from 2022 with those from previous NYTS waves is limited. However, the cross-sectional data provided by the 2022 survey are still valid and informative.<sup>3</sup>

#### *Adult Tobacco Use*

Adult tobacco use has continued to decline with an estimated 19% of U.S. adults reporting current use of any commercial tobacco product according to the 2020 National Health Interview Survey (NHIS) compared to 21% reported in 2019. NHIS is an annual, nationally representative household survey of the noninstitutionalized U.S. civilian population. Current use is defined by NHIS as having reported use of these products every day or some days at the time of survey. While e-cigarettes are the most common tobacco product of youth, an estimated 80% of adults reported using combustible products (cigarettes, cigars and pipes).<sup>4</sup>

The CDC report shows inequities in adults who smoke and use tobacco in the U.S. According to the report groups with high rates of smoking include people with lower income and less education, AI/AN adults, residents of the Midwest and South, residents of rural areas, LGB adults, and adults who regularly had feelings of anxiety or depression. Adults who are uninsured or enrolled in Medicaid smoke at more than double the rates of those with private health insurance or Medicare.<sup>4</sup>

Among all tobacco products, combustible products are the predominate cause of tobacco related morbidity and mortality indicating that policies directed at these products remain a high priority.<sup>5</sup> These policies should focus on providing access to evidence-based treatments for tobacco dependence and disincentives to smoking such as increases in taxes.<sup>4</sup>

#### EFFORTS TO ADDRESS TOBACCO CONTROL

##### *ALA Releases its 2023 State of Tobacco Report*

The American Lung Association (ALA) “State of Tobacco Control” report evaluates state and federal policies on actions taken to eliminate tobacco use and recommends proven-effective tobacco control laws and policies. The report provides letter grades to five interventions. At the federal level grades are given for regulation of tobacco products, coverage for smoking cessation, taxes, mass media campaigns and minimum sales age. At the state level the report evaluates smokefree workplace laws, sales of flavored tobacco products, state program funding, tobacco taxes, and access cessation services.

According to the American Lung Association’s 2023 State of Tobacco Report, the Federal government took major steps toward regulating tobacco products in 2022 but fell short in coverage of quit smoking treatments and increasing federal taxes. The states with the highest overall grades were California, District of Columbia, and Massachusetts. The report shows how widely tobacco policies vary from state to state. For example, some states still allow smoking in workplaces including restaurants and bars, and some states lack Medicaid coverage for tobacco cessation. Alabama, Mississippi, North Carolina, and Texas were states with the most need to enact evidence-based policies.

The report also highlights the need to continue funding programs like the CDC’s Tips From Former Smokers® (Tips®) campaign launched in 2012. The campaign profiles real people from many different backgrounds living with serious long-term health effects from smoking and secondhand smoke exposure. State level funding for cessation efforts also should be prioritized as well as efforts to provide support for community-level engagements in addressing inequities.<sup>6</sup>

### *AMA Joins with Public Health Groups to Protect Tobacco Regulation and Funding*

The CDC Office on Smoking and Health (OSH) has a proven track record in developing programs, initiatives and resources that have reduced the social, medical, and economic tolls associated with tobacco in the U.S. Dedicated and increased funding is needed by for OSH to support ongoing research that contributes to the development of innovative interventions in tobacco prevention and cessation.

In April 2022 the AMA signed on to a letter calling on the House of Representatives Appropriations Committee to increase funding for OSH by \$68.5 million, for a total of \$310 million.

In June 2022, when members of the House of Representative’s Committee on Appropriations were reviewing the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations bill the public health community raised concerns that the bill would include language weakening FDA’s authority over tobacco. The AMA was one of 70 organizations, including Federation members American Thoracic Society, American Academy of Pediatrics and American College of Cardiology, who signed a letter to the Committee calling on them to ensure that FDA has the unfettered ability to protect youth from unscrupulous marketing of any and all tobacco products.

These letters were part of a comprehensive strategy to ensure that the tobacco industry and others have limited influence in weakening the strides made in tobacco control while being prepared for new threats to public health in the future.

### *Supreme Court Upholds California Law Banning Flavored Tobacco Products*

In 2020, California Governor Gavin Newsom signed Senate Bill 793 into law. This law prohibited the sale of menthol cigarettes and most flavored tobacco products. The law was immediately challenged and thus began a two-year legal battle by R.J. Reynolds who sued the state of California and effectively delayed implementation until the law could be considered in a ballot referendum in 2022. In November 2022, California voters overwhelmingly supported the 2020 law with more than 60% voting yes on the referendum.

R.J. Reynolds and other tobacco entities immediately appealed to the Supreme Court, requesting an emergency injunction against California’s law arguing that the Federal Tobacco Control Act prohibited California from enacting its flavored tobacco law. The AMA joined with public health groups and other medical associations in an amicus brief opposing R.J. Reynolds’ emergency application. On December 12, the Supreme Court denied the suit and on December 21, California became the second state to ban the sale of flavored tobacco products and menthol cigarettes. Massachusetts was the first state to ban flavors and menthol in 2019.

### *FDA Takes Steps to Remove Menthol*

On April 28, 2022, the U.S. Food and Drug Administration (FDA) released two proposed rules on characterizing flavors in tobacco products. One of the proposed rules would ban menthol and all characterizing flavors such as strawberry flavor in cigarettes, and the other proposed rule would prohibit menthol in cigars. This news was treated with great support from public health groups, but it came after years of inaction by the FDA. The long-overdue action follows a lawsuit filed in 2020 by the African American Tobacco Control Leadership Council, Action on Smoking and Health, AMA, and National Medical Association.

According to a Substance Abuse and Mental Health Services Administration study, “85% of non-Hispanic Black and African American adults who smoke prefer menthol cigarettes, and menthol flavoring in cigarettes and e-cigarettes make it easier for youth to initiate smoking.”<sup>7</sup> “It is estimated that nearly 1 million Americans—and about 230,000 African Americans—would quit smoking within 13 to 17 months of a ban on menthol cigarettes taking effect.”<sup>8</sup>

FDA has announced that the final rules will be released sometime in 2023. Barring any delay from the anticipated lawsuits from the tobacco industry, products will have to be removed within one year.

### *Congress Closes Loophole in FDA Authority*

In March, Congress took action to expand the FDA’s regulatory authority over tobacco products using synthetic nicotine. FDA’s authority to regulate nicotine in tobacco products was previously limited to tobacco-derived nicotine. This specificity created a loophole for manufacturers including Puff Bar to reintroduce their e-cigarette with synthetic nicotine when ordered to take their flavored tobacco-derived product off the market. Congress closed this loophole by allowing the FDA to regulate nicotine regardless of the source. Several state and local jurisdictions have already passed similar laws; however, having a federal framework in place allows for a more comprehensive approach.

Despite this promising measure, the FDA has yet to take significant enforcement actions against companies still selling unauthorized synthetic nicotine products. Tribal, state, local, and territorial governments can and should move forward to implement their own laws where necessary and ensure that synthetic nicotine is included in their tobacco control efforts.

### *FDA and DoJ Take Actions Against Manufacturers*

Starting in September 2020, all tobacco product manufacturers are required to submit a premarket application and receive authorization from the FDA before introducing a new tobacco product into the market. In accordance with its regulatory authority, the FDA issued warning letters to two brands of e-cigarettes doing business as Puff Bar for “receiving and delivering e-cigarettes” without a marketing authorization order. The agency also issued marketing denial orders for 32 premarket tobacco applications, because they “lacked sufficient evidence demonstrating that these flavored e-cigarettes would provide a benefit to adult users that would be adequate to outweigh the risks to youth.”

In October 2022 the U.S. Department of Justice (DoJ), on behalf of the FDA, filed for permanent injunctions against six e-cigarette manufacturers on behalf of the FDA. According to the FDA, this action represents the first time that the agency has begun injunction proceedings to enforce premarket review requirements under the Federal Food, Drug and Cosmetic Act.

Each of the six defendants—Lucky’s Convenience & Tobacco LLC doing business as Lucky’s Vape & Smoke Shop in the District of Kansas; Morin Enterprises Inc. doing business as E-Cig Crib in the District of Minnesota; Seditious Vapours LLC doing business as Butt Out in the District of Arizona; Soul Vapor LLC in the Southern District of West Virginia; Super Vape’z LLC in the Western District of Washington and Vapor Craft LLC in the Middle District of Georgia—illegally manufactured, sold and distributed their products, even after receiving warnings from the FDA.

The defendants did not submit premarket applications for their e-cigarettes and subsequently received a warning from the FDA. While most of the 300 companies that received warning labels removed their products from the marketplace, the six defendants continued manufacturing, distributing, and selling their products.

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## 9. COUNCIL ON LEGISLATION SUNSET REVIEW OF 2013 HOUSE POLICIES

*Reference committee hearing: see report of Reference Committee B.*

### **HOD ACTION:       RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED**

Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA’s policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (HOD) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the HOD to retain it. Any action of our AMA HOD that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the HOD identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way for the HOD to handle the sunset reports.
3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.
4. The AMA councils and the HOD should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA HOD Reference Manual: Procedures, Policies and Practices.
5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
6. Sunset policies will be retained in the AMA historical archives.

### RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.



## APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-100.970	Drug Enforcement Administration Licensure Fees	Our AMA will work through appropriate channels to freeze Drug Enforcement Administration (DEA) licensure fees for physicians.  (Res. 219, I-13)	Retain – this policy remains relevant.
D-120.948	FDA Recommendation on Scheduling of Hydrocodone Combination Products	Our AMA will issue a public statement to the US Food and Drug Administration urging the FDA to maintain hydrocodone combination products as Schedule III of the Controlled Substances Act.  (Res. 518, A-13)	Sunset this policy.  This policy has been completed. See: <a href="https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Fstructured%2Fbinary%2Fletter%2FLETTERS%2Ffda-rescheduling-letter-22march2013.pdf">https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Fstructured%2Fbinary%2Fletter%2FLETTERS%2Ffda-rescheduling-letter-22march2013.pdf</a> and <a href="https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Fstructured%2Fbinary%2Fletter%2FLETTERS%2Fdea-coalition-comment-letter-28april2014.pdf">https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Fstructured%2Fbinary%2Fletter%2FLETTERS%2Fdea-coalition-comment-letter-28april2014.pdf</a>
D-145.997	Physicians and the Public Health Issues of Gun Safety	Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.  (Res. 410, A-13)	Sunset this policy.  The Surgeon General issued a report on suicide in 2021, “ <a href="#">The Surgeon General’s Call to Action to Implement the National Strategy for Suicide Prevention.</a> ” There have been more recent calls on the Surgeon General to develop a report on reducing firearm-related injuries and deaths and our AMA has more recent policies supporting government funding for research into preventing firearm injuries and deaths ( <a href="#">Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975</a> )
D-150.976	Hazards of Energy Beverages - Their Abuse and Regulation	1. Our AMA will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM),	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>Rockstar (TM), Monster (TM), Full Throttle (TM)).</p> <p>2. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol.</p> <p>3. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18.</p> <p>(Res. 909, I-11; Appended: Res. 409, A-13)</p>	
D-175.986	Physician Prosecution	<p>Our American Medical Association will consider and take action at the national level on Medicaid fraud prosecutions and related issues.</p> <p>(Res. 212, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
D-190.973	The SAFE Act	<p>Our AMA will seek immediately an opinion and guidance from Health and Human Services Office of Civil Rights regarding how physicians in New York State should handle concerns regarding safety and privacy of patients' protected health information in light of the conflicting standards set forth by the State SAFE Act and federal HIPAA regulations.</p> <p>(Res. 228, A-13)</p>	<p>Sunset this policy.</p> <p>Clarification regarding how physicians in New York State should handle concerns regarding safety and privacy of patients' protected health information in compliance with standards set forth by the State SAFE Act and with federal HIPAA regulations is provided by the New York State Office of NICS Appeals &amp; SAFE Act, set forth in FAQs and guidance documents available at: <a href="https://nics.ny.gov/safe-act.html">https://nics.ny.gov/safe-act.html</a></p> <p>Among the above-referenced FAQs is the following information:</p> <p>Q: Are such reports in compliance with HIPAA?</p> <p>A: Under HIPAA, because these informational disclosures are required by law, they can be made without the patient's consent. HIPAA permits disclosures of protected health information without the</p>

Policy Number	Title	Text	Recommendation
			authorization or consent of the individual to the extent that such disclosure is required by law and the disclosure complies with the requirements of that law.
D-190.982	HIPAA Extension	<p>Our AMA will: <del>(1) support necessary legislative and/or regulatory changes to mandate that health plans continue to accept non-standard electronic claims from physicians during a reasonable transition period following October 16, 2003, when the HIPAA transaction rule takes effect, and (2)</del> take steps to assure that Medicare continues to support free software for filing claims to Medicare and that payers continue to accept paper claims from physicians who choose to submit claims on paper.</p> <p>(Res. 224, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	<p>Retain this policy in part.</p> <p>Delete clause (1). It is no longer relevant as the transition period following October 16, 2003, when the HIPAA transaction rule took effect, has passed.</p>
D-190.983	Protection of Health Care Providers from Unintended Legal Consequences of HIPAA	<p>Our AMA will: (1) take appropriate legislative, regulatory, and/or legal action to assure that the unanticipated negative consequences of the Health Insurance Portability and Accountability Act privacy regulations, affecting the patient/doctor relationship and exposing health care providers to legal action, are corrected; and</p> <p>(2) initiate necessary legislative, regulatory, and/or legal action to assure that HIPAA violations that are not malicious in intent and are not directly related to any alleged act of medical negligence may not be attached to such litigation.</p> <p>(Res. 204, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
D-330.913	Direct-to-Consumer Advertising of Durable Medical Equipment and Medical Supplies	<p>1. Our AMA will pursue legislation or regulation as appropriate to require that direct-to-consumer advertising and any other media for durable medical equipment (DME) and other medical supplies: (a) include a disclaimer statement to the effect that eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria; (b) list the actual criteria (or a summary thereof) from the appropriate source, such as the applicable Certificate of Medical Necessity, DME Information Form (DIF), “Dear Physician Letter” from DME</p>	<p>Sunset this policy.</p> <p>Our AMA has responded to opportunities to testify on direct-to-consumer (DTC) issues that affect the membership. While this reference is to “examining the drug supply chain,” the effect of DTC on the patient-physician is on the record. See: <a href="https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLE">https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLE</a></p>

Policy Number	Title	Text	Recommendation
		<p>Contractor Medical Directors, Local Coverage Determination or associated policy article; and (c) refrain from statements to the effect that only a physician order or signature is required to obtain the desired items.</p> <p>2. Our AMA recommends that DME companies stop coercive acts which inappropriately influence physicians to sign these prescriptions for their patients. (BOT Rep. 14, A-13)</p>	<p><a href="#">TTTERS%2F2018-1-23-Dr-Harmon-Response-to-Pharmaceutical-Disribution-Chain.pdf</a>.</p> <p>In addition, other AMA policy reaffirmed at the I-22 HOD Meeting covers many of the nuances on this issue: See: <a href="#">Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988</a>.</p>
D-35.984	Physician Supervision of Invasive Procedures and the Provision of Fluoroscopy	<p>1. Our AMA will (a) advocate that interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians, and (b) develop appropriate model state legislation with interested state and medical specialty societies that reflects this policy.</p> <p>2. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physicians including those employing radiologic imaging and report back to our House of Delegates.</p> <p>(BOT Rep. 10, I-11; Reaffirmed: BOT Rep. 16, A-13)</p>	Retain – this policy remains relevant.
D-35.990	Limiting the Scope of Practice of Specialist Assistants in Radiology	<p>Our AMA supports the efforts of the American College of Radiology and will work with the Scope of Practice Partnership and interested Federation partners to obtain regulation or legislation which would preclude a Specialist Assistant in Radiology or other non-physician practitioner from rendering an official report of any image produced by any diagnostic imaging technique.</p> <p>(Res. 219, A-06; Reaffirmed: BOT Rep. 16, A-13)</p>	Retain – this policy remains relevant.
D-35.996	Scope of Practice Model Legislation	<p>Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners</p>	<p>Sunset this policy.</p> <p>This policy has been accomplished. Model</p>

Policy Number	Title	Text	Recommendation
		<p>scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners' scope of practice.</p> <p>(Res. 923, I-03; Reaffirmed: BOT Rep. 28, A-13)</p>	<p>legislation has been approved by the Council on Legislation and Board of Trustees and distributed to state and specialty medical societies. Our AMA continues to work with state and specialty medical societies on this legislation as part of our extensive scope of practice advocacy activities and policy.</p>
D-360.993	Recognition of the "Nurse as Agent" of the Prescriber in Long Term Care Settings	<p>Our AMA will urge the US Drug Enforcement Administration to amend its regulations to recognize nursing staff as agents of the prescriber/physician in long term care facilities.</p> <p>(Res. 222, A-09; Reaffirmation A-13)</p>	<p>Sunset this policy.</p> <p>This has been accomplished. See:  <a href="https://fnnpc.enpnetwork.com/nurse-practitioner-news/2092-dea-announces-policy-change-recognizing-long-term-care-nurses-as-agents-of-the-prescriber">https://fnnpc.enpnetwork.com/nurse-practitioner-news/2092-dea-announces-policy-change-recognizing-long-term-care-nurses-as-agents-of-the-prescriber</a>.</p>
D-390.955	Flexibility in Medicare Opt-Out and New Safe Harbor	<p>1. Our AMA will seek regulation or legislation to amend the Medicare law to allow physicians to opt out of the Medicare program without a requirement to reaffirm that opt-out.</p> <p>2. Our AMA will seek legislation and work with the Centers for Medicare &amp; Medicaid Services, as appropriate, to allow for a safe-harbor period for a physician to continue to remain opted out of the Medicare program, without penalty or possibility of recoupment, in those circumstances where the physician has mistakenly not been reaffirming an intention to be opted out.</p> <p>(Res. 234, A-13)</p>	<p>Retain – this policy remains relevant.</p>
D-390.971	Medicare Reimbursement for Anesthesiologists	<p>Our AMA will continue its advocacy to replace the flawed SGR payment formula, resulting in increases to the Medicare conversion factors and payments to all physicians.</p> <p>(BOT Action in response to referred for decision Res. 718, I-05; Reaffirmed in lieu of Res. 207, A-13)</p>	<p>Sunset this policy.</p> <p>The sustainable growth rate (SGR) payment formula was replaced by the Medicare Access and CHIP Reauthorization Act of 2015, which repealed the SGR formula and put in place a new payment system for physicians participating in Medicare.</p>
D-40.993	Inequity in Military Pay for Physicians	<p>Our AMA will work, as appropriate, with other interested organizations, to support immediate reintroduction of a bill based on H.R. 5353 (107th Congress) in this Congress.</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
		(BOT Action in response to referred for decision Res. 901, I-03; Reaffirmed: BOT Rep. 28, A-13)	
D-435.988	Family Protection Act	Our AMA will develop a strategy for promoting bankruptcy reform that is consistent with our AMA's efforts to promote medical liability reform.  (BOT Rep. 9, I-03; Modified: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
D-478.981	Exchange of Electronic Data Among Clinicians, Public Health Entities and Research Entities	Our AMA will proactively work with the Department of Health and Human Services and appropriate public health and research entities to develop ways to facilitate, as much as possible, seamless, properly regulated, electronic exchange of data generated in the health care setting, including the development of open standards for such data exchange, provided that such technology has intrinsic systems that include the protection of individually identifiable health information that is acceptable to patients, to the extent that law permits.  (Res. 827, I-10; Reaffirmation I-13)	Sunset this policy.  There has been on-going work in this area across the Department of Health and Human Services, including the Centers for Medicare & Medicaid Services, Office of national Coordinator, Office of Civil Rights, among other federal agencies and research entities. Our AMA consistently comments on this matter as regulations propose changes to HIT standards, existing rules relating to privacy, and interoperability of protected health information. In addition, our AMA has other policy on point: <a href="#">EHR Interoperability D-478.972</a> , <a href="#">Health Information Technology D-478.994</a> , <a href="#">Information Technology Standards and Costs D-478.996</a> , <a href="#">National Health Information Technology D-478.995</a>
H-100.979	Repeal of Federal Regulations	The AMA urges the Drug Enforcement Administration to develop an alternative system for identifying partially filled prescriptions for Schedule II drugs that does not reveal diagnostic information.  (Sub. Res. 511, A-92; Reaffirmed: BOT Rep. 28, A-03; Modified: CSAPH Rep. 1, A-13)	Retain – this policy remains relevant.
H-120.969	Dispensing Controlled Substances to Long Term Care Patients	The AMA will work with the Drug Enforcement Administration to amend the Code of Federal Regulations to allow for pharmacy service providers to use appropriately authenticated medication orders from patients' charts in place of an	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		original prescription for controlled substances for long term care patients.  (Res. 204, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: Res. 209, A-11; Reaffirmation A-13)	
H-15.961	Safety for Passengers in the Back of Pickup Trucks	The AMA supports legislation that would prohibit passengers from riding in the cargo bed of a pickup truck.  (Res. 409, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain – this policy remains relevant.
H-15.966	Preventing Underride Motor Vehicle Crash Injury	The AMA supports a federal action, regulatory or legislative as appropriate, that would require rear and side impact guards on all new tractor trailers.  (Res. 426, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CSAPH Rep. 1, A-13)	Retain – this policy remains relevant.
H-150.932	Reform the US Farm Bill to Improve US Public Health and Food Sustainability	Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.  (Res. 215, A-13)	Retain – this policy remains relevant.
H-160.931	Health Literacy	Our AMA: (1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment; (2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting; (3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information; (4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills; (5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills; (6) encourages the US Department of Education to include questions regarding	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;</p> <p>(7) encourages the allocation of federal and private funds for research on health literacy;</p> <p>(8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit;</p> <p>(9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and</p> <p>(10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.</p> <p>(CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13)</p>	
H-160.950	Guidelines for Integrated Practice of Physician and Nurse Practitioner	<p>Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:</p> <p>(1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.</p> <p>(2) The physician is responsible for managing the health care of patients in all practice settings.</p> <p>(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.</p> <p>(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.</p> <p>(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.</p> <p>(6) The role of the nurse practitioner in the</p>	Retain – this policy remains relevant.



Policy Number	Title	Text	Recommendation
		<p>delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.</p> <p>(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.</p> <p>(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.</p> <p>(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.</p> <p>(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.</p> <p>(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.</p> <p>(CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)</p>	
H-180.970	Expanded State/Federal Regulation Oversight of Multiple Employer Welfare Arrangements	<p>The AMA supports appropriate federal and state initiatives to regulate and oversee health care plans provided through multiple employer welfare arrangements.</p> <p>(Sub. Res. 204, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-180.998	Regulation of Insurance Carriers and Health Plans	<p>Our AMA believes that organizations financing health care services (e.g., insurance companies, Blue Cross, Blue Shield, HMOs, health and welfare trusts) should be certified at the state level on the basis of financial soundness, and plans should be routinely monitored by the same agency to guard against misrepresentation of costs or benefits. All carriers in a given regulatory jurisdiction should be subject to the same standards.</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(BOT Rep. A, NCCMC Rec. 7, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)	
H-190.969	Delay in Payments Due to Disputes in Coordination of Benefits	<p>Our AMA:</p> <p>(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries’ claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;</p> <p>(2) includes the “birthday rule” and the “employer first rule” in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;</p> <p>(3) urges state medical associations to advocate for the inclusion of the “employer first rule” and “birthday rule” in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;</p> <p>(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;</p> <p>(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;</p> <p>(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and</p> <p>(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients,</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>physicians, and other purchasers of health care services.</p> <p>(CMS Rep. 8, I-98; Reaffirmation I-04; Reaffirmed in lieu of Res. 729, A-13)</p>	
H-260.973	Cost and Benefits of CLIA '88 and Other Health Regulations	<p>The AMA demands from the government any proven evidence, research, study or any data concerning CLIA '88: (a) showing that this law was actually necessary, and (b) indicating in a quantitative way how any potential benefits of this law outweigh this addition to the already overburdened cost of health care.</p> <p>(Res. 245, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-260.975	Repeal of CLIA	<p>The AMA (1) will work through appropriate regulatory, legislative or judicial channels for changes in CLIA '88 or elimination of those portions of the CLIA '88 regulations that do not improve patient care; and (2) will continue to work to achieve changes that markedly reduce or eliminate the obstacles experienced by physicians under CLIA '88, with the understanding that should this not be successful, the Association shall move to seek legislative repeal of CLIA '88.</p> <p>(Sub. Res. 237, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-260.977	Commission on Office Laboratory Accreditation	<p>The AMA, with state medical and national medical specialty societies, will (1) take immediate action to cause CMS to publish the “deeming” regulations under CLIA '88; (2) take immediate action to assure that applications for deemed status under CLIA '88 are processed expeditiously and that potential accrediting organizations capable of complying with the regulations are granted deemed status as quickly as possible; (3) take immediate action to cause CMS to delay sending bills for laboratory certification fees until at least 60 days have passed from the time that at least one alternative private sector accrediting body has been granted deemed status; and (4) publicize information about the Commission on Office Laboratory Accreditation (COLA) and encourage that all physicians seek clinical laboratory accreditation through COLA in lieu of federal or other government certification.</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(Sub. Res. 264, A-92; Reaffirmation I-99; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	
H-270.954	Regulatory Modernization	Our AMA will work with regulatory bodies at the national level to identify outdated regulations and modernize them to better reflect the current state of medical practice.  (Res. 225, A-13)	Retain – this policy remains relevant.
H-270.955	Allow Physicians to Receive Dual Use Supplies for In-Office Blood Collection	Our AMA supports legislation allowing physicians to receive a limited supply of dual use supplies proportionate with the number of specimens received by a lab each month.  (Res. 208, A-13)	Retain – this policy remains relevant.
H-270.974	Acupuncture	It is the policy of the AMA that nonphysician boards should not regulate the clinical practice of medicine.  (CME Rep. M, A-93; Modified: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)	Retain – this policy remains relevant.
H-270.977	FDA Intrusion into the Practice of Medicine	The AMA strongly opposes the FDA's intrusion into the practice of medicine by making decisions for individual care and mandated informed consent documents written without the input of specialists in the related field of medicine.  (Res. 544, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)	Retain – this policy remains relevant.
H-285.985	Discrimination Against Physicians by Health Care Plans	Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans; (2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans; (3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need; (4) encourages state medical associations and national medical specialty societies to	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and</p> <p>(5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.</p> <p>(BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 110, A-13)</p>	
H-290.988	Monitoring of State Medicaid DUR Programs	<p>The AMA will continue to monitor the progress, quality and problems associated with the Omnibus Budget Reconciliation Act of 1990 mandated state Medicaid Drug Use Review (DUR) programs and assure that DUR programs focus on the quality of patient care and use appropriate scientifically based criteria to evaluate individual patient therapy and the effectiveness of physician and pharmacist activities.</p> <p>(Res. 526, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	<p>Sunset this policy.</p> <p>Our AMA has adopted broader Drug Use Review policy. See: <a href="#">Principles of Drug Utilization Review H-120.978</a> and <a href="#">Drug Utilization Review H-120.981</a>.</p>
H-30.951	Boating Under the Influence	<p>It is the policy of the AMA to support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs.</p> <p>(Res. 405, I-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain – this policy remains relevant.
H-315.989	Confidentiality of Computerized Patient Records	<p>The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data.</p> <p>(BOT Rep. F, A-93; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 17, A-13)</p>	<p>Sunset this policy.</p> <p>This policy has been superseded by more recent policy. See: <a href="#">Ransomware and Electronic Health Records D-478.960</a>, <a href="#">Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973</a>, <a href="#">Code of Medical Ethics 3.3.2 Confidentiality &amp; Electronic Medical Records</a>.</p>

Policy Number	Title	Text	Recommendation
H-330.887	Submitting Recommendations to Medicare	<p>Our AMA will work with the Centers for Medicare &amp; Medicaid Services and seek federal legislation, if necessary, to provide that the Center for Medicare and Medicaid Innovation Center website accept suggestions from physicians to improve health care and/or reduce costs, acknowledge submission by receipt, and notify the individual of the decision on possible implementation with an explanation of the reasons for the decision and, if the decision is deemed worthy, the submitter should be informed and encouraged to participate in further developing the idea if they wish to remain involved.</p> <p>(Res. 226, A-13)</p>	Retain – this policy remains relevant.
H-330.922	Waiver of Copayments of Certain Medicare Patients	<p>Our AMA seek legislative and/or regulatory action that permits physicians in the exercise of their judgment to provide free medical services and/or waive deductibles and co-payments for patients with Medicare, Medicaid, and other health insurance.</p> <p>(Res. 254, A-98; Reaffirmation I-98; Modified: BOT Rep. 12, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-330.945	Durable Medical Equipment Requirements	<p>Our AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; (2) affirm the concept that members of a physician-led interprofessional health care team be enabled to perform delegated medical duties, including ordering durable medical equipment, that they are capable of performing according to their education, training and licensure and at the discretion of the physician team leader; (3) advocate that the initiators of orders for durable medical equipment should be a physician, or a nurse practitioner or physician assistant supervised by a physician within their care team, consistent with state scope of practice laws; and (4) reaffirm the concept that physicians are ultimately responsible for the medical needs of their patients.</p> <p>(Sub. Res. 205, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmation A-04; Reaffirmed: BOT Rep. 14, A-13; Modified in lieu of Res. 802, I-13)</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-330.951	Non-Routine Waiver of Copayments and Deductibles Under Medicare Part B for Indigent Patients	The AMA will seek promulgation of a safe harbor provision by the Office of Inspector General, U.S. Department of Health and Human Services, for the non-routine waiver of Medicare Part B copayments and deductibles for indigent patients.  (Res. 210, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
H-330.960	Cost of Medically Related Services and Supplies	The AMA legislative or other appropriate department will seek a requirement that CMS and/or their contracted home health agencies, durable medical equipment suppliers, and non-emergency transportation services, provide cost estimates to physicians, to be provided along with the physician authorization form.  (Res. 812, A-92; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-99; Reaffirmation A-04; Reaffirmation A-08; Reaffirmed: BOT Rep. 14, A-13)	Retain – this policy remains relevant.
H-330.992	Medicare Definition of Physician	The AMA supports limiting the application of the definition of the term “physician” under the Medicare program to doctors of medicine or osteopathy.  (Sub. Res. 101, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: Res. 821, I-09; Reaffirmation A-13)	Retain – this policy remains relevant.
H-350.976	Improving Health Care of American Indians	Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens. (2) The federal government provide sufficient funds to support needed health services for American Indians. (3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life. (4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognize the “medicine man” as an integral and culturally necessary individual in delivering health care to American Indians. (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of	Retain – this policy remains relevant.

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		<p>alcoholism, homicide, suicide, and accidents.</p> <p>(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.</p> <p>(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.</p> <p>(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.</p> <p>(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.</p> <p>(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.</p> <p>(CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)</p>	
H-350.977	Indian Health Service	<p>The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) <u>Indian Population</u>: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to</p>	Retain – this policy remains relevant.



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		<p>expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.</p> <p>(2) <u>Federal Facilities</u>: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.</p> <p>(3) <u>Manpower</u>: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.</p> <p>(4) <u>Medical Societies</u>: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians.</p> <p>Increased support from organized medicine</p>	

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		<p>for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.</p> <p>(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.</p> <p>(CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)</p>	
H-355.989	Access to National Practitioner Data Bank “Self-Query” Reports	<p><del>(1) — The AMA again requests a written opinion from the Health Resources and Services Administration's Bureau of Health Professions and/or the HHS Office of the Inspector General, as to the confidentiality of National Practitioner Data Bank (NPDB) information that is received directly or indirectly from the NPDB. (21) The AMA recommends that physicians who are compelled to release information received from the NPDB to entities not authorized to access the NPDB require that such entity provide them with written documentation that: information disclosed to the entity will be protected from further disclosure under the relevant state peer review immunity statute(s); that the requirements that the physician self-query the NPDB and disclose the information to the entity is in compliance with the intent and protections of the Health Care Quality Improvement Act of 1986; that the information will be used only for and maintained only for those purposes, such as quality assurance activities, that are protected under the relevant state peer review immunity statute(s); and that the entity will protect the confidentiality of the information to the fullest extent permitted by both state law and the Health Care Quality Improvement Act of 1986. (32) The AMA will provide model language until such legislation is enacted that physicians can use to protect confidentiality when they release information received from the NPDB to entities not authorized to access the NPDB. The AMA urges state and county medical societies to develop a mechanism physicians can use to report problems they encounter with these entities.</del></p> <p>(BOT Rep. L, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	<p>Retain this policy in part.</p> <p>Delete clause (1). The <a href="#">National Practitioner Data Bank Guidebook</a> specifies that information reported to the NPDB is confidential and cannot be disclosed except as specified in the NPDB statutes and that the Office of the Inspector General can impose civil money penalties on those who violate the confidentiality provisions.</p>

Policy Number	Title	Text	Recommendation
H-355.990	National Practitioner Data Bank	<p>(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB). (2) The AMA requests that the Health Resources and Services Administration <del>(a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner's self-query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than \$30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (eb) and allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB's first year of operation to the AMA by July 1992.</del> (3) The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991.</p> <p>(BOT Rep. QQ, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	<p>Retain this policy in part.</p> <p>Delete clauses (2)(a)(b)(c)(f) and clause (3), which are no longer relevant. Regarding clause (3), Policy H-355.991 was rescinded in 2014.</p>
H-360.983	Registered Nurse Participation in Epidural Analgesia	<p>Our AMA, consistent with the American Society of Anesthesiologists position statement adopts the following statement on the administration of epidural analgesia: In order to provide optimum patient care, it is essential that registered nurses participate in the management of analgesic modalities. A registered nurse--qualified by education, experience and credentials--who follows a patient-specific protocol written by a</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
		<p>qualified physician should be allowed to adjust and discontinue catheter infusions.</p> <p>(Res. 530, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	
H-360.987	Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice	<p>Our AMA endorses the following principles:</p> <p>(1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.</p> <p>(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.</p> <p>(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.</p> <p>(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.</p> <p>(5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.</p> <p>(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.</p> <p>(BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13)</p>	Retain – this policy remains relevant.
H-360.988	Nurse Practitioner Reimbursement Under Medicare	<p>Our AMA supports provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician’s supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. With regard to physician assistants, such supervision in most settings includes the personal presence or participation of the physician. In certain practice settings where the physician assistant may function apart from the supervising physician, such remote function</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>(if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, appropriate site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times.</p> <p>(BOT Rep. UU, A-90; Reaffirmed: CMS Rep. 1, I-934; Reaffirmed: Res. 240 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed in lieu of Res. 207, A-13)</p>	
H-365.983	Occupational Safety and Health Administration Regulations	<p>The AMA (1) will work to modify the Occupational Safety and Health Administration regulations on Occupational Exposure to Bloodborne Pathogens to address its practicality and to make physician compliance possible; and (2) in conjunction with other national health provider groups, will work with Congress and other government regulatory agencies to ensure that all decisions regarding the regulation of medical practices be based upon scientific principles and/or fact.</p> <p>(Res. 242, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-370.962	Equal Access to Organ Transplantation for Medicaid Beneficiaries	<p>Our AMA supports federal funding of organ transplants for Medicaid patients.</p> <p>(BOT Rep. 15, A-13)</p>	Retain – this policy remains relevant.
H-375.995	Implementation of Voluntary Medical Peer Review	<p>The AMA: (1) reaffirms its policy that “peer review should be assigned the highest priority by state and county medical societies; that where these mechanisms exist, they should be strengthened, and where they do not exist they should be promptly established;” (2) recognizes the propriety of peer review organizations contracting with public as well as private organizations for financing of their review services, so long as professional direction and control are maintained; and (3) supports the development of public information programs to inform consumers about existing and newly developed quality assurance activities.</p> <p>(CMS Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-390.885	Advance Payments During Medicare Slow-Downs	<p>The AMA will continue to seek legislation requiring CMS to make interim payments available to physicians when disruptions in Medicare claims processing result in undue delays in the normal flow of Medicare payments.</p> <p>(Sub. Res. 242, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-400.973	Limited Licensed Practitioners and RBRVS	<p>It is the policy of the AMA to advocate that Medicare expenditure data clearly differentiate between the services of fully licensed physicians and those of limited licensed practitioners and of other Part B services.</p> <p>(Sub. Res. 124, I-91; Reaffirmed: BOT Rep. DD, I-92; Modified: CMS Rep. 10, A-03; Modified: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-405.992	“Doctor” as a Title	<p>The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title “Doctor,” which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.</p> <p>(Res. 138, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: Res. 218, A-12)</p>	Retain – this policy remains relevant.
H-410.950	Pain Management	<p>Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:</p> <p>Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.</p> <p>Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post-</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>operative course of care. Invasive pain management techniques include:</p> <ol style="list-style-type: none"> <li>1. ablation of targeted nerves;</li> <li>2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and</li> <li>3. surgical techniques, such as laser or endoscopic discectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.</li> </ol> <p>At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.</p> <p>When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.</p> <p>Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be</p>	

Policy Number	Title	Text	Recommendation
		performed only by physicians with appropriate training and credentialing.  (BOT Rep. 16, A-13)	
H-410.951	Physician Practice Drift	Our AMA will: (1) continue to work with interested state and national medical specialty societies to advance truth in advertising legislation, and (2) continue to monitor legislative and regulatory activity related to physician practice drift.  (BOT Rep. 5, A-13)	Retain – this policy remains relevant.
H-410.958	Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers	Our AMA: (1) encourages and supports state medical boards and state medical societies in adopting advisory opinions and advancing legislation, respectively, that interventional pain management of patients suffering from chronic pain constitutes the practice of medicine; and (2) will work to ensure that interventional pain management is the practice of medicine and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence. Further, our AMA will collect, synthesize and disseminate information regarding the educational programs in pain management and palliative care offered by nursing programs and medical schools in order to demonstrate adherence to current standards in pain management.  (Res. 903, I-07; Reaffirmed: BOT Rep. 16, A-13)	Retain – this policy remains relevant.
H-425.970	Promoting Health Awareness and Preventive Screenings in Individuals with Disabilities	Our AMA will work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities.  (Res. 911, I-13)	Retain – this policy remains relevant.
H-435.964	Federal Preemption of State Professional Liability Laws	The AMA supports professional liability reform on the federal level that will preempt state constitutional, statutory, regulatory and common laws that prohibit a cap on liability awards; and such federal legislation shall not preempt state constitutional, statutory, regulatory and common laws that set caps or other restrictions on liability awards which are lower or more comprehensive than the caps on liability awards established by such federal legislation.  (Res. 237, A-95; Reaffirmed: Sub. Res. 910, I-03; Reaffirmed: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
H-435.965	“Clear and Convincing” Standard	1. The AMA continues to support the use of the clear and convincing evidence	Retain – this policy remains relevant.



Policy Number	Title	Text	Recommendation
	of Proof in Medical Liability Cases	<p>standard of proof in medical negligence cases in which the plaintiff seeks punitive damages and will continue to advocate civil justice reform designed to prevent non-meritorious claims from being filed or to quickly resolve them before extensive litigation proceeds.</p> <p>2. Our AMA will continue to work with interested state and specialty societies on legislation adopting the clear and convincing evidence standard.</p> <p>(BOT Rep. 51, A-94; Reaffirmed: BOT Rep. 12, A-05; Appended: BOT Rep. 4, A-13)</p>	
H-435.966	Prohibit Third Party Payers from Requiring Professional Liability Coverage Beyond Mandated Limits	<p>The AMA finds unreasonable the demand by any hospital or third party payer that their providers carry professional liability coverage in excess of the minimum mandated of physicians by state law; and will design and distribute model legislation that prevents any health care institution or third party payer from requiring their physicians to carry professional liability coverage in excess of the minimum mandated by law.</p> <p>(Res. 203, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-435.998	Equitable Risk Classification in Medical Liability Premiums	<p>Our AMA supports the concept that premiums for medical liability insurance should reflect the costs and risks of providing that insurance to each category insofar as feasible based on accepted underwriting principles. Further, the policy of the AMA is that physicians who practice part-time should be entitled to reduced professional liability insurance premiums.</p> <p>(Res. 15, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed and Appended: CMS Rep. 12, A-02; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-440.926	United States Surgeon General	<p>The AMA, in order to best protect the health care needs of the American people, will seek changes in federal law to require that the Surgeon General of the United States be an MD/DO, whether the Surgeon General is confirmed by the U.S. Senate or appointed to serve on an acting or interim basis.</p> <p>(Sub. Res. 211, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-475.986	Surgical Assistants other than Licensed Physicians	<p>Our AMA: (1) affirms that only licensed physicians with appropriate education, training, experience and demonstrated current competence should perform surgical</p>	<p>Retain this policy in part.</p> <p>Delete the reference to the American College of</p>

Policy Number	Title	Text	Recommendation
		<p>procedures;</p> <p>(2) recognizes that the responsible surgeon may delegate the performance of part of a given operation to surgical assistants, provided the surgeon is an active participant throughout the essential part of the operation. Given the nature of the surgical assistant's role and the potential of risk to the public, it is appropriate to ensure that qualified personnel accomplish this function;</p> <p>(3) policy related to surgical assistants <del>consistent with the American College of Surgeons' Statements on Principles</del> states: (a) The surgical assistant is limited to performing specific functions as defined in the medical staff bylaws, rules and regulations. These generally include the following tasks: aid in maintaining adequate exposure in the operating field, cutting suture materials, clamping and ligating bleeding vessels, and, in selected instances, actually performing designated parts of a procedure. (b) It is the surgeon's responsibility to designate the individual most appropriate for this purpose within the bylaws of the medical staff. The first assistant to the surgeon during a surgical operation should be a credentialed health care professional, preferably a physician, who is capable of participating in the operation, actively assisting the surgeon. (c) Practice privileges of individuals acting as surgical assistants should be based upon verified credentials and the supervising physician's capability and competence to supervise such an assistant. Such privileges should be reviewed and approved by the institution's medical staff credentialing committee and should be within the defined limits of state law. Specifically, surgical assistants must make formal application to the institution's medical staff to function as a surgical assistant under a surgeon's supervision. During the credentialing and privileging of surgical assistants, the medical staff will review and make decisions on the individual's qualifications, experience, credentials, licensure, liability coverage and current competence. (d) If a complex surgical procedure requires that the assistant have the skills of a surgeon, the surgical assistant must be a licensed surgeon fully qualified in the specialty area. If a complication requires the skills of a specialty surgeon, or the surgical first assistant is expected to take over the surgery,</p>	<p>Surgeons' (ACS) Statements on Principles. ACS has changed their policy related to surgical assistants.</p>

Policy Number	Title	Text	Recommendation
		<p>the surgical first assistant must be a licensed surgeon fully qualified in the specialty area.</p> <p>(e) Ideally, the first assistant to the surgeon at the operating table should be a qualified surgeon or resident in an education program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and/or the American Osteopathic Association (AOA). Other appropriately credentialed physicians who are experienced in assisting the responsible surgeon may participate when a trained surgeon or a resident in an accredited program is not available. The AMA recognizes that attainment of this ideal in all surgical care settings may not be practicable. In some circumstances it is necessary to utilize appropriately trained and credentialed unlicensed physicians and non-physicians to serve as first assistants to qualified surgeons.</p> <p>(BOT Rep. 32, A-99; Reaffirmed: Res. 240, 708, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13)</p>	
H-475.989	Laser Surgery	<p>Our AMA (1) adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services; and (2) encourages state medical associations to support state legislation and rulemaking in support of this policy.</p> <p>(Sub. Res. 39, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13)</p>	Retain – this policy remains relevant.
H-480.947	Medical Patents and Their Infringement on the Art of Medicine	<p>Our AMA supports for the Ganske Compromise and discourages the medical community from soliciting patents on medical methodology.</p> <p>(BOT Action in response to referred for decision Res. 223, A-03; Modified: CSAPH Rep. 1, A-13)</p>	<p>Sunset this policy.</p> <p>AMA Code of Medical Ethics <a href="#">7.2.3 Patents &amp; Dissemination of Research Products</a>, modified in 2017, captures the intent of this older policy.</p>
H-520.986	The Future of Genito-Urinary Treatment and Research	<ol style="list-style-type: none"> <li>Our AMA supports legislation and/or regulations to ensure both Active Duty members of the Armed Forces and Veterans suffering from genito-urinary injuries receive the best possible surgical and mental health care.</li> <li>Our AMA, in consultation with relevant medical specialty societies, will promote the study of genito-urinary trauma in members</li> </ol>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>of the Armed Forces and Veterans to improve the diagnosis, prevention and treatment of genito-urinary injuries. (Res. 227, A-13)</p>	
H-60.959	Uniformity of State Adoption and Child Custody Laws	<p>The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the “best interest of the child” as the most important criterion determining custody, placement, and adoption of children.</p> <p>(Sub. Res. 219, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	<p>Sunset this policy.</p> <p>The Uniform Adoption Act was retired as an act of the Uniform Law Commission (ULC, previously known as the National Conference of Commissioners on Uniform State Laws) in July 2017. According to ULC meeting minutes, the ULC discontinued the uniform act because it had only been adopted by one state and contained outdated provisions.</p>
H-60.969	Childhood Immunizations	<ol style="list-style-type: none"> <li>1. Our AMA will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine.</li> <li>2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics.</li> <li>3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards.</li> <li>4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation.</li> <li>5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age.</li> <li>6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare &amp; Medicaid Services to deactivate coding edits that cause a decrease in immunization rates</li> </ol>	<p>Retain – this policy remains relevant.</p>

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		for children, and to make these edit deactivations retroactive to January 1, 2013. (Res. 542, A-92; CSA Rep. 4, I-95; Reaffirmed by BOT Rep. 24, A-97; Reaffirmation A-05; Appended: Res. 121, A-13)	
H-70.939	Definition of Consultation: CMS vs. CPT 4 Coding Manual	(1) Our AMA and the Federation make known to CMS that redefining consultation to achieve cost savings is unacceptable to the medical profession. (2) That if necessary the AMA seek regulatory and/or legislative relief to overcome this regulatory decision on the part of CMS. (3) Our AMA urges the CPT Editorial Panel to review the CPT definitions for consultations and make any needed clarifications. (Res. 822, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12)	Retain – this policy remains relevant.

## 10. AMERICAN MEDICAL ASSOCIATION CENTER FOR HEALTH EQUITY ANNUAL REPORT

*Informational report; no reference committee hearing.*

**HOD ACTION: FILED**

### BACKGROUND

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-180.981, 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” and instructing the “Board to provide an annual report to the House of Delegates regarding AMA’s health equity activities and achievements.” The HOD provided additional guidance via Policy H-180.944: “Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.” HOD policy was followed by creation of the AMA Center for Health Equity (“Center”) in April 2019 and the AMA’s Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 (“Plan”) in May 2021. In 2022, updated Policy H-65.946 specified that this report will also include “updates on [the AMA’s] comprehensive diversity and inclusion strategy.”

### DISCUSSION

Our AMA has committed itself to advancing health equity, advocating for racial and social justice, and embedding equity across the organization and beyond. In 2022, the Center continued to collect enterprise-wide equity related work and track progress toward the five strategic approaches detailed in the AMA’s Plan. This report outlines the activities conducted by our AMA during calendar year 2022, divided into five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing. The diversity and inclusion strategy updates are included within the Embed Equity section.

### *Embed Equity*

Ensuring a lasting commitment to health equity by our AMA involves embedding equity using anti-racism, structural competency, and trauma-informed lenses as a foundation for transforming the AMA’s staff and broader culture, systems, policies, and practices, including training, tools, recruitment and retention, contracts, budgeting,

communications, publishing, and regular assessment of organizational change. The following are some of the relevant accomplishments during 2022:

- The AMA engaged 1,000,000 users of health equity-related content on the website, a +43% increase over the prior year, by producing 108 new health equity-related articles or other content, significantly more than any other year. The most consumed content included: (1) “GME –These courses create health equity champions in your Residency Program” (193K users), (2) “2022 a critical year to address the worsening drug overdose crisis” (13K users), (3) “The AMA’s Strategic plan to embed racial justice and advance health equity” (11k users).
- The AMA incorporated health equity into the annual Medical Student Advocacy Conference (MAC) and the annual Research Challenge, which is the largest national, multi-specialty medical research conference for medical students, residents and fellows, and international medical graduates to showcase and present research. Changes included incorporating customized diversity, equity, and inclusion (DEI) statements in Research Challenge marketing, reducing bias in the Research Challenge abstract review process by removing author names, incorporating subtitles in Research Challenge and MAC training videos, and producing an education session at MAC on redefining social determinants of health in organized medicine.
- The AMA continued to reflect its commitment to health equity in its messaging, speeches, and announcements on an ongoing basis on various fronts including the All-Employee Meeting, Frontline Communicator Training, Board of Trustees message/media training, and beyond.
- The AMA produced six Prioritizing Equity episodes (including voting and health and reproductive health care as a human right) and eight podcast episodes (five Stories of Care episodes on health equity and infection control, two LGBTQ-themed episodes, and one episode on embedding racial and health equity in health systems), hosted 2 webinars on social determinants of health and racial and health equity for health systems, and published a STEPS Forward toolkit (Racial and Health Equity: Concrete STEPS for Health Systems) and five health-equity centered issues of the Journal of Ethics (Inequity Along the Medical/Dental Divide, Toward Abolition Medicine, Health Equity in US Latinx Communities, Inequity and Iatrogenic Harm, What We Owe Workers in Health Care Who Earn Low Wages) with a combined 1 million unique journal website visitors during the months of those issues.
- AMA Councils produced three reports including health equity considerations adopted by the House of Delegates on pandemic ethics, rural public health, and climate change and public health. The Board of Trustees produced two health-equity related reports adopted by the House of Delegates on a [global non-discrimination policy](#) and [language related to discrimination and harassment](#).
- AMA staff updated over 50 years of publication illustrations of patients in procedural descriptions for the Current Procedural Terminology (CPT) Pro Book. The 2023 CPT PRO Book will have over 20 illustrations that reflect diversity in skin tones and ethnicity, with plans for more in future years.

The AMA’s employee life cycle and internal diversity, equity, and inclusion (DEI) framework help to operationalize DEI initiatives across the enterprise. Within embedding equity, updates on the AMA’s diversity and inclusion strategy include:

- All of the AMA’s business units (BUs) created their first annual equity action plans.
- The AMA developed the second phase of its embedding equity curriculum, for launch in 2023, to help staff practically apply inclusive skills.
- The AMA developed dashboards including demographics of existing staff and new hires, with data included in the annual report to AMA senior management.
- The AMA continued to diversify its outside counsel legal spend by working with law firms owned by Black attorneys, attorneys of color and/or women, some of whom are members of the National Association of Minority & Women Owned Law Firms (NAMWOLF).
- The AMA continued efforts toward expanding its vendor base to a more diverse group.

- The AMA added to its suite of Employee Resources Groups with the launch of the Immigrant Xchange ERG. [ERGs<sup>1</sup>](#) are voluntary, self-coordinating employee-driven groups which are based on a constituency or shared interest, and provide community, support and networking opportunities.
- The AMA continued its partnership with Urban Alliance’s Alumni Internship Program (AIP), which matches graduates of the High School Internship Program with paid 6-week summer internships at the AMA, to help them gain valuable professional experience and earn income to support their future.
- The AMA committed to improving workplace accessibility including installing auto-operators on doors in Chicago and DC, and reduced size of conference room tables to improve accommodation for mobility devices and other factors.
- The JAMA Network Equity Action Team (JNEAT) led work including an anonymous pulse survey of staff and bi-monthly newsletters and learning sessions for staff. Webinars attracting over 325 employees included a dialogue with Dilla Thomas on the history of medicine in Chicago through the lens of its marginalized groups, a learning session with Open Books Chicago on literacy levels within Chicago’s marginalized communities, and an interactive practice session for staff to learn about updates and practice applying inclusive language and reporting guidance in medical publication.

### *Build Alliances and Share Power*

Building strategic alliances and partnerships and sharing power with historically marginalized and minoritized physicians and other stakeholders is essential to advancing health equity. This work centers previously excluded voices, builds advocacy coalitions, and establishes the foundation for true accountability. The following are some of the relevant accomplishments during 2022:

- The AMA continued to sponsor events that engaged historically marginalized audiences, including National Association of Black Journalists (NABJ), National Association of Hispanic Journalists (NAHJ), the Association of LGBTQ Journalists (NLGJA).
- The AMA completed a community impact plan for improving blood pressure control in collaboration with West Side United (WSU). In October, working with the City Club of Chicago, AMA convened business and civic leaders to highlight the collaboration and the AMA’s additional \$3 million social impact investment, bringing the AMA’s multi-year total investment to \$5 million, with the intention of benefitting Chicago’s 500,000 West Side residents (33% Black, 39% Hispanic or Latino, 21% white). This investment leverages AMA’s new commitment as an anchor mission partner with WSU—adding to a group of collaborators committed to addressing structural inequities, eliminating health disparities and improving economic vitality and educational opportunities in Chicago’s west side communities, which have been devastated by decades of neglect and disinvestment.
- The national Release the Pressure (RTP) campaign, led by the AMA in collaboration with the American Heart Association, the AMA Foundation, the Association of Black Cardiologists, the Minority Health Institute, and the National Medical Association, was designed to increase awareness of heart health, heart disease and high blood pressure among Black women. The campaign continued momentum in 2022 with over 67,000 video views and almost 31,000 pledges.
- The Medical Justice in Advocacy Fellowship, an educational initiative in collaboration with Morehouse School of Medicine’s Satcher Health Leadership Institute (SHLI), showcased capstone projects of the first cohort of 12 physician fellows at the AMA HOD Interim Meeting and launched the second cohort of 11 physician fellows with intensive training at Morehouse School of Medicine.

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<sup>1</sup>Immigrant Xchange joins Access, BEAN (Black Employees, Advocates and Allies Network), InspirASIAN, Pride, Unidos, Veterans Community Resource Group, and Women Inspired Now (WIN).

- As part of the Physician Data Collaborative (Collaborative), the AAMC, ACGME and AMA continue to work together to establish best practices for data sharing and collection and reporting standards for sociodemographic data, including race and ethnicity, sexual orientation, gender identity and more. These efforts enable meaningful, collaborative research to better understand the dynamics of the physician workforce continuum. During 2022, the Collaborative agreed on race and ethnicity data collection standards and the addition of a Middle Eastern and North African category (establishing a pilot on the addition of this category), and continued to refine a collaborative research agenda.
- The AMA participated in or led four meetings with Association of American Medical Colleges (AAMC) and Accreditation Council for Graduate Medical Education (ACGME) about diversifying physician workforce, three ACGME Diversity Officers Forums, two webinars (Enhancing Diversity Among Academic Physicians: Recruitment, Retention and Advancement; Removing barriers and facilitating access: Supporting trainees with disabilities across the medical education continuum), two presentations to Academic Physicians Section (equity, diversity, and belonging activities in medical education; minoritized physician burnout and wellbeing), and three presentations on the implications of the pending Supreme Court decision on *Students for Fair Admissions v. Harvard / University of North Carolina*.
- The AMA provided seven speaking engagements or workshops with organizations that serve historically marginalized communities (including one with AllianceChicago and three with Arizona Alliance, both consortia of Federally Qualified Health Centers, or FQHCs), completed burnout assessments in 32 FQHCs (representing approximately 31% of all burnout assessments during the year), updated demographic questions in burnout assessments, and built a racial bias assessment tool (to be validated in 2023). The AMA piloted the stratification of all burnout assessment data for each health system report for a 3-month period to better understand how it informs systems as well as the limitations of the data.
- The AMA engaged with Illinois March of Dimes in workgroups on dismantling racism, increasing care access, and engaging communities in private practices to support maternity care deserts.
- The health equity content on AMA's Ed Hub has established itself as an impetus for institutional memberships and partnerships, with six additional health equity-focused external partners signed and launched during the year (Clinical Problem Solvers, Boston Children's Hospital, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, Hope for Justice, and Accreditation Council for Graduate Medical Education or ACGME). The UNC Health Systems recently selected the Ed Hub's "Basics of Health Equity" as required education for their entire medical staff. During the Mpox outbreak, the established relationships with LGBTQ health organizations allowed for swift response with accurate, effective, and destigmatizing education reaching the large Ed Hub audience.
- The AMA ChangeMedEd initiative implemented grants awarded in November to various recipients, including Kaiser Permanente (Early Assurance: Community College to Medical School) and UC Davis (Learning from Bright Spots in Equitable Grading Practices).
- The AMA continued its work with organizations representing historically minoritized and marginalized physicians, including Association of American Indian Physicians (AAIP), GLMA, National Council of Asian Pacific Islander Physicians (NCAPIP), National Hispanic Medical Association (NHMA), and National Medical Association (NMA). The AMA concluded a second year of Health Equity Strategic Development (HESD) grants, an investment in these organizations in support of the advancement of their individual organizational mission and strategic goals, and in recognition of the collective impact of their work on the field of medicine. In addition, the Center convened the organizations quarterly, building a crosswalk of shared policy priorities to identify opportunities to build on each other's advocacy in future years. The LGBTQ Advisory Committee has a permanent position for a representative from GLMA on the committee, which allowed for continued regular coordination and collaboration with GLMA. The Minority Affairs Section has permanent positions on its Governing Council for representatives from AAIP, NHMA, and NMA.
- The Medical Student Section (MSS) Assembly includes delegates from the Association of Native American Medical Students (ANAMS), the Latino Medical Student Association (LMSA), and the Student National Medical Association (SNMA). MSS continued collaborating with the Minority Affairs Section (MAS) to enhance engagement of medical students who are underrepresented in medicine (URM), sending select members of both Governing Councils as ambassadors to the annual conferences of URM medical student societies including SNMA, LMSA and ANAMS. This year, MAS launched its Leader-To-Leader initiative



to better align the section's priorities around increasing diversity, equity, inclusion, and representation in the physician workforce. MAS and MSS members worked together to host receptions at the SNMA and LMSA annual conferences where our URM AMA leaders could meet with their elected and appointed leaders to open new lines of communication, to establish informal networks, and to learn more about organizational priorities. In April, MAS supported registration and housing for approximately 10 elected leaders of MSS, SNMA, LMSA and ANAMS to attend the annual Leadership Summit on Health Disparities, to foster network expansion, informal networking, and educational opportunities among these future doctors. The MAS and MSS Governing Councils also hosted a meeting in November to specifically convene URM medical student leaders who attended our Interim Meeting in Honolulu.

- The AMA formalized its collaboration with Stanford supporting research using AMA data to explore the effects of the COVID pandemic on international medical graduate (IMG) physicians, patterns of care provided by IMGs across the U.S., and their role in providing patient care for underserved communities during COVID-19.

### *Push Upstream*

Pushing upstream requires looking beyond cultural, behavioral, or genetic reasons to understand structural and social drivers of health and inequities, dismantle systems of oppression, and build health equity into health care and broader society. The following are some of the relevant accomplishments during 2022:

- On the international stage, the World Medical Association (WMA) General Assembly adopted a new policy to address racism in medicine, to which the AMA contributed substantial language and support, based largely on HOD policy. The AMA has also been leading the ongoing revision of a seminal WMA document, the Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects, prioritizing diverse perspectives and issues of equity, such as ethical research in vulnerable populations. Finally, the AMA has continued centering equity in other WMA policy revisions, including addressing the disproportionate impact of forced sterilization on certain groups.
- The AMA was a powerful voice on reproductive health following the Supreme Court's *Dobbs* decision in June and continued to be visible on this topic in the media and speeches and published numerous AMA Viewpoints on topics important to health equity including LGBTQ health, pulse oximeters, and Black maternal health.
- In cases ranging from COVID-19 standards of care and firearm regulations to climate change and transgender rights, the AMA continued to fight for physicians and patients in state and federal courts. The AMA was a plaintiff in *African American Tobacco Control Leadership Council v. HHS*, which forced the federal government to take the first steps toward banning menthol cigarettes. In support of the consideration of race in higher education admissions, the AMA joined an AAMC-led U.S. Supreme Court [amicus brief](#) in the *Students for Fair Admission v. Harvard* and *Students for Fair Admission v. University of North Carolina* cases. Together with the American Academy of Pediatrics, the AMA submitted an [amicus brief](#) urging the U.S. Supreme Court to uphold the Indian Child Welfare Act (ICWA) of 1978. And in the wake of the U.S. Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision, the AMA joined numerous briefs promoting access to reproductive care and opposing government interference in the patient-physician relationship.
- The AMA now looks at every advocacy issue with an eye towards its impact on historically marginalized and minoritized communities. The AMA issued more than 175 advocacy letters to policymakers, and more than 40 percent of those were directly related to our health equity work.
- AMA advocated in many ways for policies to advance health equity including:
  - Securing legislation extending telehealth payment and regulatory flexibilities through the end of 2024, including audio-only telephone visit services. The AMA also launched model legislation that states can use to advance telehealth coverage and policies.
  - Supporting maternal and child health. The AMA developed new model state legislation to support maternal and child health in partnership with leading medical societies and national organizations. The model bill is part of a national campaign to support pregnant, postpartum and parenting individuals, newborns, children and families affected by substance use disorders. The AMA

- supported 27 states and DC in extending Medicaid coverage to 12 months postpartum and secured a permanent option to support states in the Consolidated Appropriations Act of 2023 (CAA).
- Securing key provisions of the Mainstreaming Addiction Treatment (MAT) Act (such as repealing the X-waiver requirement for buprenorphine prescribing) in the CAA, revisions to CDC guidelines for prescribing opioids that emphasize the need to treat patients as individuals, Food and Drug Administration (FDA) policy allowing harm reduction organizations to more easily obtain naloxone to prevent overdose deaths, and a Drug Enforcement Administration (DEA) commitment to working for permanent availability of medication assisted treatment based on telehealth visits. The AMA also helped multiple states enact legislation to decriminalize fentanyl test strips and other drug testing supplies and equipment, acknowledging the annual more than 100,000 deaths are primarily due to illicitly manufactured fentanyl and fentanyl analogues.
  - The AMA Substance Use and Pain Care Task Force continued to advocate to reduce health care inequities, including those that disproportionately affect historically minoritized and marginalized communities. Reports from the Task Force and those conducted with Manatt Health make clear that reversing the nation's overdose and death epidemic must directly address structural barriers and social determinants of health. The Task Force continues to gather input from member organizations Association of American Indian Physicians, National Hispanic Medical Association and National Medical Association.
  - Supporting multiple state efforts to enact legislation to strengthen mental health and substance use disorder parity laws. These include requiring payers to demonstrate compliance with parity laws and for state departments of insurance and attorneys general to investigate payers' compliance.
  - The AMA and several collaborators sent a [letter](#) to Attorney General Merrick Garland urging the Department of Justice to investigate the threats of violence against physicians, hospitals and families of children for providing and seeking [evidence-based gender-affirming care](#). The organizations also call on technology platforms to do more to stop the rhetoric that often incites threats or acts of violence and has led to harassment campaigns across the country, much of it directed at children's hospitals and the physicians and staff who provide care.
  - Highlighting inequities in Medicare Advantage including quality and administrative barriers. In a [letter](#) to the United States Department of Health and Human Services (HHS), the AMA noted that Black, Asian, and Latino enrollees sign up for Medicare Advantage (MA) at higher rates than white enrollees but tend to be in plans with lower quality ratings. Kaiser Family Foundation data show that nearly all (99 percent) of MA enrollees are in plans that require prior authorization (PA) for some services, up from 80 percent in 2018. Institute for Patient Access data show that patients with chronic conditions who identify as Black or Latino experience insurance claim rejections at least 40% more often than white patients, going on to experience more emergency room visits and hospitalizations. The AMA helped move a bipartisan House bill to reform prior authorization for Medicare Advantage plans, H.R. 3173, the "Improving Seniors' Access to Care Act," passed via voice vote, and a companion Senate bill now with 51 co-sponsors.
  - Developing principles for Medicare physician payment reform endorsed by more than 120 medical societies, which incorporate concepts to advance equity and reduce disparities.
  - Cosigning a letter in conjunction with over 60 national medical specialty, hospital and patient organizations urging the [House](#) and [Senate](#) Judiciary Committees to pass the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize the Conrad 30 waiver policy for an additional three years, to ensure international medical graduates (IMGs) can continue to play a pivotal role in greater access to health care.
  - Submitting a [Statement for the Record](#) to the U.S. House of Representatives Committee on the Judiciary Subcommittee on Immigration and Citizenship as part of the hearing entitled "Is there a Doctor in the House? The Role of Immigrant Physicians in the US Healthcare System." Additionally, the AMA submitted a [Statement for the Record](#) to the U.S. Senate Subcommittee on Immigration, Citizenship, and Border Safety as part of the hearing entitled, "Flatlining Care: Why Immigrants Are Crucial to Bolstering Our Health Care Workforce."
  - The AMA continues to support laws that prohibit so-called conversion therapy. We successfully supported the Oklahoma State Medical Association in opposing a bill that would have protected

conversion therapy and worked with the AMA's Advisory Committee on LGBTQ+ issues to update and disseminate an issue brief summarizing the medical literature demonstrating the harm caused by conversion therapy.

- Supporting a Dear Colleague letter to the FDA Commissioner urging the end of the blanket three-month blood donation deferral period for men who have sex with men. The Dear Colleague letter was ultimately cosigned by nearly 150 members of Congress. The FDA has signaled that it will continue existing flexibilities.
- Every bi-weekly issue of the AMA's Advocacy Update includes at least one article related to our health equity work. Equity-related episodes of the AMA's Advocacy Insights webinar series, such as the limited time Public Service Loan Forgiveness Program waiver, the future of telemedicine, and the impact of the nation's drug overdose epidemic on children and adolescents, have had significant participation (hundreds of attendees) and engagement (30+ questions) each session.
- The AMA launched a bi-monthly health equity newsletter and the Federation Equity Exchange, attracting dozens of attendees each month for state and specialty societies to share promising practices.
- This is the first year covered by the AMA's annual Health Equity in Organized Medicine Survey. The survey seeks to understand the specific actions that Federation organizations are taking or contemplated taking to advance health equity, gather shareable successes stories, and confidentially identify barriers and resource needs.
  - Eighty organizations completed the survey: half (n=40) were specialty societies, about 1 in 3 (n=25) were state and District of Columbia associations, and about 1 in 5 (n=15) were local associations.
  - Most organizations (70%) indicated that health equity was a strategic priority.
  - Most organizations were aware of the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity (85%), and the AMA and AAMC's Advancing Health Equity: A Guide to Language, Narrative and Concepts (54%). Among the organizations that were aware, about half referenced or used the materials. More than half (n=44) indicated they provided equity training to staff and leadership.
  - More than 1 in 3 (n=30) organizations indicated they had identified historical harms in their organization's policies and practices, and 30% of organizations indicated that they have taken action to address past harms caused by their organization.
  - Note: All results are preliminary. The survey results are still being analyzed, with a full summary planned for later in 2023.
- The JAMA Network published over 632 articles on topics related to equity, diversity, and inclusion, viewed in full text 4 million times.
- AMA staff contributed to at least 10 publications in related to health equity.
- The AMA's Ed Hub published an unprecedented volume of health equity content (78 activities), with usage of equity-related content exceeding the prior year (124,374 engagements; 21,625 course completions). One highlight included: undergraduate / graduate (UME/GME) and continuing medical education (CME) versions of the Historical Foundations of Racism modules were published, as well as adapted versions accessible for UME and GME curricular enhancement program (UCEP/GCEP) members and individual learners: Medical Mistrust and Medical Distrust; Pain and Racism in Medicine and Health Care. In addition, the AMA led 4 presentations at health care meetings demonstrating educational best practices for integration of equity.
- The AMA concluded its year-long Peer Network learning collaborative, led by AMA with The Joint Commission (TJC) and Brigham and Women's Hospital as key collaborators, positively influencing the development of TJC equity accreditation standards for health systems.
  - The pilot program of 49 learning sessions included more than 40 participants from eight health systems, of which 3 were AMA group members, graduating the health systems into a Quality Safety and Equity Network integrated into the Physician Innovation Network.
  - Successes of over 26 new improvement practices implemented by the health system teams included embedding a bias/discrimination question into safety reporting to track and take action on equity-related harm events, incorporating fundamental data collection tools to stratify data sets by race, ethnicity, and language (REAL), improving on disability, sexual orientation and gender

- identity (SOGI) data collection, developing educational content to better equip staff on how to identify inequities, bringing together multidisciplinary stakeholders across the system to identify improvements that will result in better patient and staff experience and outcomes, and incorporating health equity into the development and implementation of a racial equity plan.
- At mid-year, survey respondents agreed or strongly agreed that the quality of the Peer Network was excellent (100%) and that it equipped them to advance health equity, strengthened their knowledge of inequities, and empowered them to dismantle structural racism (>80%).
  - Products included creating seven Ed Hub modules with CME and a Prioritizing Equity episode highlighting the work of two group member health systems, Atlantic Medical Group and Ochsner Health.
  - The Peer Network was covered in 37 articles with over 10 million views.
  - The AMA laid the groundwork for Rise to Health: A National Coalition for Equity in Health Care, an effort that unites individuals and organizations in shared solutions for high-impact structural change. The Coalition, co-led by the AMA and the Institute for Healthcare Improvement (IHI), secured other collaborators including Race Forward, Groundwater Institute, the American Hospital Association (AHA), the National Association of Community Health Centers (NACHC), Association of Health Insurance Plans (AHIP), the Council of Medical Specialty Societies (CMSS), Policy Link, and HealthBegins, with a general audience launch planned for 2023.
  - The AMA expanded its social impact investments with an additional \$3 million multi-year investment in West Side United (WSU), a community-based collaborative that is addressing determinants of health and helping restore economic vitality on the Chicago's west side.
    - This new investment builds on the AMA's initial \$2 million investment in 2020 and will continue to support WSU's multi-pronged social impact investing approach. WSU-coordinated impact investing is done in partnership with community development financial institutions (CDFIs) to help provide much-needed capital to foster economic opportunity, revitalize neighborhoods and support community transformation. AMA's renewed commitments will lead to more investments in affordable housing, healthy food options, job creation projects and educational programs.
    - To date, WSU partners have invested a combined \$177 million in Chicago's West Side neighborhoods through local procurement, small business grants, and impact investing, including the AMA's 5-year, \$5 million investment. Since 2018, the collaborative's funding has contributed to approximately 475 low-interest loans, including entrepreneurs, small businesses, and community-based organizations. CDFIs leveraged these investments for an additional \$28 million to support the west side community and business projects. The WSU investments also resulted in the creation and preservation of 420 housing units, as well as the construction and preservation of more than 34,000 square feet of non-profit and commercial real estate projects. Additionally, these investments have supported 432 construction jobs, preserved 64 local jobs, and created 126 community employment opportunities.
  - In collaboration with West Side United and West Side Health Equity Collaborative, the AMA, trained more than 100 community health workers. In addition, the AMA MAP BP program was implemented and demonstrated success in improving blood pressure control at Cook County Health, a large health care organization serving mostly patients from historically marginalized communities.

### *Ensure Equity in Innovation*

The AMA is committed to ensuring equitable health innovation by embedding equity in innovation, centering historically marginalized and minoritized people and communities in development and investment, and collaborating across sectors. The following are some of the relevant accomplishments during 2022:

- The AMA launched the In Full Health Learning & Action Community to Advance Equitable Health Innovation initiative which seeks to provide a framework for shared understanding and a community for stakeholders committed to learning and action to center equity within their health innovation investment, development, and purchasing efforts by committing resources to innovations created by, with, and that measurably improve health and do no harm for Black, Latino, Indigenous, communities of color, women, LGBTQ+ communities, people with disabilities, people with low income, rural communities, and other

communities historically marginalized by the health industry. The initiative established an external advisory group and published Principles for Equitable Health Innovation.

- The AMA completed a health equity assessment on Verifi Health Self-Measured Blood Pressure (SMBP), an app for remote blood pressure monitoring, and continues to build features into the product that promote health equity.
- The AMA created a prototype Social Needs Administrative Coder (SNAC) and began a Voice-of-the-Customer campaign across societies, technology vendors, state level entities, health insurers, community organizations and health information exchanges to better understand the need for consistent coding of health-related social needs (HRSN) screening data into nationally accepted codesets like ICD-10-CM.

### *Foster Truth, Racial Healing, Reconciliation, and Transformation*

The AMA recognizes the importance of acknowledging and rectifying past injustices in advancing health equity for the health and well-being of both physicians and patients. Truth, racial healing, reconciliation, and transformation is a process and an outcome, documenting past harms, amplifying and integrating narratives previously made invisible, and creating collaborative spaces, pathways, and plans. The following are some of the relevant accomplishments during 2022:

- The 175th anniversary workgroup included AMA archivists as key stakeholders, supporting truth and reconciliation, through development of historical research for programming and educational modules and networking with other medical association professionals looking to examine their histories in this way.
- The AMA began creating a charter and identifying potential participants for the Truth, Reconciliation, Healing, and Transformation Advisory Committee called for by the AMA House of Delegates, so the committee can commence work in 2023.
- AMA staff engaged in educational sessions and community events including: AMA History/Transformative Narrative, Guide to Allyship, Time for Personal Reflection, Liberation Health: Allyship, My Hood / My Block, My City Event, Color of Care Screening and Breakouts, ERG Review & Recruitment, Gardeneers Event, Women Inspired Now (WIN) Reproductive Rights Session and Discussion. One session was a deeper look at the history of work toward reproductive justice within the AMA, findings from qualitative research with patients who have received obstetric, gynecological, and related care, and policy-related implications for maternal health given recent federal level court and legislative actions, state politics, transitional care, contraceptive access for patients, providers, and public health. A Reproductive Justice panel featured obstetrics and gynecology experts as guests, and opening remarks provided by former AMA President Patrice Harris, MD, MPH.
- Dilla Thomas was invited to speak to staff on the Black History of Medicine in Chicago. He titled the event, "Everything Dope Comes from Chicago: A Look into the History of Chicago in Medicine Through the Lens of its Marginalized Groups."

### *Challenges and Opportunities*

As cities and states across the nation updated social distancing guidance, staff returned to AMA offices and began adjusting to new hybrid schedules which required an additional layer of planning and coordination. This required strategizing innovative ways to build connections and foster engagement in a new work environment. Commonly noted challenges to advancing health equity work included: 1) limited staff time and capacity, resource constraints, and competing priorities with tight deadlines; 2) varying levels of understanding of health equity, with persistence of some common narratives that sustain inequity; 3) still fledgling structures and processes for cross-enterprise dialogue, coordination, and reporting on initiatives and measures; and 4) the capacity, infrastructure, and time needed to develop external collaborations. While turnover was mentioned as a challenge to sustaining the health equity work, in some cases the scarcity of open positions posed challenges to increasing diversity in promotion.

Prioritizing and matching workload to capacity were mentioned as essential in avoiding contributing to burnout. Additional curriculum and sessions that foster conversations and self-reflection to further understanding and undoing harms in a psychologically safe space require substantial time, timeliness, skilled facilitators, and openness and commitment from team leaders. Additional structures and processes that support transparent sharing of goals,

planning, resources, implementation, and accountability across teams and with external collaborators can help bring focus to priorities and promote sustainability.

## CONCLUSION

AMA staff were asked for their most prominent equity-related accomplishments, and not everything submitted could be included in this report, so the above represents a fraction of the work completed in 2022. The AMA increased engagement of health equity content to 1,000,000 website users, including 124,374 engagements driven by publication of 78 new activities on Ed Hub. The AMA engaged in at least two Supreme Court amicus briefs and

issued more than 70 advocacy letters to policymakers related to health equity, securing wins in the Consolidated Appropriations Act. The AMA expanded its social impact investments with an additional \$3 million multi-year investment. Overall, the AMA has made significant progress towards fulfilling the commitments outlined in the Plan during its second year.

## 11. HPSA AND MUA DESIGNATION FOR SNFS

*Reference committee hearing: see report of Reference Committee B.*

### **HOD ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED**

*See Policies D-200.980, H-200.954, H-280.979, H-465.981 and H-465.988*

At the June 2022 Annual Meeting, the House of Delegates referred Resolution 224-A-22, “HPSA and MUA Designation for SNFs,” sponsored by the Society for Post-Acute and Long-Term Care Medicine (AMDA). Resolution 224-A-22 asked the American Medical Association (AMA) to advocate for legislative action directing the U.S. Department of Health and Human Services (HHS) to “designate all skilled nursing facilities (SNFs), irrespective of their geographic location, as health professional shortage areas (HPSAs) and/or medically underserved areas (MUAs) to facilitate recruitment and retention of health professionals using the usual and customary support made available for such designations.”

Testimony regarding this resolution was generally positive, highlighting the benefits of HPSA and MUA designations to areas in need of additional health care resources. Testimony indicated that, due to a rapidly aging population (along with the lack of commensurate increases in medical school and residency positions, early retirement of health care professionals from burnout and the pandemic, and a lack of direct incentives to practice in senior living communities), there is an acute shortage of health care professionals, including physicians, nurses, and clinical practitioners in nursing facilities. Testimony also indicated that the AMA has ample policy that supports legislation to address the need to enhance resources for physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold. In addition, testimony stated that AMA policy includes clear instruction for the AMA to support legislation and encourage federal and state governments to provide financial assistance to assist physician practices in shortage areas. Due to the mixed testimony provided, Resolution 224-A-22 was referred. This report focuses on physician shortages in the U.S. and the need to incentivize physicians to practice in nursing facilities and to facilitate recruitment and retention of health professionals in these settings.

### BACKGROUND

Physician shortage is a significant issue in the U.S. To address this issue, the federal government developed HPSA and MUA designations used to identify areas and population groups that experience physician shortages and to improve access to health care for patients in these areas. It is projected that by 2032 there will be a 50 percent growth in the population of those aged 65 and older, compared with only a 3.5 percent growth for those aged 18 or younger.<sup>1</sup> By 2033 it is estimated that there will be a shortage of between 54,100 and 139,000 physicians, which includes a projected primary care physician shortage of between 21,400 and 55,200, as well as a shortage of non-primary care specialty physicians of between 33,700 and 86,700.<sup>2</sup> Furthermore, the COVID-19 pandemic put an incredible strain on our health care system and drastically exacerbated physician shortages in many rural and underserved areas across the country, which forced states to take extraordinary measures such as recalling retired physicians, expanding scope of practice, and temporarily amending out of state licensing laws.<sup>3</sup> However, none of these adjustments are expected to permanently fill the physician shortage gap in the long term.

## HEALTH PROFESSIONAL SHORTAGE AREAS AND MEDICALLY UNDERSERVED AREAS

HPSAs are intended to improve access to health care in areas, population groups, or facilities within the U.S. that experience physician shortages. This designation allows physicians to gain eligibility for financial incentives, such as loan repayment and scholarships, that can help attract and retain physicians in rural and underserved areas, which typically experience physician shortages. However, according to a report by the Government Accountability Office (GAO), only about one-third of primary care shortage areas were designated as HPSAs as of 2019.<sup>4</sup>

MUAs, like HPSAs, allow physicians to be eligible for financial incentives, such as loan repayment and scholarships, to help attract and retain physicians in shortage areas. In addition, MUAs can increase the availability of primary care services in areas with high poverty rates. Similar to HPSAs, MUAs may not cover all shortage areas and the financial incentives may not be enough to attract and retain physicians.

## ADDITIONAL CONSIDERATIONS

To provide financial incentives for physicians who work in shortage areas, several programs have been implemented to address the financial burden of medical education, which is a major barrier to physicians choosing to work in shortage areas. In addition, the federal government has implemented several programs to incentivize physicians and other health care providers to work in underserved areas and with underserved populations.

### *Incentivizing Physicians and Medical Students*

The National Health Service Corps (NHSC) is a federal program that provides scholarships to medical students starting at the beginning of medical school, and loan repayment post completion of residency training in a primary care specialty, for a minimum of two years commitment work in HPSAs throughout the United States and United States territories. The NHSC also has scholarship and loan repayment programs for dentists, nurse practitioners, nurse midwives, and physician assistants.<sup>5</sup> In addition to the NHSC, the Indian Health Service (IHS) is a federal program that provides loan repayment and housing assistance to physicians and other health care providers who work in Indian Health Service facilities. The IHS is intended to improve the health status of American Indian and Alaska Native people by increasing access to health care services.<sup>6</sup>

To incentivize medical students, some medical schools offer scholarships to students who commit to working in underserved areas after graduation. For example, the University of Washington School of Medicine offers the WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho) program, which provides scholarships to medical students who commit to certain states that experience physician shortages after graduation.<sup>7</sup> In addition, medical schools may partner with health care facilities in underserved areas to provide clinical experiences for students, which can help attract and retain health care professionals.

## J-1 AND H-1B VISAS

As a strategy to help provide additional physicians, international medical graduates (IMGs) often work in rural and underserved areas.<sup>8</sup> In 2017, nearly 30 percent of medical residents were IMGs, with about half working as physicians on non-immigrant visas.<sup>9</sup> The AMA recognizes that it is important to support and create pathways for these physicians to be able to remain in the U.S. and care for their patients.

J-1 visas attract foreign medical graduates with the needed expertise to work in nursing facilities and assisted living facilities where they can help improve the quality of care for patients. By expanding the J-1 visa program to include geriatrics and post-acute and long-term care as designated areas of need, the U.S. can attract more qualified physicians to work in these care settings keeping in mind that J-1 visa programs must have language requirements to ensure that clinicians have a sufficient level of proficiency in English to communicate effectively with patients and other health care workers.

H-1B visas are a type of temporary work visa that allow foreign workers to enter and work in the U.S. in specialty occupations. In health care, this can include physicians who have completed their medical training outside the U.S. and want to practice in the U.S. H-1B visa programs can be effective in addressing the shortage of qualified clinicians in nursing facilities and assisted living, particularly in underserved areas.

## LOAN FORGIVENESS INCENTIVES

Loan forgiveness programs can be an effective way to incentivize clinicians to work in nursing facilities. These programs provide financial assistance to clinicians in exchange for a commitment to work in an underserved area. By providing financial incentives, loan forgiveness programs can help address physician shortages in nursing and assisted living facilities.

## AMA POLICY

AMA policy supports legislation to extend the 10 percent Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' HPSA status (Policy H-465.981, "Enhancing Rural Physician Practices"). The same policy supports legislation that would allow physician practices in shortage areas to qualify as Rural Health Clinics without the need to employ one or more physician extenders and directs the AMA to undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities. This policy recognizes that many rural and low-income areas may have difficulty attracting and retaining physicians with specialized training, including geriatricians, and seeks to address this issue through targeted financial and non-incentives. Additionally, Policy H-200.972, "Primary Care Physicians in Underserved Areas", provides a plan for the AMA to improve the recruitment and retention of physicians in underserved areas with underserved populations and can also help to address the shortage of physicians, including those with geriatrics training, in these areas.

AMA policy also supports efforts to quantify the geographic maldistribution and physician shortage in many specialties and encourages medical schools and residency programs to consider developing admissions policies, practices, and targeted educational efforts aimed at attracting physicians to practice in shortage areas and to provide care to underserved populations; encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other shortage areas as a means to support educational program objectives and to influence the choice of graduates' practice locations; and encourages medical schools to include criteria and processes in the admission of medical students that are predictive of graduates' eventual practice in shortage areas and with underserved populations (Policy H-200.954, "US Physician Shortage.")

AMA policy also supports full appropriation for the NHSC Scholarship Program, with the provision that medical schools serving states with large rural and underserved populations have a priority and significant voice in the selection of recipients for those scholarships (Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage.")

## DISCUSSION

The shortage of physicians and other qualified clinicians in skilled nursing facilities and assisted living facilities is a growing problem that has a significant impact on patient care. Patients in these settings often have complex medical needs and require specialized care from physicians with expertise in geriatrics and post-acute and long-term care (PALTC). Increasing the supply of qualified physicians (e.g. geriatricians) to SNFs will help to improve the quality of care provided, decrease medical errors, and improve outcomes as the need for physicians with additional training in geriatrics and PALTC continues to grow as the population ages.

Further, improving care in underserved areas and populations is a critical issue in our country. However, designating all SNFs, irrespective of their geographic location, as a HPSA or MUA would be a fundamental shift away from viewing geographic areas and populations as a designation criteria to looking at a specific type of facility, including facilities that may be located outside a HPSA/MUA or facilities that are not financially disadvantaged. Also, the goal of the resolution looks beyond facilitating the recruitment and retention of physicians to potentially extend the HPSA/MUA incentive to non-physicians. AMA policy supports a physician-led team with regard to mid-level trained health care workers such as nurse practitioners, nurse midwives, and physician assistants.

Under the current system, HPSA and MUA designations are a valuable tool for identifying areas with a shortage of physicians and other health care providers, which can help allocate resources to improve access to health care services. Rather than designating a specific type of facility, such as SNFs, they provide a broader framework for addressing health care disparities and physician shortage issues. Regarding scope of practice concerns, SNFs often rely on a team-based approach to care, which includes physicians, nurse practitioners, and other health care



professionals. However, without a physician leading the care team, there is a risk that the overall quality of care as well as resident training may suffer. Physicians play a critical role in providing guidance and oversight to the care team, ensuring that residents receive appropriate training and education. In this regard, it is important to note that, to the extent that SNF patients are in a HPSA, MUA, or generally in an underserved area, the AMA already has policy<sup>10</sup> in place to incentivize physicians to practice in those areas.

## CONCLUSION

The Board of Trustees (Board) recognizes that the shortage of physicians in SNFs is a critical issue and shares the goal of ensuring that patients in SNFs receive high-quality care and believes that Resolution 224-A-22 provides another example of how the shortage of physicians is impacting patient access to care, including in SNFs. However, the solution offered in this resolution would fundamentally change how shortage areas and underserved populations are determined and raises scope of practice concerns. As discussed above, the AMA has existing policy that more broadly addresses the physician shortage issue and can be applied in a way to address the shortage of physicians practicing in SNFs. These policies include efforts to quantify geographic maldistribution, encourage medical schools and residency programs to provide courses and experiences in underserved areas, and support the NHSC Scholarship Program. The Board, therefore, recommends reaffirmation of existing policy in lieu of adopting Resolution 224-A-22.

## RECOMMENDATIONS

The Board of Trustees recommends that the following policies be reaffirmed in lieu of Resolution 224-A-22, and the remainder of the report be filed:

1. That our AMA reaffirm Policy [H-465.981](#), which asks our AMA to:
  - a. support legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status;
  - b. encourage federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements;
  - c. explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result;
  - d. supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders; and
  - e. undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy [H-200.972](#), "Primary Care Physicians in Underserved Areas", which provides a plan for the AMA to improve the recruitment and retention of physicians in underserved areas with underserved populations. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy [H-280.979](#), which asks our AMA to support the following:
  - a. continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;
  - b. continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;
  - c. efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and
  - d. assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy [D-200.980](#), which asks our AMA to advocate for the following:
  - a. Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations;
  - b. Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program;
  - c. Adequate funding for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas; and
  - d. Encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.  
(Reaffirm HOD Policy)
5. That our AMA reaffirm Policy [H-200.954](#), which encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy [H-465.988](#), which provides educational strategies for meeting rural health physician shortages. (Reaffirm HOD Policy)

#### REFERENCE

- 1 <https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf>.
- 2 AAMC (2020, June) The Complexities of Supply and Demand: Projections from 2018 to 2033. Retrieved from AAMC: <https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projectionsjune-2020.pdf>.
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- 4 U.S. Government Accountability Office. (2020). Health Professional Shortage Areas: Opportunities Remain to Improve Designation Process. GAO-21-47.
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- 9 <https://www.americanprogress.org/article/immigrant-doctors-can-help-lower-physician-shortages-rural-america>.
- 10 AMA Policy D-200.980, Effectiveness of Strategies to Promote Physician Practice in Underserved Areas; H-200.972, Primary Care Physicians in Underserved Areas; H-200.954, US Physician Shortage H-200.954; H-465.988, Educational Strategies for Meeting Rural Health Physician Shortage.

## 12. PROMOTING PROPER OVERSIGHT AND REIMBURSEMENT FOR SPECIALTY PHYSICIAN EXTENDERS AND NON-PHYSICIAN PRACTITIONERS

*Reference committee hearing: see report of Reference Committee B.*

**HOD ACTION:       RECOMMENDATIONS ADOPTED AS FOLLOWS  
REMAINDER OF REPORT FILED**

*See Policies H-35.965, H-35.989 and H-360.987*

#### INTRODUCTION

At the 2022 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD), referred Resolution 248-A-22 for report at the 2023 Annual Meeting. The resolution was introduced by the Organized Medical Staff Section and asks:

[That] our AMA work with state medical boards to improve oversight and coordination of the work done with physician extenders and non-physician practitioners (Directive to Take Action); and be it further

That our AMA adopt the position that Boards of Medical Examiners or its equivalent in each state should have oversight of cases involving specialty care as boards with oversight over physician extenders and non-physician practitioners do not have the training to oversee specialty care (New HOD Policy); and be it further

That our AMA adopt the position that in each state the Board of Medical Examiners or its equivalent should have oversight over physician extenders and non-physician practitioners if billing independently or in independent practice as their respective oversight boards do not have experience providing accurate oversight for specialty care (New HOD Policy).

The Reference Committee heard that our AMA has existing policy and model state legislation that addresses physician supervision of non-physicians, state medical board oversight of physician-led teams, and medical board oversight of physician agreements with non-physicians. This policy, H-35.965, "Regulation of Physician Assistants," H-35.989, "Physician Assistants," and H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice," not only addresses the first Resolve, but also the sentiment of the entire resolution. Further, there was overall agreement that the intent of the second Resolve was unclear, yet the Board of Trustees notes that clarification was not provided during testimony. Finally, the HOD generally supported the concept of the third Resolve but agreed it was too broad as written. The Reference Committee, as a result, recommended that an alternative resolution be adopted in lieu of Resolution 248. The alternative resolution, offered by our AMA Council on Legislation, sought to focus the language, achieve the goal of the third Resolve, and add to existing AMA policy. Due to the complexity of the issue, the HOD referred Resolution 248 for a report back at the 2023 Annual Meeting.

This report provides background information on the role of health care regulatory boards, including but not limited to state medical boards and boards of nursing. Moreover, this report discusses current state laws allowing for joint oversight of certified nurse practitioners and certified nurse midwives by the state boards of medicine and nursing. This report also includes a summary of AMA policy and model state legislation that supports joint regulatory board oversight of advanced practice registered nurses (APRNs). Finally, this report recommends reaffirmation of existing AMA Policy, H-35.965, "Regulation of Physician Assistants," as well as an amendment to AMA Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice" by addition and deletion.

## BACKGROUND

### *The role of occupational boards*

The licensing and regulation of health care professionals is within the purview of state occupational and regulatory boards. Health care professional regulatory boards ensure that only individuals meeting the minimal qualifications and competencies can obtain a license to practice in the profession. Typically state legislatures or regulatory boards set forth the standards required to obtain a license, such as graduation from an accredited educational program and the requisite degree, certification, passage of a professional examination, and completion of a background check. These measures are in place to protect the public from unqualified health care professionals through licensure. Regulatory boards also ensure that the health care professionals whom they license practice within the applicable standard(s) of care and the scope of practice of their profession. As such, regulatory boards also have the authority to investigate and discipline their licensees who fail to meet these standards.

### *The role of medical boards*

The primary role of a state medical board is to protect the health and safety of the public by licensing physicians, investigating complaints, and disciplining physicians based on the state medical practice act. There are currently 71 state and territorial medical boards, including more than 50 allopathic (MD) and composite (MD and DO) medical boards and 14 osteopathic (DO) boards. In addition to licensing physicians, state medical boards also license several non-physicians, such as physician assistants, podiatrists, chiropractors, respiratory therapists, occupational therapists, genetic counselors, radiologist assistants, certified anesthesiologist assistants, naturopaths, and acupuncturists. The types of non-physicians licensed and regulated by state medical boards varies widely by state.

### *Regulatory oversight of non-physicians*

Non-physicians may be regulated directly by a state medical board, through an advisory committee to a state medical board, or by an entirely separate licensing board. For example, while physician assistants are licensed and regulated by the board of medicine in most states, a few states have a separate physician assistant licensing board, and some states have a physician assistant advisory committee under the board of medicine. Similarly, naturopaths are typically licensed by a separate naturopathic board or the board of medicine in states that license naturopaths. Likewise, acupuncturists may be licensed by the board of medicine or a separate board of acupuncture. In contrast, in most states, psychologists are licensed and regulated by a separate board of psychology, and pharmacists are licensed by the board of pharmacy in each state.

In most states, certified nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists, often referred to collectively as “Advanced Practice Registered Nurses” (APRNs) are licensed and regulated exclusively by the board of nursing. Every state has at least one nursing regulatory board and four states (California, Georgia, Louisiana and West Virginia) have two nursing boards: one that regulates registered nurses and one that regulates licensed practical nurses and vocational nurses. At least one state, Nebraska, has a board for registered nurses and a separate board for APRNs. Certified nurse midwives, a type of APRN, are regulated by the board of nursing in most states. At least one state, however, has a separate midwifery board responsible for regulating certified nurse midwives and certified professional midwives. In other states, certified nurse midwives may be regulated by the board of medicine or public health, often with a midwifery advisory committee or council.

Similarly, in several states the board of medicine and board of nursing have joint regulation of nurse practitioners and other types of APRNs. For example, in Virginia, nurse practitioners are jointly licensed by the Virginia Boards of Medicine and Nursing. Other states have created a separate joint board for regulatory oversight of nurse practitioners practicing independently. For example, in Arkansas, the Full Independent Credentialing Committee (committee) located in the Department of Health, reviews and approves all applications for nurse practitioners who have met the standards for independent practice and apply for a certificate of full independent practice authority. The committee is comprised of four physicians and four nurse practitioners. In addition to approving or denying all applications, the committee is also responsible for reviewing complaints against nurse practitioners who have a certificate. Finally, in several states, the boards of medicine and nursing have joint oversight of some aspect of advanced practice registered nursing. For example, the Alabama Board of Medical Examiners and Board of Nursing jointly approve collaborative practice agreements between physicians and certified nurse midwives or physicians and certified nurse practitioners.

### EXISTING AMA MODEL STATE LEGISLATION AND POLICY

#### *AMA model state legislation*

The AMA’s “Model Act to Support Physician-Led Team Based Health Care” (Model Act) includes a provision stating that APRNs shall be jointly licensed and regulated by the state board of medicine and board of nursing. The Model Act provides a joint regulatory framework and practice parameters including a requirement that the APRN practice as part of a physician-led patient care team.

#### *AMA policy*

The AMA also has existing Policy H-35.965, “Regulation of Physician Assistants,” that supports the “authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel” and “opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies’ authority and purview.” AMA Policy H-35.989, “Physician Assistants,” indicates that state medical boards shall approve physician assistant applications to practice with a licensed physician or group of physicians and provides parameters for such applications. AMA Policy H-360.987, “Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice,”

states in part that “[p]hysicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.”

## DISCUSSION

Our AMA has existing policy, H-35.965, “Regulation of Physician Assistants,” and H-35.989, “Physician Assistants,” supporting the licensure and regulatory oversight of physician assistants by state medical boards. These two policies support the current regulatory structure in most states, are aligned with AMA’s scope of practice advocacy, and address the sentiment of Resolution 248. Our AMA also has policy encouraging state medical and nursing boards to explore working together to coordinate their regulatory activities, H-360.987, “Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice.” While this language provides the basis for a joint state medical and nursing board regulatory model, the Board of Trustees believes these policies should be strengthened to affirmatively support joint state medical and nursing board licensing and regulatory oversight of certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists, when appropriate. The Board of Trustees believes the proffered amendment provides clarity as to the appropriate role of state medical boards in regulating the practice of APRNs seeking scope expansions.

As discussed above, there is precedent in state law for joint state medical and nursing board regulatory oversight of APRNs. Moreover, AMA’s Model Act also includes language supporting a joint medical and nursing board regulatory structure. The AMA will continue to work with state, specialty and national medical societies interested in pursuing AMA’s Model Act.

## RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 248-A-22 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm existing Policy H-35.965, “Regulation of Physician Assistants,” and H-35.989, “Physician Assistants.”
2. That Policy H-360.987, “Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice” be amended by addition and deletion as follows:

(5) ~~Physicians should encourage~~ Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards ~~explore the feasibility of working together to coordinate their regulatory initiatives and activities.~~

## 13. DELEGATE APPORTIONMENT AND PENDING MEMBERS

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: RECOMMENDATIONS ADOPTED  
REMAINDER OF REPORT FILED**  
*See Policies G-600.016 and G-600.959*

At the November 2022 Interim Meeting, Board of Trustees Report 3, “Delegate Apportionment and Pending Members,” was considered and referred.

## BACKGROUND

At the 2018 Interim Meeting, policy was adopted calling for the inclusion of pending members in the delegate apportionment process. Per Board of Trustees Report 1-I-18 pending members are those who at the time they apply

for AMA membership are not members and who pay dues for the following calendar year. This typically occurs in the last few weeks of one year, with the individual's membership becoming active on January 1 of the following year. The policy was refined in Board of Trustees Report 12-A-19 to address issues related to counting such members as well as distinctions between constituent and specialty societies, and the necessary bylaws amendments were adopted at the 2019 Interim Meeting in the Council on Constitution and Bylaws Report 3-I-19. This formed AMA Policy G-600.016, "Data Used to Apportion Delegates," which also called for an evaluation at A-22. Board of Trustees Report 20-A-22 provided a review on the effects of counting pending members and included six recommendations. One recommendation was adopted which defined the apportionment process for 2023 and was predicated on not counting pending members. (Policy G-600.959 paragraph 1). Recommendation 1 of BOT Report 20-A-22 was referred for decision and the remaining recommendations were referred.

In September 2022, your Board voted to adopt Recommendation 1 of Board Report 20-A-22, which had been referred for decision. By this action pending members would not be counted for apportionment purposes, which was subsequently recorded as paragraph 2 of Policy G-600.959, "Delegate Apportionment and Pending Members."

Board of Trustees Report 3-I-22 dealt with the remaining referred items from Board Report 20-A-22. The report included a recommendation to rescind Policy G-600.016. The House of Delegates (HOD) referred the report back to the Board. Also at I-22, the HOD considered Constitution & Bylaws Report 1-I-22 which recommended changes to Bylaw §2.1.1.1 specifying how apportionment would be accomplished for 2023 and recommended deletion of the following sentence, "*The December 31 count will include pending members for purposes of apportionment; however, pending members shall not be recounted the following year absent membership renewal.*" The HOD adopted the bylaw amendment specifying the 2023 apportionment but referred the recommended deletion of the sentence reproduced above. Given the Board's September action, to no longer count pending members and the adopted bylaw which specifies the process to be used for 2023, the referred sentence although retained in Bylaw §2.1.1.1 has no impact. Furthermore, the amendment adopted by the House includes a sunset provision for the entirety of Bylaw §2.1.1.1 as of December 31, 2023.

## DISCUSSION

The original policy adopted by the HOD regarding pending members called for a subsequent evaluation of the policy with recommendations regarding its continuation. This evaluation showed that the intended goals of counting pending members for apportionment of HOD Delegates had not been realized. In addition, your Board believes that counting pending members diminishes the role of active members themselves, devalues other benefits of membership and unnecessarily complicates the apportionment process.

There is little to no evidence that suggests that the offer to count pending members for apportionment purposes has led to membership gains. Virtually all the pending members identified in the initial adoption of the policy had already joined prior to the implementation of the experiment. Anecdotes suggesting that being counted toward representation in the House of Delegates is a motivation for members to join late in the membership cycle has not been confirmed with data over the trial years. Physicians consistently report valuing the advocacy that emerges from House of Delegates (HOD) policy, not representation in the House of Delegates itself *per se*.

There may be isolated instances where state delegations at risk for losing a seat in the House may be motivated to recruit pending members, but it would seem these efforts should be undertaken earlier in the membership year to recruit members for the actual year used for apportionment not the following year. In fact, our current bylaws (2.1.1.2.1) provide that if the membership information as recorded at the end of a year warrants a decrease in the number of delegates, the association is permitted to retain their delegate number, without decrease, for an additional year to intensify their recruitment of members. Counting pending members, those who pay dues not for that additional grace year but for the following year, in effect extends the grace period and creates an opportunity for members to join every third year while still being counted for apportionment.

The notion that pending members gain representation by being counted for apportionment purposes belies the fact that delegates represent the needs of not only members but patients, their sponsoring societies, and the profession, including nonmembers. This is explicitly stated in the [HOD Reference Manual](#). Pending members are in fact NOT members. Individuals who join late in the year wishing to be represented in the HOD could join for the current year by paying half-year dues. It has been said that counting pending members more fairly apportions delegation count. On the contrary, since representation in HOD is based upon membership numbers, allowing certain societies to inflate their delegate numbers beyond their true proportional representation by including pending members

diminishes the vote of other societies that have fulfilled their membership requirements and may be thought to disenfranchise the current members.

Some delegations hoped that including pending members would increase their number of delegates. Upon implementation virtually all the increase came in the first year of the experiment and few states actually gained delegates even in that initial year. Any increase was short lived as pending members provide a net membership increase only in their initial count. Ultimately, there is no evidence that pending members have any positive effect on apportionment numbers.

Others have argued that not counting pending members is tantamount to treating them as second-class members. As noted above, they are indeed not members, at least not initially, and once they are members they will be counted just like all other members in the year in which their membership dues apply. Decisions about apportionment need not be linked to more concrete member benefits. In fact, members do begin receiving most membership benefits shortly after the membership decision is made.

Although physicians and medical students make the membership decision throughout the year, AMA membership, similar to most every other medical society membership, is calendar year based. For example, medical students, particularly first year students, often join in July or August and most continuing members renew their membership for the following year in November and December. As such, the membership count varies from day to day. Determination of membership count and thus apportionment could theoretically be done on any date but has to be completed on a defined date. The date of December 31 is specified in multiple provisions within our bylaws. The AMA recognizes dues revenue in financial statements for the calendar membership year. Legally, members are listed as members for the calendar year membership designated on the membership application, regardless when submitted and paid.

Finally, as a practical matter, once someone becomes a pending member, the individual must be tracked across time in perpetuity solely for apportionment lest membership become an on-again, off-again process to game the system. The timing of one's dues payment and one's membership status at the time of that payment affect how and whether one is counted for apportionment purposes. These elements cannot be captured by AMA's membership accounting system across a potential 40- or 50-year career in medicine. To track the information would require an estimated quarter million dollar change to the membership accounting system.

## CONCLUSION

While the composition of the House is the province of the HOD, your Board maintains that the long-standing policy of counting actual members for apportionment, including a one-year grace period for societies at risk of losing a delegate seat, has served our association, the House, and members well. There is no clear evidence that counting pending members increases membership or provides benefit to constituent societies. Counting pending members can be considered to diminish or discount actual members' value as much as it can be seen to enhance representation. In addition, it unnecessarily complicates the apportionment process and adds additional cost of tracking pending members over time. Your Board concludes that the trial of counting pending members for apportionment purposes should not be continued.

The adoption of the Policy G-600.959 [1] and the bylaw amendment from CC&B Report 1-I-22 specified the process that was followed for apportionment for 2023. The amended Bylaw §2.1.1.1 includes a sunset provision for the entirety of the bylaw as of December 31, 2023. Given that the apportionment process for 2023 is complete, Policy G-600.959 [1] should be rescinded as it has been accomplished.

## RECOMMENDATION

Therefore, your Board of Trustees recommends that paragraphs 2-4 of Policy G-600.016 and paragraph 1 of Policy G-600.959 be rescinded and the remainder of the report filed.

## RELEVANT AMA POLICY

Data Used to Apportion Delegates G-600.016

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review of its current AMA membership count.
2. "Pending members" (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity.
3. Our AMA will track "pending members" from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year.
4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy.

#### Delegate Apportionment and Pending Members G-600.959

1. Delegates will be apportioned to constituent societies for 2023 with each society getting the greatest of the following numbers:

- The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members;
- The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
- For societies that would lose more than five delegates from their 2022 apportionment, the number of delegates, apportioned at the rate of 1 per 1000, or fraction thereof, AMA members, plus 5.

2. Pending members will no longer be counted for delegate apportionment.

BOT Rep. 20, A-22; BOT Action in response to referred for decision: BOT Rep. 20, A-22

## **14. ADVOCACY OF PRIVATE PRACTICE OPTIONS FOR HEALTHCARE OPERATIONS IN LARGE CORPORATIONS**

*Reference committee hearing: see report of Reference Committee G.*

### **HOD ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED**

*See Policies D-140.951, D-160.909, D-160.912, D-405.988, H-160.891, H-185.939 and H385.904*

### **INTRODUCTION**

At the 2022 Annual Meeting, the House of Delegates (HOD) adopted Policy D-160.912, "Advocacy of Private Practice Options for Healthcare Operations in Large Corporations." This policy directs our American Medical Association (AMA) to: (1) study the best method to create pilot programs which advance the advocacy of private practice and small business medicine within the rapidly growing area of internal healthcare within Fortune 500 corporations in America with a report back at the 2023 Annual Meeting; (2) use proposals for the advocacy of small business medicine and private practice models in healthcare as a pilot project in the development of advocacy programs within major leading corporations like Amazon and Walmart which are currently entering the healthcare service market with internalized models of healthcare in the complete absence of more diverse private practice (small business) options, and (3) prioritize advocacy efforts that emphasize small private practice utilization within the investment and business efforts of Fortune 500 corporations that are currently seeking to enter into the healthcare industry.

### **BACKGROUND:**

Over the last two decades, large corporations have increasingly entered health care delivery—a trend that has accelerated following the onset of the COVID-19 pandemic. These entities include Walmart, CVS, Walgreens and Amazon, as well as national health insurance corporations such as UnitedHealth Group. Even unexpected corporate retailers like Dollar General are offering health care delivery models. These corporations have assumed various roles within health care, such as in-person and virtual health care delivery, pharmaceuticals, wellness and employer-sponsored health insurance.



Following blocked mergers of Aetna-Humana and Anthem-Cigna in 2017, these large national insurers, along with United Healthcare, accelerated acquisitions of other types of health care companies.<sup>1</sup> This represented a shift from horizontal integration (two health insurers merging) to vertical integration (different parts of the health care delivery system merging). These acquisitions and mergers include retail pharmacies (e.g., Aetna-CVS), pharmacy benefit managers (e.g., Cigna-Express Scripts) and data/analytic companies (e.g., United-Change Healthcare). In addition, these organizations are acquiring a broad spectrum of health care delivery organizations, from physician practices to home health companies to mental health care companies. For example, UnitedHealth Group's Optum Health is now the largest employer of physicians in the country.<sup>2</sup>

In addition to traditional health insurers, new entrants such as large retailers (e.g., Walmart) and new and established technology companies (e.g., Amazon) are entering the health care delivery space. These organizations are entering health care delivery as a new revenue source to drive shareholder value, create synergy with other portions of their business (e.g., pharmacy) and help control employee health care costs.<sup>3,4,5,6</sup> While these investments have not been as expansive as the large national health insurers, they will likely shake up health care delivery with new models of pricing, the integration of technology and alignment with their other offerings.

The consumerization of health care is one factor that has fostered opportunities for corporations not traditionally involved in health care delivery to enter these spaces and offer greater convenience at a lower cost.<sup>3</sup> Occurring alongside this trend is the acquisition of independent physician practices by these large corporations, as well as by hospitals and payers. According to one estimate, corporate entities acquired over 30,000 additional physician practices between 2019 and 2021.<sup>7</sup> The 2020 AMA Physician Practice Benchmark survey found that less than half of patient care physicians worked in private practice, nearly five percent lower than two years prior.<sup>8</sup>

Some see this trend of corporate entry into health care as positive, believing it will make health care more sustainable and provide physicians greater access to capital, negotiating power and the latest technology. However, others view it as disruptive to high-quality, coordinated care delivered by a physician-led team, believing it decreases access and competition.<sup>8</sup> There is also limited scrutiny of the impact on market competition, as some proposed transactions involving the corporate acquisition of physician practices may not come to the attention of antitrust enforcers if the transaction is not sufficiently large enough to trigger statutory reporting obligations.<sup>9</sup>

Further, restrictive networks are commonly associated with these acquisitions. For instance, patients receiving care from a physician employed by a hospital or large corporation may only receive referrals to other clinicians employed by said hospital or corporation. This can lead to less patient choice and arbitrary removal from networks of independent physicians.<sup>10</sup> As these large corporations continue their entry into the health care market, this can result in more harm than good if the voices of patients and community-based private practice physicians are not integrated into their plans.

### *The Role of Large Corporations in Health Care: Recent Examples*

#### Amazon

Amazon's entry into health care predominantly consists of health care services, such as in-person care, telehealth, and pharmaceuticals. For example, the company launched a telehealth service, Amazon Care, after first piloting it to its employees.<sup>3</sup> Designed to address high employee health care costs, the app-based platform partnered with One Medical to offer members in-person and virtual primary, urgent, and preventive care services, including COVID-19 and flu testing, vaccinations, and treatment for illnesses and injuries.<sup>3,11</sup> One Medical places medical offices near the workplace, and its members use an app to book appointments and track health records.<sup>12</sup> The platform reported a membership of 790,000 customers at the end of June 2022.<sup>13</sup> In June 2022, Amazon announced its intent to purchase OneMedical for \$3.9 billion.<sup>14,15</sup> After an eight month review, the Federal Trade Commission (FTC) declined to challenge the acquisition and the deal was finalized on February 22, 2023.<sup>12,16</sup>

#### CVS

Perhaps the most established in health care of the mentioned corporations, CVS, is focused on journeying further into primary care.<sup>4,5</sup> The company has offered walk-in health care services since the early 2000s. Today, consumers may take advantage of routine physicals, screenings, vaccinations, treatment for illnesses and minor injuries, mental health counseling and services that address social determinants of health, such as wellness and health education classes, tobacco cessation support and sleep assessments.<sup>4</sup> In addition to the company's 10,000 pharmacy locations,

CVS recently amassed a 10,000-clinician-network that makes in-person and virtual home visits through its Signify Health acquisition.<sup>6</sup>

A key part of its strategy to deliver on its goal, announced in 2021, to facilitate 65 billion health care interactions over the next decade, is to transform the number of stores converted to the HealthHUB model. With over 20 percent of the store dedicated to these HealthHUBs, this concept is designed to provide patients with chronic disease management consultations and other health and wellness services such as sleep apnea assessments and blood draws. Further, the concept will offer an array of durable medical equipment and other medical supplies<sup>17</sup>. As the HealthHUBs are currently staffed by nurse practitioners, CVS aims to hire physicians to staff the primary care sites. In addition to offering convenience to customers, the company also believes these efforts will reduce health care costs.<sup>5</sup>

Most recently, CVS acquired Oak Street Health for \$10.6 billion. Oak Street's centers predominantly serve low- to middle-income patients aged 65 and older with Medicare Advantage plans. The company operates in 169 locations throughout 21 states, and its locations are expected to increase to 300 by 2026.<sup>18</sup>

### Walmart

Walmart continues to disrupt the health care industry through low-cost health care services and insurance.<sup>19</sup> The company opened comprehensive health clinics in 2019 that offer affordable services such as primary care, urgent care, dental care, mental health counseling, and vision and hearing services.<sup>5</sup> In addition to the 20 clinic locations that the company currently operates in Georgia, Walmart has over 5,000 pharmacy locations and aims to expand to Florida in 2023.<sup>11,12</sup> Walmart now also offers virtual care through its telehealth platform, MeMD, and recently procured an agreement with UnitedHealth Group, the world's largest insurer.<sup>5,6</sup> Through this partnership, Walmart and UnitedHealth Group will offer a Medicare Advantage plan. UnitedHealth Group will provide data analytics and decision support tools to Walmart clinicians, and Walmart Health's virtual care services will be included as part of one of UnitedHealth's commercial PPO plans.<sup>4</sup>

### Walgreens

Walgreens is also focused on offering health care services, as demonstrated by its recent launch of Walgreens Health. The company currently owns 70 VillageMD primary care clinics. Walgreens continues to provide in-store services such as health tests, screenings and help with medications. The company also created an online marketplace where users may schedule appointments.<sup>5</sup>

### Elevance Health

Elevance Health, formerly Anthem, combines care delivery tools and technology in its Carelon Division with its health insurance companies, with aspirations of growing beyond providing health insurance to become a "lifetime partner" in the delivery of healthcare to its members.<sup>20</sup> Unique among other insurance companies that have purchased physician practices as part of their delivery network, Elevance is investing in an "Aggregator Strategy." Through this strategy, Carelon, with other third-party partners, provides infrastructure and data analytics to independent primary care physician practices to enable them to effectively participate in value-based contracts so they can remain independent in local communities.<sup>20,21</sup>

### UnitedHealth Group

UnitedHealth Group is an example of a large vertically-integrated health care corporation that comprises a health insurance company, UnitedHealthcare, a solutions service, Optum, and a provider group subsidiary, Optum Health. Optum Health owns physician practices inclusive of approximately 60,000 physicians who treat over 20 million patients annually. Much of this growth is derived from the group's focus on value-based care. Optum's CEO, Andrew Witty, expects that the company will have four million patients in accountable care arrangements in 2023.<sup>21</sup> The company plans to continue its expansion of value-based services—Witty informed investors that Optum Health intends to integrate further behavioral and home health offerings into its health care strategy.<sup>23</sup>

### Dollar General

In January 2023, Dollar General announced a partnership with DocGo, a publicly traded company that offers "last-mile care" via mobile health care clinics with trained providers, a transportation and logistics network, and an

advanced data analytics network to deliver quick and easy health visits outside Dollar General stores. DocGo onsite care is provided by certified medical assistants, emergency medical technicians, licensed practical nurses, paramedics and physicians via remote technology. Services offered at Dollar General locations will include preventive visits and chronic care management. Dollar General, with over 18,000 stores nationwide—many in underserved rural and urban areas—seeks to make health care more accessible and convenient for its shoppers.<sup>24</sup>

### Others

Other companies, including National Public Radio (NPR), CHG Healthcare Services, USAA, Goldman Sachs, CustomInk, Anthrex, JM Family Enterprises and QuikTrip, have begun providing their employees with on-site health care services. NPR's and CHG's health clinics are available at no cost to all employees regardless of their enrollment status within the companies' health plans. USAA offers its employees cancer screenings, flu shots, blood pressure checks, massages and physical rehabilitation. Goldman Sachs' and QuikTrip's health care benefits are available to all enrolled employees and their families. Further, many physicians employed by QuikTrip work exclusively for the company.<sup>25</sup>

### Investments and Support of Private Practices

Also accelerating is private sector investment in small- to medium-sized physician practices for the purpose of providing infrastructure to transition to value-based models. There has been significant growth in companies specifically designed to help independent practices succeed in value-based models, including Aledade, Emergence Healthcare Group, Redesign Health and Privia. Representing a shift from the 2010s, wherein founders of venture capital-backed health tech mainly pursued large payers and employers, as well as hospitals, there has been recent interest in selling to small- to medium-sized businesses which include private practices. Owners of private practices are increasingly seeking to remain independent, and these opportunities provide them with the agency and revenue to do so.<sup>26</sup> Private equity firms see significant opportunities in investing in physician practices across specialties to offer administrative support.<sup>27</sup>

#### *AMA Market Analysis*

The AMA conducted confidential informational interviews to better understand the evolving market landscape and identify opportunities to create pilot programs to advance the advocacy of private practice and small business medicine within the rapidly growing area of health care delivery within Fortune 500 corporations in America.

To better understand the best method to explore the creation of potential pilots, the AMA: (1) conducted (1) a market landscape assessment based on publicly available news articles and studies; and (2) qualitative informational interviews among a sample of national corporate entities. The confidential informational interviews were conducted between Fall 2022 and Winter 2023 with individuals directly responsible for each organization's strategy in health care delivery. The interviews were conducted with a series of pre-determined questions regarding corporate entities' approaches and strategic thinking on health care delivery and the role of private practices in the community. Interviews included a selection of large national insurers vertically integrating into the delivery of care through acquisitions, along with national retailers and large technology companies entering the health care delivery marketplace.

Three key themes emerged from this market analysis:

1. Corporate entities are increasingly investing in opportunities in care delivery and believe this strategy will increase value for their insured employees, their customers and shareholders.
2. Corporations believe "value-based" payment and delivery models will drive better patient outcomes and lower health care costs and are investing heavily in these models.
3. While acquisition of independent practices is accelerating in certain markets, some corporate entities, particularly among vertically integrated health insurers, have a strategy of working with independent practices in communities. These companies express a goal of supporting integrated networks of practices, with the aim of providing more enhanced, coordinated care for patients and preventing practice acquisition by larger health care systems or hospitals that can lead to consolidation and attendant price increases. Newer corporate retail and technology entrants will continue experimenting with various arrangements subject to market conditions and shareholder priorities.

## AMA POLICY

The AMA supports preserving the value of the private practice of medicine and its benefit to patients. AMA will:

- a. Utilize its resources to protect and support the continued existence of solo and small group medical practice and to protect and support the ability of these practices to provide quality care. They will also advocate in Congress to ensure adequate payment for services rendered by private practicing physicians.
- b. Work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt. The organization will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine.
- c. Create, maintain and make accessible to medical students, residents and fellows, and physicians resources to enhance satisfaction and practice sustainability for physicians in private practice.
- d. Create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.
- e. Issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices (Policy D-405.988, "The Preservation of the Private Practice of Medicine").

The AMA also supports the consideration of prospective payment elements in the development of payment and delivery reform that are consistent with AMA principles, as well as the following principles to support physicians who choose to participate in prospective payment models:

- a. The AMA, state medical associations and national medical specialty societies should be encouraged to continue to provide guidance and support infrastructure that allows independent physicians to join with other physicians in clinically integrated networks, independent of any hospital system.
- b. Prospective payment model compensation should incentivize specialty and primary care collegiality among independently practicing physicians.
- c. Prospective payment models should take into consideration clinical data, where appropriate, in addition to claims data.
- d. Governance within the model must be physician-led and autonomous.
- e. Physician practices should be encouraged to work with field advisors on patient attributions and a balanced mix of payers.
- f. Quality metrics used in the model should be clinically meaningful and developed with physician input.
- g. Administrative burdens, such as those related to prior authorization, should be reduced for participating physicians (Policy H-385.904, "Prospective Payment Model Best Practices for Independent Private Practice").

The AMA will identify financially viable prospective payment models and develop educational opportunities for physicians to learn and collaborate on best practices for such payment models for physician practice, including but not limited to independent private practice (Policy H-385.904, "Prospective Payment Model Best Practices for Independent Private Practice").

Additionally, the AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

- a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
- b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
- c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
- d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.

- e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
- f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments but should not otherwise limit patient care choices.
- g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
- h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
- i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972) (Policy H-185.939, “Value-Based Insurance Design”).

The AMA will also study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership or management of physician practices and report back on the status of any ethical dimensions inherent in these arrangements, including consideration of the need for ethical guidelines as appropriate. Such a study should evaluate the impact of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices (Policy D-140.951, “Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices”).

Moreover, the AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:

- a. Physicians should consider how the practice’s current mission, vision and long-term goals align with those of the corporate investor.
- b. Due diligence should be conducted that includes, at minimum, review of the corporate investor’s business model, strategic plan, leadership and governance and culture.
- c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
- d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
- e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
- f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
- g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
- h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
- i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy and physician due process under corporate investor partnerships.
- j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non-physician practitioners.
- k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs (Policy H-160.891, “Corporate Investors”).

Further, the AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices, encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty and supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine (Policy H-160.891, “Corporate Investors”).

Additionally, AMA policy states that any individual, company, or other entity that establishes and/or operates worksite health clinics should adhere to the following principles:

- a. Worksite health clinics must have a well-defined scope of clinical services, consistent with state scope of practice laws.
- b. Worksite health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic.
- c. Worksite health clinics that use nurse practitioners and other health professionals to deliver care must establish arrangements by which their health care practitioners have direct access to MD/DOs, as consistent with state laws.
- d. Worksite health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated.
- e. Worksite health clinics should develop expertise in specific occupational hazards and medical conditions that are likely to be more common in the particular industry where the company offers products and services.
- f. Worksite health clinics must use evidence-based practice guidelines to ensure patient safety and quality of care.
- g. Worksite health clinics must measure clinical quality provided to patients and participate in quality improvement efforts in order to demonstrate improvement in their system of care.
- h. Worksite health clinics must adopt explicit and public policies to assure the security and confidentiality of patients' medical information. Such policies must bar employers from unconsented access to identifiable medical information so that knowledge of sensitive facts cannot be used against individuals.
- i. Worksite health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community. Such protocols must ensure after-hours access of employees and eligible family members, as well as the transmission of reports of all worksite clinic visits and treatments to the physicians of patients with an identified community physician.
- j. Worksite health clinics administering immunizations must establish processes to ensure communication to the patient's medical home and the state immunization registry documenting what immunizations have been given.
- k. Patient cost-sharing for treatment received outside of the clinic must be affordable and not prohibit necessary access to care.
- l. Worksite health clinics should allow the involvement of community physicians in clinic operations.
- m. Employers implementing worksite health clinics should communicate the eligibility for services of employees' family members.
- n. Worksite health clinics should be encouraged to use interoperable electronic health records as a means of communicating patient information to and facilitating continuity of care with community physicians, hospitals and other health care facilities (Policy H-160.910, "Worksite Health Clinics").

The AMA also acknowledges that the corporate practice of medicine: (1) has the potential to erode the patient-physician relationship; and (2) may create a conflict of interest between profit and best practices in residency and fellowship training (Policy H-160.887, "Corporate Practice of Medicine").

Furthermore, (1) the AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine; (2) At the request of state medical associations, the AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings and physicians contracting with corporately-owned management service organizations; and (3) the AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues (Policy H-215.981, "Corporate Practice of Medicine").

## DISCUSSION

### *Opportunities for Corporation-Provided Health Care*

Large corporations, equipped with large amounts of capital, massive active user bases, and data and technology capabilities, have the potential to offer greater options for how patients receive care and streamline and automate processes to potentially alleviate high costs, burnout and inefficiencies.

Additionally, large corporations, which collect and maintain significant amounts of customer data, claim to utilize this data to address social determinants of health. For example, Dollar General and Walmart plan to expand access to care in rural communities, and Walmart is prioritizing diversity in clinical trials, as 20 percent of drugs reportedly respond differently across ethnic groups.<sup>5,18</sup>

Further, new venture capital-backed companies, of which many are physician-led, are specifically designed to provide opportunities to improve the care delivery and financial sustainability of underinvested-in small to medium-independent physician practices.

#### *Challenges for Corporation-Provided Health Care*

Trust and a lack of health care background remain significant barriers to success for large corporations, particularly Big Tech companies such as Apple, Google, Microsoft and Amazon. For example, consumers, regulators and privacy advocates have all raised concerns about the implications of Big Tech having access to patient's health records, as well as a potential cybersecurity crisis.<sup>5,12</sup> This concern has only further intensified following the overturning of *Roe v. Wade*, which sparked questions about the use of personal data to surveil people seeking reproductive health services.<sup>12</sup>

Others have pointed to the underperformance of large corporations' investments in health care. For instance, Haven, an effort by Amazon, JPMorgan Chase and Berkshire Hathaway that sought to reduce health care costs and improve patient outcomes, failed after just two years. Additionally, margins in health care are small. As large corporations are used to high margins and rapidly scaled businesses, some experts question their preparedness for the health care industry where profit margins are typically small.<sup>28</sup>

Further, common adverse effects of mergers and acquisitions on physicians include workflow disruptions, organizational changes that may increase workloads and staff burden, technological transitions such as shifts in EHR implementation and even lower wages. Athenahealth's 2021 Physician Sentiment Index report demonstrated that physicians undergoing a merger or acquisition expressed less willingness to remain at their organization and were more likely to experience burnout. While 68 percent of physician respondents undergoing a merger or acquisition reported that they would recommend their health care organization to friends or family, 85 percent of physicians not undergoing a merger or acquisition reported that they would recommend their organization to loved ones. The National Institute for Health Care (NIHCM) Foundation found that after a hospital merger, skilled workers experienced a four percent decrease in wages, and nurses and pharmacy workers saw a 6.8 percent decrease.<sup>29</sup>

Finally, value-based payment models have persistent and ongoing methodologic and implementation challenges for payers, large integrated health care systems and independent private practices alike, including designing adequate risk models, measuring quality, providing access to timely and actionable data, and imposing significant administrative burdens. These fundamental design and implementation challenges must be addressed to ensure sustainable success for any of these investments.<sup>30,31</sup>

#### CONCLUSION

With the continued growth of corporate entrants in care delivery pursuing new practice ownership strategies and delivery models, particularly among small-to-medium-sized physician practices, this report highlights opportunities for the AMA to work directly with corporate entities to advocate for and support independent physician practices in communities. Health care costs continue to increase, and the quality of and access to care continues to erode in many local communities. Thus, we support corporate entities to work with and assist independent physician practices with the capabilities to deliver highly coordinated care that is critical to improving patient outcomes and competition in many markets.

#### RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm the following policies:
  - a. D-405.988, "The Preservation of the Private Practice of Medicine"
  - b. H-385.904, "Prospective Payment Model Best Practices for Independent Private Practice"

- c. H-185.939, “Value-Based Insurance Design”
  - d. D-140.951, “Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices”
  - e. H-160.891, “Corporate Investors”; and
2. That our AMA will: (1) inform corporate efforts about the value of private practices to successfully participate in new “value-based” models; (2) identify and work with a corporate entity that is advancing these models to explore a two year pilot among independent private practices in which the AMA will: (a) convene physician practices in a community; (b) provide educational resources and technical assistance to practices to support their participation with the corporate entity and (c) formally evaluate the pilot for outcomes; and (3) advocate with commercial payers and health plans and federal and state payers and policymakers to support private practice through policies and models that provide adequate payment, infrastructure and data to succeed in “value-based” models.
  3. That Policy D-160.912 be rescinded as having been accomplished by this report.

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## 15. NATIONAL CANCER RESEARCH PATIENT IDENTIFIER

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

**HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**  
**REMAINDER OF REPORT FILED**  
*See Policy H-460.883*

Resolution 021-A-22, “National Cancer Research Identifier,” sponsored by the Mississippi Delegation, was referred by the House of Delegates. Resolution 021-A-22 asks our AMA to establish:

“[The] National Cancer Research Identifier (NCRI) [...] to improve care for patients with cancer.” The NCRI as described would be overseen by a nonprofit entity, and the role of the NCRI would be to collect identifying patient information to create:

“a privacy-ensuring, unique cancer research identifier [that] could travel with the anonymous fragments of medical information currently collected by large databases, and therefore allow the fragments to be reunited into a complete, yet anonymous cancer journey that researchers can study to improve care”.

The summary of testimony from A-22 acknowledges concerns regarding the creation of the NCRI and recommends Resolution 021 for referral. Testimony was strongly in support of referral, noting the complexity of the issue, i.e., a national identifier may exclude some people from clinical trials, may dissuade some people with privacy concerns from joining trials, may put undue burdens (e.g., further EHR responsibilities) on some physicians, and it may implicate privacy, trust, and surveillance concerns. Testimony also noted concern about what organizations would be involved in overseeing the NCRI process and questioned why the resolution should be limited to cancer rather than be broader in scope.

### BACKGROUND

In the US, all 50 states have laws that require newly diagnosed cancers to be reported to a central cancer registry [1]. The CDC’s National Program of Cancer Registries (NPCR) and NCI’s Surveillance, Epidemiology, and End Results (SEER) Program are the two primary central registries that collect cancer incidence data in the US. Together, the NPCR and the SEER Program collect data from the entire US population, and according to a 2017 joint report by the CDC and NIH, the two comprehensive surveillance systems work collaboratively to collect, compile, and disseminate information on more than 1.7 million cancer cases annually [2].

### ALTERNATIVES TO NCRI

While Resolution 021-A-22 claims that the formation of the NCRI would “dramatically increase the speed and power of real-world research” it is unclear if this would be the case. Using identified data may in fact slow down the research process if the identified data are subject to the Common Rule, which would require researchers using NCRI data to go through IRB approval. Furthermore, as noted in BOT 16 N-21 “De-Identified Data” and Resolution 003-A-18 “Proposing Consent for De-Identified Patient Information,” once data has been de-identified, HIPAA no longer applies, which raises potential concerns if certain entities obtain access to the NCRI. This is particularly troubling because of the unequal power between those whose data has been collected and those who control that data, an issue that has been referred to as the “Big Data Divide” [3]. This is also a threat to justice within clinical research, as data subjects from lower socioeconomic and/or minority backgrounds tend to have even less control over their data and are thus more vulnerable to misuse of their data [4].

Meanwhile current cancer research is clipping along at a steady pace. A 2020 report by Springer Nature found that “[t]he number of cancer research articles published in journals listed in the Nature Index increased by 25.8 percent between 2015 and 2019. This is four times the growth for overall article output in this period” [5]. The report also found that the US’s National Cancer Institute (NCI) “is by far the world’s biggest funder of cancer research” [5].

Supporting the NCRI’s data modernization efforts to move to modern cloud-based systems, working to ensure that data collection is conducted in a just and equitable manner for all peoples, and encouraging physicians to discuss

opportunities with cancer patients about participating in cancer research may be more appropriate avenues for our AMA to approach improving cancer research instead of forming the NCRI.

Our AMA could also seek to promote data and code sharing in oncology research as an alternative means of accomplishing the goal of Resolution 021. The practice of code sharing involves stating explicitly, in text or supplementary material, in research publications if and where any or all data or code underpinning the results is available for access. A recent research paper found that data and code sharing occur infrequently in oncology despite the prevalence of mandatory sharing policies outlined by publishers; additionally, there is a large gap between oncology researchers who declare their data to be available, and those who actually archive data in a way that facilitates its reuse [6].

#### ETHICAL CONCERNS SURROUNDING NCRI

The AMA's *Code of Medical Ethics* does not explicitly prohibit such a patient identifier so long as the body adheres to the Code's opinions on protecting patient confidentiality, respecting patient privacy, providing appropriate informed consent, and ensuring the data is used in a manner that promotes justice (see [Opinion 3.2.1](#) Confidentiality; [Opinion 3.3.2](#) Confidentiality & Electronic Medical Records; [Opinion 3.2.4](#) Access to Medical Records by Data Collection Companies; [Opinion 4.1.3](#) Third-Party Access to Genetic Information; [Opinion 3.1.1](#) Privacy in Health Care; [Opinion 7.3.7](#) Safeguards in the Use of DNA Databanks; [Opinion 2.1.1](#) Informed Consent; [Opinion 7.1.2](#) Informed Consent in Research; [Opinion 8.5](#) Disparities in Health Care).

However, Policy [H-315.962](#) "Research Handling of De-Identified Patent Information" states, "[o]ur AMA supports efforts to promote transparency in the use of de-identified patent data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information." The collection and use of identified patient data pose several concerns as even de-identified data do not eliminate the risk of re-identification that can potentially harm patients. The Board observes the Council on Ethical and Judicial Affairs is in the process of reviewing existing ethics guidance on the use of patient information in research.

#### CONCLUSION

For these reasons, the Board concludes that the creation of a national cancer patient research identifier is neither necessary nor desirable. AMA resources might be better utilized to support data modernization efforts by existing cancer registries, work to ensure that no groups face barriers to data collection efforts, encourage physicians to educate and engage patients to participate in existing cancer research, and urge cancer researchers to improve data and code sharing.

#### RECOMENDATIONS

In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of Resolution 021, A-22, "National Cancer Research Patient Identifier," and the remainder of this report be filed:

Our AMA encourages greater use of code and data sharing to enhance the timely conduct of research in oncology and implementation of innovations in care.

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## 16. INFORMAL INTER-MEMBER MENTORING

*Informational report; no reference committee hearing.*

### **HOD ACTION: FILED**

At the November 2021 Special Meeting of the House of Delegates (HOD), Policy D-635.980, “Informal Inter-Member Mentoring,” was adopted. As reported at the 2022 Interim Meeting (Board Report 6), last year our AMA convened on an ad hoc basis a Mentorship Steering Committee consisting of representatives from each of the AMA sections. This group was charged with identifying mentorship opportunities and best practices within individual sections and more broadly across the organization. The Committee’s key conclusion was that the AMA should create informal, organic opportunities for mentors and mentees to identify one another and connect, as opposed to establishing more formal programs with assigned mentors/mentees.

The Committee’s discussions prompted a variety of mentorship initiatives of this connective nature within the sections in 2022, including for example:

- The Women Physicians Section implemented a “speed mentorship” event that connected members in small group discussions with facilitators versed in career-building topics.
- The Young Physicians Section hosted a “leadership boot camp” for young physician members interested in pursuing leadership opportunities beyond the YPS and throughout the AMA.
- The Minority Affairs Section hosted a webinar and networking reception to engage and build connections among current and future MAS and AMA leaders from minoritized and marginalized backgrounds.

While many individual sections have instituted informal mentorship opportunities designed primarily to connect members, with others in the works, cross-sectional and broader organizational mentorship initiatives have remained elusive, largely due to issues of scalability. In 2023, a reconstituted Mentorship Steering Committee representative of the broad swath of AMA member backgrounds and experiences will be reconvened to continue consideration of opportunities to connect members for mentorship purposes outside the confines of any particular section. Your Board will continue to provide updates via HOD implementation status documents as this work proceeds.

## 17. AMA PUBLIC HEALTH STRATEGY

*Reference committee hearing: see report of Reference Committee D.*

**HOD ACTION: RECOMMENDATIONS ADOPTED  
REMAINDER OF REPORT FILED**  
*See Policy D-440.912*

### BACKGROUND

Policy D-440.922, “Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems” adopted by House of Delegates (HOD) at I-21 directed our American Medical Association (AMA) to:

develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress.

Policy D-135.966, “Declaring Climate Change a Public Health Crisis,” adopted by the House of Delegates at A-22 directed our AMA to:

develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

Resolution 605-A-22, “Fulfilling Medicine’s Social Contract with Humanity in the Face of the Climate Health Crisis” was referred by the House of Delegates and asked the AMA to:

establish a climate crisis campaign that will distribute evidence-based information on the relationship between climate change and human health, determine high-yield advocacy and leadership opportunities for physicians, and centralize our AMA’s efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050.

Policy D-145.992, “Further Action to Respond to the Gun Violence Public Health Crisis” has also called for the AMA to:

report annually to the House of Delegates on our AMA’s efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

Given the number of requests from the HOD for ongoing reports on public health-related topics as well as large national campaigns, the Board of Trustees is taking this opportunity to outline the AMA’s work in public health, so the HOD has clarity on current efforts and priorities. Our intent is to provide regular updates on the status of this work to the HOD.

## METHODS

This report is informed semi-structured, in-depth interviews with public health and physician experts (n=17), members of the AMA Board of Trustees (n=11), and members of the AMA’s Senior Management Group (n=11). Public health experts had federal, state, and local public health experience and were affiliated with governmental public health organizations, national public health organizations, schools of public health, public health foundations, and national medical specialty societies. Stakeholder organizations were identified by the members of the Council on Science and Public Health (CSAPH). Members of the AMA Board of Trustees were asked to participate in interviews at the discretion of the Board Chair. Members of the Senior Management Group were identified based on whether they reported that their work involves public health.

### *What is Public Health?*

Since its founding in 1847, the AMA’s mission has been “to promote the art and science of medicine and the betterment of public health.” Through the course of the interviews conducted across stakeholders, it was clear that there are many different definitions and understanding of what public health is.

According to the World Health Organization (WHO) public health is “the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society.”<sup>1</sup> Public health promotes and protects the health of people and the communities where they live, learn, work and play.<sup>2</sup> Public health practice is a different field than clinical medicine with different motivating values, responsibilities, and goals.<sup>3</sup> While a doctor treats people who are sick, those working in public health try to prevent people from getting sick or injured in the first place. A public health professional’s duty is to the community rather than an individual patient.

### *Connection with Health Equity*

It is important to acknowledge that health equity is a central concept in public health and is essential to improving the health of populations. The WHO defines health equity as the “absence of unfair and avoidable or remediable differences in health among social groups.”<sup>4</sup> It calls for just opportunities,

conditions, resources and power for all people to be as healthy as possible. Public health interventions and policies aim to reduce health disparities and are essential for promoting health equity and improving the health of entire populations. Opportunities and resources for health are inequitably distributed, public health seeks to right this inequity.

The AMA's health equity strategy recognizes that structural and social drivers of health inequities shape a person's and community's capacity to make healthy choices, noting that downstream opportunities provided by the health care system and individual-level factors are estimated to only contribute 20 percent to an individual's overall health and well-being, while upstream opportunities of public health and its structural and social drivers account for 80 percent of impact on health outcomes.<sup>5</sup>

The five strategic approaches of the health equity strategy are highly relevant to the AMA's public health work and include:

1. Embed racial and social justice throughout the AMA enterprise culture, systems, policies and practices.
2. Build alliances and share power with historically marginalized and minoritized physicians and other stakeholders.
3. Push upstream to address all determinants of health and the root causes of inequities.
4. Ensure equitable structures and opportunities in innovation.
5. Foster pathways for truth, racial healing, reconciliation and transformation for the AMA's past.

The AMA already develops an annual report on health equity activities. While integral to the AMA's public health strategy, progress towards the health equity strategy will continue to be reported in the BOT's annual health equity report. (See BOT 10-A-23, "Center for Health Equity Annual Report.")

## CURRENT AMA APPROACHES TO PREVENTION & PUBLIC HEALTH

### **1. Promote evidence-based clinical and community preventive services.**

Clinical preventive services involve the care provided by physicians and other health care professionals during a routine one-to-one encounter.<sup>6</sup> They have a strong evidence base for efficacy in health improvement and/or cost-effectiveness. These services are not public health, but rather clinical care. However, they are included here because they are necessary to achieve the goals of public health. Community preventive services are evidence-based options that decision makers and affected community members can consider when determining what best meets the specific needs, preferences, available resources, and constraints of their jurisdictions and constituents.<sup>7</sup> They are not oriented to a single patient or all of the patients within a practice. The target is an entire population or subpopulation usually identified by a geographic area.<sup>8</sup>

A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Community Preventive Services Task Force (CPSTF) and support the dissemination of recommendations to physicians.

The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services. The AMA is USPSTF Dissemination and Implementation (D&I) partner, through which we contribute expertise by helping disseminate the work of the task force to physician members to help put the recommendations into practice.<sup>9</sup> Partners are also a powerful vehicle for ensuring the U.S. primary care workforce remains up to date on USPSTF recommendations.

The Advisory Committee on Immunization Practices (ACIP) comprises medical and public health experts who develop recommendations on the use of vaccines in the civilian population of the United States. The recommendations stand as public health guidance for safe use of vaccines and related biological products. In addition to the voting members, there are 30 non-voting representatives from professional organizations, including the AMA, that are highly regarded in the health field.<sup>10</sup> These members comment on ACIP's recommendations and offer the perspectives of groups that will implement the recommendations.

The Community Preventive Services Task Force (CPSTF) is an independent, non-federal panel whose members are appointed by the CDC Director. CPSTF members represent a broad range of research, practice, and policy expertise in prevention, wellness, health promotion, and public health. The CPSTF was convened in 1996 by the Department of Health and Human Services (HHS) to identify community preventive programs, services, and policies that increase health, longevity, save lives and dollars, and improve Americans' quality of life. The CPSTF's recommendations, along with the systematic reviews of the evidence on which they are based, are compiled in the *The Community Guide*. The AMA serves as an organizational liaison to the CPSTF.<sup>11</sup>

B. Help prevent cardiovascular disease (CVD) by addressing major risk factors (AMA Strategic Priority led by the Improving Health Outcomes Group)

The AMA is committed to improving the health of the nation and reducing the burden of chronic diseases. In collaboration with health care leaders and organizations, the AMA is developing and disseminating new chronic disease prevention and management approaches. Our primary focus is cardiovascular disease (CVD), the leading cause of death in the U.S., accounting for 1 in 4 deaths.<sup>12,13</sup> The AMA engages in this work through strategic alliances with various organizations including the CDC, the American Heart Association (AHA), and West Side United in Chicago.

Two major risk factors for CVD are hypertension and type 2 diabetes. An estimated 116 million adults have hypertension and 96 million have prediabetes which can lead to hypertension.<sup>14,15</sup> Obesity also leads to the development of cardiovascular disease and cardiovascular disease mortality independently of other cardiovascular risk factors.<sup>16</sup> To help prevent Type 2 diabetes, the AMA developed clinical practice tools that support the screening and managing of people with prediabetes in alignment with clinical guidelines. The AMA also developed AMA MAP BP™, a clinical quality improvement program that includes population dashboards and reports as well as coaching, training and support for clinical teams. IHO provides the AMA MAP BP program to health care delivery organizations and other collaborators to support improvement in blood pressure control for patients. The AMA MAP™ framework is expanding to include management for other cardiovascular disease risk factors, including cholesterol, prediabetes, and type 2 diabetes. The AMA is examining how to integrate obesity into its chronic disease portfolio. It completed a landscape assessment to identify existing opportunities and will convene an expert panel to review recommendations from the landscape assessment to provide guidance.

Additionally, in response to the high prevalence of uncontrolled blood pressure and to support physicians in managing their patients' high blood pressure, the AMA, in collaboration with the American Heart Association, developed Target: BP™, a national initiative offering a series of online resources, using the latest evidence-based information. Target: BP recognizes organizations committed to improving blood pressure control. In 2022, the program recognized 1,309 health care organizations (HCO) for their efforts in representing 49 states or U.S. territories and serving more than 28 million patients, including 8.1 million people with hypertension.

Black, Latinx, Indigenous, Asian/Pacific Islanders, and other people of color are disproportionately impacted by CVD risk factors and resulting morbidity and mortalities.<sup>17</sup> To better address these disparities the AMA partnered with the American College of Preventive Medicine and Black Women's Health Imperative to increase Black and Latinx women's enrollment in the CDC's National Diabetes Prevention Program lifestyle change program.

The AMA, along with physician groups and heart health experts, launched the Release the Pressure (RTP) campaign.<sup>18</sup> The campaign has reached over 300,000 Black women, encouraging them to pledge to "know your numbers, talk with your doctor, bring your squad," in addition to training 75,000 individuals to track their blood pressure via self-monitoring blood pressure tracking tools.

C. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral Hepatitis and latent tuberculosis (LTBI).

Through funding from the CDC, the AMA has been engaged in work on a project entitled, "Promoting HIV, Viral Hepatitis, STDs and LTBI Screening in Hospitals, Health Systems and Other Healthcare Settings." The scope of this project includes developing, piloting and launching a toolkit that outlines ways to increase routine screening for HIV, STIs, viral hepatitis and latent TB infection.

As a first phase of this work, the AMA conducted in-depth interviews, virtual clinic visits and co-creation groups with clinicians working in organizations where a well-defined routine screening process is already in place in order

to better understand best practices, key challenges and critical considerations when implementing a routine screening program. The findings from these sessions were synthesized and used as the framework to build out the toolkit and its key recommendations.

The toolkit consists of a series of webpages on the AMA's corporate website. Information and recommendations are organized along the screening and testing continuum and offer helpful resources and best practices from the AMA, CDC and other organizations. The resources include a mix of both implementation and training-related materials for the care team. It is intended to be flexible, allowing an organization to follow along throughout the entire continuum to help improve the end-to-end screening and testing approach or narrow in and focus on a specific stage where additional guidance and support may be needed. Two versions of the toolkit are being developed—one targeted to community health centers and a second to emergency departments.

In order to validate the initial iteration of the community health center toolkit that was developed, the AMA conducted a pilot with a cohort of 6 community health centers across the country.<sup>19</sup> This work included pilot sites implementing 2-3 toolkit recommendation during the pilot period as well as participating in a series of 5 telementoring sessions with other pilot sites, with each session being focused on a different section of the toolkit. A second pilot to test elements of the toolkit in practice is planned to take place in the spring of 2023 with a cohort of emergency departments. Following these pilots, any feedback and comments received from pilot sites will be prioritized and incorporated into the toolkit before the toolkit is launched more broadly.

D. Promote evidence-based preventive services to the public in collaboration with the Ad Council and other health partners.

While the AMA's primary audience is physicians, there are limited instances where the AMA has partnered on public information campaigns on select priority issues. This work has been made possible through partnerships with other health-related organizations and the Ad Council. The AMA will explore opportunities for future campaigns on an ongoing basis, with recognition that we have to prioritize our efforts and engaging in these campaigns alone is not feasible due to cost.

### 1. Get My Flu Shot

The Ad Council, AMA, CDC and the CDC Foundation have partnered since the 2020-2021 flu season through an annual campaign to motivate more people to get vaccinated against seasonal influenza (flu) to protect themselves and their loved ones. During a severe season, flu has resulted in as many as 41 million illnesses and 710,000 hospitalizations among the U.S. population. The *Get My Flu Shot* campaign PSAs are launched nationwide to reach people with the message that a flu shot can help you stay healthy, reduce risk of severe outcomes, such as hospitalization and death, and avoid missing work, school, or special moments with family and friends. The campaign ads direct audiences to [GetMyFluShot.org](https://www.getmyflushot.org) for more information, including where to get a flu vaccine in their area.

### 2. It's Up to You

The Ad Council and COVID Collaborative, including the AMA, led a massive communications effort to educate the American public and build confidence around the COVID-19 vaccines. Guided by the leading minds in science and medicine and fueled by the best talent in the private sector, the COVID-19 Vaccine Education Initiative is designed to reach different audiences, including communities of color who have been disproportionately affected by COVID-19. Under the umbrella of the "It's Up to You" campaign, we worked to ensure that Americans have accurate and timely information to answer their questions and concerns about vaccine side effects, efficacy, and clinical trials. The goal being to shift the public mindset from vaccine concern to vaccine confidence.

### 3. Do I have Prediabetes

More than one in three American adults have prediabetes and are at high risk of developing type 2 diabetes—a serious health condition that can lead to heart attack or stroke. Of these individuals, more than 80% of people with prediabetes don't know they have it. However, the vast majority of people with prediabetes can take steps to reduce their risk. Prediabetes can often be reversed through weight loss, diet changes, and increased physical activity. The AMA, in collaboration with the CDC developed a series of PSAs encouraging viewers to visit



[DoIHavePrediabetes.org](https://www.doIHavePrediabetes.org), where they can take a one-minute risk test to highlight the importance of early diagnosis and speaking with their physician. Over 12.5M risk tests have been completed since 2016.

#### 4. Get Down with Your Blood Pressure

Nearly half of all American adults have high blood pressure, yet only about 1 in 4 individuals have their condition under control. Because of the pandemic and persisting health inequities, there is an increased risk of high blood in communities of color, particularly for Black, Hispanic/Latinx, and Native American adults. The AMA and AHA “Get Down With Your Blood Pressure” campaign teaches adults that self-monitoring their blood pressure is as easy as four simple steps: get it, slip it, cuff it, check it. Along with talking to your health care provider about a blood pressure management plan, taking these steps can decrease the incidence of stroke, heart attack, and heart failure. The AMA in collaboration with the AHA maintain both [ManageYourBP.org](https://www.ManageYourBP.org) or [BajaTuPresion.org](https://www.BajaTuPresion.org) which host tools and resources to help educate patients about the how to self-monitor your blood pressure and speak to your health care provider.

## 2. Responding to public health crises impacting physicians, patients, and the public.

The AMA’s public health work has also been focused around responding to public health crises. These crises are often associated with significant health risk for patients, raising concerns among physicians. However, these crises are unlikely to be solved in a clinical setting alone. The AMA’s response to public health crises are typically focused on (1) ensuring physicians and trainees have the data and resources needed; (2) identifying evidence-based policies and interventions; (3) elevating the voices of physician leaders through AMA channels and platforms; and (4) convening and collaborating with stakeholders to advance priority policies and interventions.

### A. Address the public health crisis of climate change.

At 2022 Annual Meeting of the House of Delegates, policy was adopted declaring “climate change a public health crisis that threatens the health and well-being of all individuals.” At I-22, the Council on Science and Public Health presented a council-initiated report on this topic “due to the significant public health threat that climate change represents and the impact on the health of patients, with marginalized populations expected to be disproportionately impacted.” That report noted the health effects of climate change include increased allergies, asthma, respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather events; heat-related deaths due to continued warming; changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health. The report’s recommendations, which were adopted by the HOD called for a reduction in US greenhouse gas (GHG) emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050. In the coming year the AMA’s priorities will be as follows:

#### 1. Educate physicians and trainees on the health effects of climate change.

The AMA has made climate change education available via the Ed Hub™ from a variety of sources including the AMA Journal of Ethics (JOE), the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA). However, the AMA has not developed a CME module for physicians and trainees on climate change, that will be an area of focus over the coming year.

#### 2. Identify and disseminate information to physicians on decarbonizing the health care sector and reducing GHG emissions.

The U.S. health sector accounts for 25 percent of global health sector emissions, the highest proportion attributable to any individual country’s health sector. The Joint Commission is in the process of convening a technical advisory panel to initiate a directional standard that encourages health systems to address reducing their own carbon footprint, and to review existing standards to be sure, explicitly, that they do not require excess consumption. With the goal of reducing U.S. GHG emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, the AMA will create a resource page to share information on high-impact actions needed to decarbonize the health care sector.

There are several resources that already exist including Health Care Without Harm’s Road Map that provides a plan to get health care toward zero emissions.<sup>20</sup> The Road Map identifies seven high-impact actions as key to health care decarbonization. Agency for Healthcare Research and Quality (AHRQ) and Institute for Healthcare Improvement’s

primer that offers guidance on high-priority measures and strategies for health care organizations to reduce their carbon footprint.<sup>21</sup> The primer describes six domains contributing to GHG emissions in health care: building energy, transportation, anesthetic gas, pharmaceuticals and chemicals, medical devices and supplies, and food. To meaningfully track and reduce GHG emissions, the primer recommends health care organizations should use the Greenhouse Gas Protocol (GHGP) framework, a globally recognized standard for quantifying and reporting on emissions. The National Academy of Medicine's Action Collaborative on Decarbonizing the U.S. Health Sector has also hosted a series of Carbon Clinics designed for health care delivery organizations to learn about carbon accounting. The Carbon Clinics will soon be made public along with related resources.

### 3. Elevate the voices of physician leaders on the issue of climate change and health.

Through the AMA's video updates and podcast series, we amplify physician voices and highlight developments and achievements throughout medicine. On January 20, 2022, the AMA featured Renee Salas, MD, MPH, MS, a climate and health expert and emergency medicine physician who discussed research on the intersection of health and the climate crisis.<sup>22</sup> On August 25, 2022, the AMA featured Colin Cave, MD, medical director of external affairs, government relations and community health, Northwest Permanente to discuss the link between health and climate change, and how physicians and health systems can be a part of the solution.<sup>23</sup> The AMA will continue to look for opportunities to highlight physicians doing this important work.

### 4. Collaborate with stakeholders to advance policies and interventions with a unified voice.

Medical Society Consortium on Climate and Health. The AMA will continue to engage in the Medical Society Consortium on Climate and Health (Consortium), which brings together associations representing over 600,000 clinical practitioners to carry three simple messages:

- A. Climate change is harming Americans today and these harms will increase unless we act;
- B. The way to slow or stop these harms is to decrease the use of fossil fuels and increase energy efficiency and use of clean energy sources; and
- C. These changes in energy choices will improve the quality of our air and water and bring immediate health benefits.<sup>24</sup>

The Consortium recognizes that medical societies have an important opportunity to weigh in to help ensure that the health risks of climate change and the health benefits of climate solutions, especially clean energy, are clearly understood. The voices of America's medical societies have the potential to help reframe the dialogue – putting human health and wellbeing front and center in the conversation. This is especially important to communities who are experiencing a disproportionate impact from climate change.

#### National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector.

The AMA is also a member of the National Academy of Medicine Action Collaborative on Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health Care Delivery Workgroup. The Climate Collaborative is a public-private partnership of leaders from across the health system committed to addressing the sector's environmental impact while strengthening its sustainability and resilience. The Climate Collaborative provides a neutral platform for its participants to align around collective goals and actions for decarbonization, based on evidence, shared solutions, and a commitment to improve health equity.<sup>25</sup>

In the first year of the Climate Collaborative, the Health Care Delivery Workgroup has focused on the following goals:

- Goal 1: Make the multi-faceted case for health systems and hospitals to minimize their carbon footprints and operate more sustainably;
- Goal 2: Identify a set of policy and regulatory barriers preventing progress on decarbonization and resilience from accelerating, and identify solutions;
- Goal 3: Identify a core set of sustainability metrics for hospitals and clinical practice;
- Goal 4: Develop decarbonization playbooks and best practices for hospitals and health care delivery institutions, leveraging existing frameworks and success stories.

At the time of this report, the Health Care Delivery Workgroup is in the final stages of building consensus around goals for 2023.

Healthy Air Partners. The AMA has joined the American Lung Association's Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing and health care organizations engaged in healthy air advocacy efforts.<sup>26</sup> The Coalition is united in its calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change. So far in 2023, the AMA has joined partners on a letter to the EPA urging them to quickly strengthen and finalize the Standards of Performance for New, Reconstructed, and Modified Sources and Emissions Guidelines for Existing Sources: Oil and Natural Gas Sector so that implementation can begin and communities can begin to see the benefits of the pollution reductions.<sup>27</sup>

The Inflation Reduction Act (IRA), which was signed into law on August 16, 2022, was the most significant measure ever adopted by the U.S. Congress to combat climate change. The IRA is likely to play an important role in mitigating the adverse health effects of climate change. Implementation of the IRA will require extensive rulemaking; therefore, we anticipate that to be the focus of our advocacy efforts in the coming year.

## B. Prevent firearm injuries and deaths.

In the 1980's the AMA recognized firearms as a serious threat to the public's health as the weapons are one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence represents a public health crisis which requires a comprehensive public health response and solution." Since that time firearm injuries and deaths have increased and disparities have widened.<sup>28</sup>

1. Educate physicians on how to counsel at risk patients on firearm injury prevention and what steps to take if a patient is at risk.

In 2018, the AMA created a CME module with physician experts on "The Physician's Role in Firearm Safety." The learning objectives of the module are as follows: (1) Describe the epidemiology of firearm morbidity and mortality in the U.S.; (2) Recognize common risk factors that elevate the potential for firearm injury; (3) Identify barriers to communicating with patients about firearm safety; (4) Determine practical approaches to prepare for firearm safety counseling; and (5) Effectively communicate how to reduce the risk of firearm injury and death.<sup>29</sup> The module had 619 completions from 2019 - 2023 and has an overall quality rating of 4.4/5.0. The AMA is currently in the process of updating the information in the module and will add a new case study around dementia and firearms. The updated version is expected to launch in May of 2023. We recognize that a broader dissemination strategy of the updated module will be necessary to improve uptake among health care professionals.

Along with the updated CME, the AMA will launch an online tool to provide physicians with state-specific laws in their jurisdiction related to counseling restrictions, safe storage and child access protection laws, temporary transfer requirements, and extreme risk protection orders. This information will help guide physicians when they identify patients at risk of firearm injury and death by sharing details on what is allowed under state law.

2. Advocate for common sense policies to prevent firearm injuries and increased funding for research.

Congress succeeded in passing the first major firearm legislation in over 30 years with S. 2938, the "Bipartisan Safer Communities Act" (Murphy, D-CT/Cornyn, R-TX), which the AMA supported. President Biden signed this bill into law on June 25, 2022, and AMA Board Chair Sandra Adamson Fryhofer, MD, attended the signing ceremony. Key provisions of the bill include:

- Providing grants for states to establish or strengthen extreme risk protection orders;
- Adding convicted domestic violence abusers in dating relationships to the National Instant Criminal Background Check System (NICS);
- Requiring the NICS to contact authorities to see whether an individual under the age of 21 has a "disqualifying" juvenile record for buying a firearm;
- Making it a federal crime to buy a firearm on behalf of an individual who is prohibited from doing so; and
- Including new spending for school security and mental health treatment.

Our AMA is now focused on advocating to ensure that the new funding authorized in the new law is actually appropriated, advocating for states to establish or strengthen extreme risk protection orders, and ensuring that the

other provisions are properly and quickly implemented. Pursuant to the new law, the Department of Justice recently awarded over \$200 million in grants to states, territories, and the District of Columbia to fund state crisis intervention court proceedings, including but not limited to, extreme risk protection order (ERPO) programs that work to keep guns out of the hands of those who pose a threat to themselves or others.

The AMA has also advocated for Congress to appropriate increased funding for research to prevent firearm violence. The AMA is working with medical specialties, including the American Academy of Pediatrics, to support \$60 million in funding for the CDC and the National Institutes of Health (NIH) to conduct public health research on firearm morbidity and mortality prevention. This would double the amount of funding provided last year. Our AMA will continue to monitor appropriations developments and advocate to ensure that this funding is approved by Congress.

Through the AMA's litigation center, we work to represent the interests of the medical profession on this issue in the courts by providing support or becoming actively involved in litigation of importance to physicians. The AMA has created a website broadly outlining the organization's advocacy efforts on gun violence prevention, this includes cases for which the AMA has filed amicus briefs.<sup>30</sup>

### 3. Elevate the voices of physician leaders on the issue of firearm injury and violence prevention.

Through the AMA's video updates and podcast series, we amplify physician voices and highlight developments and achievements throughout medicine. In June of 2022, the AMA featured Megan Ranney MD, MPH, a practicing emergency physician, researcher and national advocate for innovative approaches to public health at Brown University, talking about gun violence and why we need to approach it as a public health issue with physicians playing an important role.<sup>31</sup> On February 23, 2023, Emmy Betz, MD, MPH, professor of emergency medicine and director of the Firearm Injury Prevention Initiative at the University of Colorado School of Medicine was featured to discuss firearm-related injury and suicide and the role physicians can play in helping to prevent it.<sup>32</sup> AMA leaders, including Immediate Past President Gerald Harmon, MD, have also talked about firearm injuries and deaths being a public health crisis that can affect everybody and that requires a comprehensive public health response and a solution.<sup>33</sup>

### 4. Collaborate across the federation of medicine and with other interested partners to address the public health crisis of firearm injuries and deaths with a unified voice.

American Foundation for Firearm Injury Reduction in Medicine. The AMA is a partner organization of AFFIRM at The Aspen Institute, which is a non-profit dedicated to ending the American firearm injury epidemic using a health-based approach. AFFIRM combines the health expertise with the knowledge and traditions of responsible firearm stewardship to achieve consensus recommendations. AFFIRM is committed to reducing the rate of firearm injuries and deaths. AFFIRM at The Aspen Institute also builds partnerships with non-medical organizations that are equally committed to preventing firearm injury, including groups committed to firearm safety and shooting sports.

ACP-Led Call to Action on Firearm-Related Injury and Death. The AMA has joined the American College of Physicians (ACP), American Academy of Family Physicians, American Academy of Pediatrics, American College of Surgeons (ACS), American Psychiatric Association, and the American Public Health Association in calling for policies to help stem firearms-related injuries and deaths in the United States. The organizations endorsed the article, "Firearm-Related Injury and Death in the United States: A Call to Action From the Nation's Leading Physician and Public Health Professional Organizations."<sup>34</sup>

Medical Summits and Coalition for Firearm Injury Prevention. The AMA also participated in a 2019 meeting on firearm violence organized by ACS and participated in a follow-up Medical Summit on Firearm Injury Prevention sponsored by ACS in collaboration with the ACP, the American College of Emergency Physicians, and the Council of Medical Specialty Societies in September of 2022. The objectives of the 2022 summit were to use a consensus-based, non-partisan approach to selecting recommendations for executive action and/or legislation at the federal, state, and municipal levels that would decrease firearm-related injuries and identify elements of the most effective programs that can be implemented by physician practices/clinics/hospitals/health systems in partnership with their communities to effectively lower the risk of violence, with an emphasis on marginalized communities that are disproportionately impacted by violence. The Summit included representatives from 46 organizations, making it one of the largest gatherings of medical and injury prevention professionals on this issue. The proceedings of the

Summit were published in the *Journal of the American College of Surgeons*.<sup>35</sup> To achieve the goals outlined at the Summit, the sponsoring organizations agreed to establish the Healthcare Coalition for Firearm Injury Prevention.<sup>36</sup>

AMA convened task force. On February 27, 2023, the AMA convened Phase I of the gun violence task force, which consisted of those Federation members who have been most highly engaged on the issue of firearm injury prevention for many years. Representatives from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Physicians, American College of Surgeons, American Psychiatric Association met with members of the AMA Board and staff. AMA Board Chair Sandra Adamson Fryhofer, MD, Chair of the first phase of this Task Force, led the meeting. The goal was to better understand work already underway to address this issue, what has worked well, and the unique role an AMA convened task force could play. Gun violence advocacy organizations (Brady, Giffords, and the Johns Hopkins Center for Gun Violence Solutions) were also invited to share their perspectives on the role of physicians and organized medicine in firearm injury prevention. The advocacy groups strongly encouraged organized medicine to pick one or two things to focus on and to speak on them with a unified voice.

#### C. Respond to emerging and reemerging infectious disease threats and prepare for future pandemics.

Infectious diseases continue to be a threat to the U.S. population. Although some diseases have been conquered by modern advances such as antibiotics and vaccines, new ones are constantly emerging, whereas others reemerge in drug-resistant forms (e.g., malaria, tuberculosis, and bacterial pneumonias). Because no one knows what new diseases will emerge, the health system must be prepared for the unexpected. Because the AMA is relied upon as a source of information by physicians and patients, the AMA has to maintain a level of capacity to respond and share information and advocate for physicians, patients, and the public in line with AMA policies. Over the course of the past few years, this work has focused heavily on responding to the COVID-19 pandemic and the outbreak of monkeypox (mpox).

##### 1. Educate physicians on how to protect themselves and their patients from infectious disease threats.

The AMA is a collaborator in Project Firstline, the CDC's National Training Collaborative for Healthcare Infection Control. Project Firstline offers educational resources in a variety of formats to meet the diverse learning needs and preferences of the health care workforce.<sup>37</sup> Resources are designed to empower and enable health care professionals to think critically about infection control, using adult learning principles, educational best practices, CDC recommendations, and the science that informs them. Project Firstline encourages all health care professionals to take advantage of these free infection control training resources – that were developed with health care professionals, specifically for health care professionals. For COVID-19 and mpox, the AMA also developed resource centers to share information on testing, therapeutics, and vaccines along with the latest clinical information.

##### 2. Address preparedness for future infectious disease outbreaks and pandemics.

With over 1,000,000 individuals in the U.S. who have died as a result of COVID-19, it is critical that we evaluate shortcomings and successes and provide evidence-based guidelines to protect our patients and the public from COVID-19 and other future infectious pathogens. Given the challenges that patients, physicians, hospitals, health care facilities, and our communities have endured and continue to experience, we need to work to remedy the problems experienced during the COVID-19 pandemic regarding effective testing strategies, timely directives on appropriate utilization of public health mitigation strategies, evidence-supported efforts to maintain strategic stockpiles of personal protective equipment, ventilators, and other supplies, and to inform future health system preparedness.

#### D. End the nation's drug overdose epidemic.

Ending the nation's drug overdose epidemic will require increased physician leadership, a greater emphasis on overdose prevention and treatment, and better coordination and amplification of the efforts and best practices already occurring across the country.

##### 1. Educate physicians on overdose prevention, substance use treatment, and pain management.

The AMA makes education available to physicians on this topic via the AMA Ed Hub™ to help physicians gain critical knowledge around acute and chronic pain management, substance use treatment, overdose prevention, and

pain treatment. Courses are both developed by AMA as well as by other partners. The AMA is also a member of the Providers Clinical Support System (PCSS), which is made up of a coalition of major health care organizations all dedicated to addressing this health care crisis and is led by the American Academy of Addiction Psychiatry. PCSS provides evidence-based training and resources to give health care providers the skills and knowledge they need to treat patients with opioid use disorders and chronic pain.<sup>38</sup>

2. Promote consistency in overdose-related outcome data and increase awareness for the need of standardized state-level data.

The AMA has also developed an End the Epidemic Dashboard which compiles state-level data for several indicators, including overdose mortality, non-fatal overdoses, opioid prescriptions, and prescription drug monitoring program queries.<sup>39</sup> The dashboard also highlights which states are missing data for any of the indicators. The goal of this dashboard is to continue to promote consistency in overdose-related outcome data and increase awareness for the need of standardized state-level data.

3. Convene the AMA Substance Use and Pain Care Task Force to advance evidence-based recommendations for policymakers and physicians, including harm reduction strategies.

In 2015, the American Medical Association convened more than 25 national, state, specialty and other health care associations to develop industry-wide recommendations for physicians to help end the nation's opioid epidemic. In 2019, the AMA Pain Care Task Force highlighted efforts needed to help patients with pain. In 2021, the AMA joined the two task forces to address the changing—and worsening—drug overdose epidemic, emphasizing tangible actions needed to increase access to evidence-based care for patients. The task force, under the leadership of Bobby Mukkamala, MD, Immediate Past Chair of the AMA Board of Trustees, continues to advance evidence-based recommendations for policymakers and physicians to help end the nation's drug-related overdose epidemic. The task force recommendations are largely focused in the health care sector, addressing access to treatment.<sup>40</sup> Recommendation 4 is focused on public health and harm reduction.

- Recommendation 1: Support patients with pain, mental illness or a substance use disorder (SUD) by building an evidence-based, sustainable and resilient infrastructure and health care workforce.
- Recommendation 2: Remove barriers to evidence-based treatment for SUDs, cooccurring mental illness and pain.
- Recommendation 3: Support coverage for, access to, and payment of comprehensive, multi-disciplinary, multi-modal evidence-based treatment for patients with pain, a substance use disorder or mental illness.
- Recommendation 4: Broaden public health and harm reduction strategies to save lives from overdose, limit the spread of infectious disease, eliminate stigma and reduce harms for people who use drugs and other substances.
- Recommendation 5: Improve stakeholder and multi-sector collaboration in an effort to ensure that the patients, policymakers, employers, and communities benefit from evidence-based decisions.

The AMA develops on annual report on the overdose epidemic outlining accomplishments and what still needs to be done.<sup>41</sup>

4. Collaborate with external stakeholders to address the opioid addiction crisis.

The AMA is a member of the National Academy of Medicine (NAM) Action Collaborative on Countering the U.S. Opioid Epidemic. The Action Collaborative was formed in 2018 as a public-private partnership to foster greater coordination and collective action across the health system and beyond in addressing the opioid addiction crisis.<sup>42</sup> The Action Collaborative uses a systems approach to convene and catalyze public, private, and non-profit stakeholders to develop, curate, and disseminate multi-sector solutions designed to reduce opioid misuse, and improve outcomes for individuals, families, and communities affected by the opioid crisis.

The Action Collaborative conducts its work around four core priority areas: Health Professional Education and Training; Pain Management Guidelines and Evidence Standards; Prevention, Treatment, and Recovery Services; and Research, Data, and Metrics Needs. The Action Collaborative produces discussion papers to advance the field and accelerate action where the evidence dictates; conducts outreach; and leads convenings, webinars, and other special events to accelerate the translation of the most promising opportunities to reverse the opioid crisis.

### **3. Strengthen the health system through improved collaboration between medicine and public health.**

#### **A. Strengthen physician and trainee knowledge of public health and social determinants of health.**

The AMA makes education on public health and health equity available on the AMA Ed Hub™ to empower individuals and organizations, in health care and beyond, in advancing health equity and the betterment of public health. The Ed Hub contains curated education from trusted sources on a wide range of public health issues. The AMA's Center for Health Equity has developed educational content to empower individuals and organizations, in health care and beyond, in advancing racial justice and equity.<sup>43</sup>

The AMA is transforming medical education across the continuum and collaborating with undergraduate and graduate medical education institutions to create a system that trains physicians to meet the needs of today's patients and anticipate future changes. This includes working with schools to implement instruction in health systems science (HSS), the third pillar of medical education, along with the basic and clinical sciences. The HSS curriculum includes issues related to how social determinants of health affect the entire population and the improvement strategies at the population health level to address gaps in care such as the organized assessment, monitoring or measurement of key health metrics necessary to improve health outcomes for a group of individuals.<sup>44</sup>

#### **B. Maintain AMA relationships with national public health organizations.**

The Association of State and Territorial Health Officials (ASTHO), National Association of City and County Health Officials (NACCHO), and the American Public Health Association (APHA) are all designated liaisons to the Council on Science and Public Health. AMA staff are engaged in regular discussions to understand their perspectives and opportunities for collaboration.

#### **C. Collaborate with leading health care organizations to strengthen the interface between public health and health care.**

A new health care industry consortium has agreed to work together, in partnership with public health, to focus on strengthening the interface between public health and health care. The consortium includes some of the most prominent and influential organizations from the health care sector. Core membership organizations will include: AHIP (formerly America's Health Insurance Plans), Alliance of Community Health Plans (ACHP), American Hospital Association (AHA), American Medical Association (AMA), and Kaiser Permanente (KP).

The consortium, which will be governed by senior leaders from each of the core member organizations and staffed by independent policy analysts and other experts, will focus on areas where there is significant opportunity for consensus building and where health care partners are uniquely positioned to play a significant role in advancing the work. The consortium has agreed to focus its initial work on four specific priorities and will work over the coming months to further define concrete, pragmatic, and tangible actions to advance these priorities.

Priority Actions Areas will include.

- 1) Formalizing agreements and supporting coordinated efforts between public health and health care with clear communication of goals, roles, responsibilities, tasks, and deliverables.
- 2) Evolving and supporting robust scalable emergency preparedness programs.
- 3) Establishing national standards, processes and use cases for stratifying public health and health care data by sociodemographic variables to identify disproportionate health impacts and outcomes at the community level.
- 4) Modernizing and integrating an infectious disease surveillance system that unifies data across sectors, agencies, and data systems, including novel data sources (e.g., social media) and advanced analysis methods.

### **4. Combat the spread of misinformation and disinformation.**

At the 2022 Annual Meeting of the HOD, the Board's report on, "Addressing Public Health Disinformation Disseminated by Health Professionals" was adopted. AMA Policy, D-440.914, "Addressing Public Health

Disinformation Disseminated by Health Professionals,” outlines a comprehensive strategy to address health-related disinformation disseminated by health professionals. Aspects most relevant to public health include the following:

A. Maintaining AMA as a trusted source of evidence-based information for physicians and patients.

While the public’s trust in many institutions has waned during the COVID-19 pandemic, people generally still trust their doctors. In his November 12, 2021, address to the AMA House of Delegates, AMA CEO/EVP James Madara, MD, noted that, “[t]he AMA exists to benefit the public, but we do so in a very particular way—by being the physicians’ powerful ally in patient care. We serve the public by serving those who care for the public. Supporting physicians and improving our nation’s health has been our focus since 1847.”<sup>45</sup>

B. Combat public health mis- and disinformation that undermines public health initiatives.

The AMA has continued to issue press statements, noting the harm of mis- and disinformation and has urged the CEOs of six leading social media and e-commerce companies to assist the effort by combatting misinformation and disinformation on their platforms. The AMA has remained a source of trusted information providing physicians with up-to-date information on public health issues.

C. Collaborate with stakeholders to ensure all patients have equitable access to and confidence in accurate, understandable, and relevant information necessary to make health decisions.

The AMA has engaged in several collaborates to address mis- and disinformation. The recently announced Coalition for Trust in Health and Science brings together reputable associations representing academics, researchers, scientists, doctors, nurses, pharmacists, drug and insurance companies, consumer advocates, and public health professionals.<sup>46</sup> The coalition will support efforts to advance people’s scientific and health literacy, earn public trust and improve health outcomes and health equity as well as to correct misinformation and counter disinformation that threatens health and well-being. The AMA has also been engaged with the work led by NAM, WHO, and the Council of Medical Specialty Societies on a project focused on identifying credible sources of health information in social media.<sup>47</sup>

## CONCLUSION

The strategy outlined provides an overview of the work the AMA is doing in public health and indicates our current priorities. While much of this work resides in Health, Science and Ethics, other business units lead portions of this work including Improving Health Outcomes, the Center for Health Equity and Medical Education. Advocacy, Communications, the Ed Hub team, Marketing and Member Experience are also vital to advancing these efforts. Many of the public health crises being addressed by the AMA are not going to be solved by our organization alone. Collaboration is going to be critical, and the AMA has taken steps to engage other organizations in this work where it makes sense. While there are many areas where the AMA is asked to engage, the areas outlined above represent our focus in advancing the AMA’s mission towards the betterment of public health.

## RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 605-A-22 and the remainder of the report be filed.

1. Our AMA will distribute evidence-based information on the relationship between climate change and human health through existing platforms and communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA’s efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050.

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## 18. MAKING AMA MEETINGS ACCESSIBLE

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION:       RECOMMENDATIONS ADOPTED  
                          REMAINDER OF REPORT FILED**

Policy G-630.140 [8], adopted by the American Medical Association House of Delegates (HOD) at the 2022 Annual Meeting, called for a report to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize meeting participation for members and invited attendees with disabilities. This report responds to G-630.140 [8].

### BACKGROUND

AMA meeting venues are selected several years in advance to secure locations and begin meeting planning. Among the other considerations, management is directed by current AMA policy to choose hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. For our Interim and Annual Meetings, efforts are made to locate the Section Assembly Meetings in the House of Delegates meeting hotel or in a hotel in proximity.

When planning an event, it is important to consider accessibility for individuals with disabilities, and AMA management takes this responsibility seriously by researching venues and assessing their accessibility features, considering unique needs, and providing necessary aids for optimal participation.

To ensure accessibility for individuals with disabilities, AMA management follows a thorough process. This includes researching venues that have necessary accessibility features and conducting in-person site visits to assess various features such as parking, entrances, elevators, ramps, restrooms, all gender restrooms, seating arrangements, and audiovisual capabilities. Additionally, AMA management considers unique needs such as sensory processing issues and provides options for individuals to retreat to quiet spaces as needed. To further enhance participation, AMA management offers various audio and visual aids to accommodate those who are sight or hearing impaired. For individuals with hearing impairments, options include sign language interpreters, assistive listening devices, and captioning. For individuals with visual impairments, options include audio descriptions, tactile maps and models, Braille and large-print materials, and accessible technology such as screen readers or magnification software.

For the hearing assistance device, management will work to ensure that the device is available and working properly during management meetings. Members who require this device can inform management in advance, and staff will make sure that the device is set up and ready for use. This information will be included in the registration form for the meeting, or members can contact management directly to request the device.

For an in-person interpreter, management will work to ensure that a qualified interpreter is available for members who require this service. The cost of the interpreter will be covered by the AMA, not by the member. Meeting services will coordinate with the interpreter and the member to ensure that the interpreter is available at the appropriate time and location. Members who require an interpreter can inform management in advance, and staff will make sure that an interpreter is available.

For members in wheelchairs, management will work to ensure that the meeting venue is accessible and that accommodations are made as needed. This may include providing accessible seating, ensuring that there are accessible paths of travel throughout the venue, and making sure that any equipment or materials needed by the member are available and accessible. Members who require accommodations for mobility issues can inform management in advance, and staff will work with the member to ensure that their needs are met.

Overall, management is committed to ensuring that all members are able to participate fully in meetings and that their needs are accommodated appropriately. Members who require special accommodations should inform management in advance, and staff will work to ensure that these accommodations are made.

Further, the House of Delegates (HOD) Affairs Office provides an opportunity for delegates and alternate delegates to request special accommodations thru the delegate credentialing process. Any requests are handled by the Director, HOD Affairs, in conjunction with meeting services. The HOD Office has been made aware of three instances where

accommodations were needed. In those instances, the attendees provided their own accommodations and informed the HOD Office for awareness purposes.

#### CONCLUSION

Ensuring accessibility for all attendees, including those with disabilities, is an important aspect of event planning and management. Providing accommodations such as assistive technologies and sign language interpreters can help ensure that all attendees have an equal opportunity to participate fully in the conference and benefit from its content. It is also important to ensure that the accommodations are communicated clearly to attendees, so they know how to request them if needed. By taking these steps, the conference organizers are demonstrating their commitment to inclusion and creating a welcoming environment for all attendees.

AMA management considers that all the venues for the conference have taken steps to ensure that they are compliant with the Americans with Disabilities Act (ADA) requirements. This means that attendees with disabilities will have access to all areas of the venue, including entrances, restrooms, and meeting rooms.

#### RECOMMENDATION

The Board of Trustees recommends that Policy G-630.140 [8] be rescinded as being accomplished by this report, and the remainder of the report be filed.

### 19. MEDICAL COMMUNITY VOTING IN FEDERAL AND STATE ELECTIONS

*Informational report; no reference committee hearing.*

#### **HOD ACTION: FILED**

Resolution 616 “Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections,” was adopted at the AMA House of Delegates’ 2022 Annual Meeting. Per the first resolve of Resolution 616, now AMA Policy D-65.982:

Our AMA will: (1) study the rate of voter turnout in physicians, residents, fellows and medical students in federal and state elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community.

This report completes the request for such a study.

#### EXISTING RESEARCH ON PHYSICIAN VOTING TRENDS AND BEHAVIOR

The consensus conclusion of publicly available studies and analysis addressing physician voting is that physicians consistently vote at lower rates than the general public. Three such reports that help uphold this conclusion are “Trends in Physician Voting Practices in California, New York, and Texas, 2006-2018”<sup>1</sup> by Hussain Lalani, MD, MPH, et al., published in *JAMA Internal Medicine* 2021; “Voting Behavior of Physicians and Healthcare Professionals”<sup>2</sup> by Rachel Solnick, MD, MSc, et al., published in the *Journal of General Internal Medicine* 2020; and “Do Doctors Vote?”<sup>3</sup> by David Grande, MD, MPA, et al., published in the *Journal of General Internal Medicine* 2007. Through modeling analysis incorporating a variety of publicly available and commercially acquired data, the authors of these studies found physicians voting anywhere from 9 to more than 12 percent less than the general public going back to 2002.

Lalani et al. looked at the states with the highest physician populations in their study. Their finding that physicians who were eligible to vote did so at rates at least 9 percent less than the general population takes into account data as recent as 2018. The authors offer their proposed reasons as to why physician turnout was lower, including fear of appearing “political” as well as other “administrative and psychological barriers.” However, it should be noted that Lalani et al. acknowledge that this reasoning is speculative and that the true source(s) of limited physician engagement in voting is “unclear” as well as the possible link between physicians who register to vote and those who actually turn out to vote.

In their study, Solnick et al. looked at physicians as well as other health care professionals including dentists, nurses, physician assistants and pharmacists and found that they also consistently voted at rates lower than the general public, although except for dentists somewhat higher than physicians. The researchers based their findings on a biennial nationally representative household survey that collects self-reported or household member-reported voting rates and behavior from congressional and presidential elections. They estimated physicians voting at approximately 12 percent below that of the public. The authors further found that 70 percent of physicians who were either not registered to vote or did not vote reported that this was due to being “Too busy, conflicting work or school.” Physicians were 30 percent more likely to vote by mail and 15 percent more likely to vote prior to election day compared to the public. Solnick et al. also examined non-health care related professions as part of this study; specifically, those requiring advanced education and/or training including, postsecondary teachers, chief executives, civil engineers, social workers and lawyers. Solnick et al. found that of these, postsecondary teacher turnout was highest; 14 percent above the general population. The authors suggest that further research examine whether health care professionals voting rates can be improved by Election Day flexible scheduling, health care organization campaigns to emphasize the social value of voting, voter registration drives, and education on mail-in voting.

Finally, Grande et al. compared adjusted physician voting rates in 1996-2002 congressional and presidential elections with those of lawyers and the general population. Like the others, they found physicians voting at lower rates when compared to the public (8.7 percent lower on average) for each of these elections except in 1996. Lawyers meanwhile had voting rates that were 13.5 percent higher than the public during this same time span. Additionally, Grande et al. noted that these trends occurred even in the face of a renewed commitment at that time to prioritize civic participation and engagement within the medical profession led by multiple medical organizations including the American Medical Association that in 2001 issued its “Declaration of Professional Responsibility Medicine’s Social Contract with Humanity,” which included a commitment to “advocate for...political changes that ameliorate suffering and contribute to human well-being.”<sup>4</sup>

## CONCLUSION

Apart from the studies referenced in this report, there would seem to be a paucity of in-depth, credible analysis on the issue of physician voter turnout. For the studies examined as part of this report however, it is notable that in each, to the extent that the authors explored possible reasons for why physicians overall voted at lower rates than the general public, their conclusions were speculative. It seems reasonable to conclude that physicians as a group do indeed tend to vote at rates both lower than the general public and lower than that of selected professions requiring advanced education and training. With so little data available and to better inform on the issue, the AMA may consider including questions related to the subject of physician voting habits in future polling projects if appropriate.

## REFERENCES

- 1 Hussain Lalani, et al. “Trends in Physician Voting Practices in California, New York, and Texas, 2006-2018,” *JAMA Internal Medicine* 181, 3 (2021): 397–399. [10.1001/jamainternmed.2020.6887](https://doi.org/10.1001/jamainternmed.2020.6887)
- 2 Rachel Solnick, et al. “Voting Behavior of Physicians and Healthcare Professionals,” *Journal of General Internal Medicine* 36, 1 (2021): 1169–1171. [10.1007/s11606-020-06461-2](https://doi.org/10.1007/s11606-020-06461-2)
- 3 David Grande, et al. “Do Doctors Vote?” *Journal of General Internal Medicine* 22, 5 (2007): 585–589. [10.1007/s11606-007-0105-8](https://doi.org/10.1007/s11606-007-0105-8)
- 4 American Medical Association, Declaration of Professional Responsibility: Medicine’s Social Contract with Humanity (2001). Accessed February 27, 2023, at <https://www.ama-assn.org/delivering-care/public-health/ama-declaration-professional-responsibility>

## 20. SURVEILLANCE MANAGEMENT SYSTEM FOR ORGANIZED MEDICINE POLICIES AND REPORTS

*Reference committee hearing: see report of Reference Committee F.*

**HOD ACTION: RECOMMENDATIONS ADOPTED  
REMAINDER OF REPORT FILED**  
*See Report G-600.013*

Resolution 609 A-22 “Surveillance Management System for Organized Medicine Policies and Reports,” sponsored by Georgia Delegation, was referred to the Board of Trustees. Resolution 609 A-22 asked:

1. That our American Medical Association develop a prioritization matrix across both global and reference committee specific areas of interest (Directive to Take Action);
2. That our AMA develop a web-based surveillance management system, with pre-defined primary and/or secondary metrics, for resolutions and reports passed by their respective governance body (Directive to Take Action);
3. That our AMA share previously approved metrics and results from the surveillance management system at intervals deemed most appropriate to the state and local membership of organized medicine, including where and when appropriate to their patients. (Directive to Take Action)

### BACKGROUND

Resolution 609 describes a need to have appropriate surveillance and dissemination system(s) in place that addresses the informational needs of physicians at the state and local levels including those who are members of House of Delegates within organized medicine. Further, the resolution asks that a prioritization matrix be created to aid delegates’ and Federation societies’ decision-making in submission of relevant and timely resolutions.

#### *The role of prioritization matrices*

Decision-making and prioritization frameworks are in common use across industries. Prioritization can be determined by any number of factors, but typical examples may include:

- Importance
- Urgency
- Relevancy
- Probability of Successful Outcome
- Risk

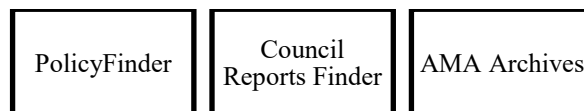
Matrices are used when executive decision-making is required to move forward. Typically, scoring values (e.g. Rank-Order, Likert Scales) must be captured in a consistent manner. Furthermore, the relative weighting of each factor is another important design element that must be determined.

#### *Current resources within AMA*

By nature of our AMA’s councils, sections, and delegates structures, resolutions are shaped through a rigorous process of research, proposal, discussion, review and ultimately debate and voting.

Members of our House of Delegates today have access to a detailed House of Delegates microsite within *ama-assn.org*. The site provides a preliminary agenda that incorporates a “Bookmark” feature to allow delegates to be notified of changes over time.

There are three primary database tools available to the public:



AMA's [PolicyFinder](#) resource allows delegates and other interested parties to search prior AMA policies with free text and Boolean keyword search. Information from this search includes Topic, Meeting Type, Action, Council & Committees, Year Last Modified, and Type. In addition to a description of the policy, there is a timeline that shows the trajectory of that policy, including relevant hyperlinks to council reports where possible (see Figure).

AMA's [Council Report Finder](#) contains 347 artifacts as of February 2023. Users may search based on keywords and filter by meeting date and by Councils and Committees among others.

AMA [Archives](#) contains digests of official actions, historical monographs, HoD proceedings, and Transactions (records of day-to-day activities). As of this writing, the database houses materials from 1847 to 2019.

**hypertension** ✕ 🔍

**Preventive Medicine** Explore topics

**Medical Evaluations of Healthy Persons H-425.994**

<b>Topic:</b> Preventive Medicine	<b>Policy Subtopic:</b> NA
<b>Meeting Type:</b> Interim	<b>Year Last Modified:</b> 2017
<b>Action:</b> Reaffirmed	<b>Type:</b> Health Policies
<b>Council &amp; Committees:</b> NA	

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The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as **hypertension**, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations.

**Policy Timeline**

CSA Rep. D, A-82 Reaffirmed: CLRPD Rep. A, I-92 Reaffirmed: CSA Rep. 8, A-03 Reaffirmed: CSAPH Rep. 1, A-13 Reaffirmed: CMS Rep. 03, I-17

In addition to keyword searches, users can enable a variety of filters and flags to explore AMA policy. The screenshot below highlights some of these options:

### *Prior organizational investments in House of Delegates usability*

Our AMA maintains a website [repository of proceedings](#), accessible to the public, from prior House of Delegates meetings, covering the prior decade. Visitors to this site can determine the implementation status of reports and resolutions. Materials are available in PDF format and searchable. Meetings dating prior to 2012 are located on AMA's [archive database](#), also available to members, the research community, and public.

In late 2022, AMA's Strategic Insights team was asked to lead a user experience study on our PolicyFinder. Study subjects specifically incorporated members of our HOD, Council, and Reference Committee staff. The goals of the study were to better understand:

- The extent to which the design and functionality of PolicyFinder align with the needs and expectations of target users (with particular attention to the search functionality)
- Usability issues that may impact the user experience and highlight opportunities for further enhancement

This project is concluding at the time of this writing. The conclusions will be used to inform the product development roadmap for PolicyFinder.

Significant financial and logistical challenges exist to maintain a prioritization matrix tool for use by delegates. Any new tool deployment would require rigorous market and user research, product development roadmaps, and significant data exchange infrastructure among states and specialties that do not exist today. We anticipate there would be a high degree of manual data entry and monitoring for changes that would require dedicated staff members. Additionally, a multi-organization governance mechanism would need to be established that describes the prioritization dimensions. We believe this would be a significant cost burden among AMA and the Federation, without adding great value for the AMA, delegates, and societies.

### *Federation Activities*

The experience of accessing policy and council reports from our Federation ranges widely. State and specialty societies' resources and capabilities devoted to policy databases and reporting systems are unknown but likely vary widely.



We reviewed options for three state medical societies. One society has testimony, letters, and advocacy content available to the public, but the reports of its councils are not publicly available. Another state medical society provided a downloadable Policy Compendium from their House of Delegates but the link was broken. Another state medical association did not have a similar option.

One large specialty society provided a functional public database to browse Guidelines, Expert Consensus Statements, Policy Documents, and artifacts. Another specialty examined did not have any discernable publicly available database or archive of materials from their annual meeting.

#### RECOMMENDATION

In view of these considerations, your AMA recommends that the following recommendations be adopted in lieu of Resolution 609-A-22 and that the remainder of this report be filed:

1. That our American Medical Association (AMA) maintains the existing resolution management structure within the House of Delegates without imposing a potentially confusing or unsustainable prioritization matrix on delegates and reference committees.
2. That our AMA continues to invest in critical information technology and other appropriate infrastructure that allows for the tracking of past resolutions, existing policy, and supporting materials.

### **21. SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW**

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

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

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2023 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

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

The following organizations were reviewed for the 2023 Annual Meeting:

Aerospace Medical Association  
 American Academy of Dermatology  
 American Academy of Facial Plastic and Reconstructive Surgery, Inc.  
 American Academy of Family Physicians  
 American Academy of Hospice and Palliative Medicine  
 American Academy of Neurology  
 American Academy of Psychiatry and the Law  
 American Association for Hand Surgery  
 American Association of Clinical Urologists, Inc.  
 American Clinical Neurophysiology Society  
 American College of Medical Quality  
 American Rhinologic Society  
 American Society for Reconstructive Microsurgery  
 American Society of Addiction Medicine

American Society of Echocardiography  
American Society of Neuroimaging  
American Society of Ophthalmic Plastic and Reconstructive Surgery  
Endocrine Society  
GLMA—Health Professionals Advancing LGBTQ+ Equality  
North American Neuromodulation Society  
North American Neuro-Ophthalmology Society  
Spine Intervention Society

The American Society of General Surgeons, American Society of Hematology, American Society of Transplant Surgeons, International Society for Hair Restoration Surgery, and United States and Canadian Academy of Pathology were also reviewed at this time because they failed to meet the requirements in June 2022.

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

The materials submitted indicate that: Aerospace Medical Association, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgeons, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association for Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American Rhinologic Society, American Society of Addiction Medicine, American Society of Echocardiography, American Society of Hematology, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society of Transplant Surgeons, Endocrine Society, International Society for Hair Restoration Surgery, North American Neuromodulation Society, North American Neuro-Ophthalmology Society, and Spine Intervention Society meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

The materials submitted also indicate that the American College of Medical Quality, American Society for Reconstructive Microsurgery, American Society of General Surgeons, American Society of Neuroimaging, GLMA—Health Professionals Advancing LGBTQ+ Equality, and United States and Canadian Academy of Pathology did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

## RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. The Aerospace Medical Association, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgeons, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association for Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American Rhinologic Society, American Society of Addiction Medicine, American Society of Echocardiography, American Society of Hematology, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society of Transplant Surgeons, Endocrine Society, International Society for Hair Restoration Surgery, North American Neuromodulation Society, North American Neuro-Ophthalmology Society, and Spine Intervention Society retain representation in the AMA HOD.
2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the American College of Medical Quality, American Society for Reconstructive Microsurgery, American Society of Neuroimaging, GLMA—Health Professionals Advancing LGBTQ+ Equality be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5 at the end of the one-year grace period, the American Society of General Surgeons and United States and Canadian Academy of Pathology lose representation in the AMA HOD but

retain it for the AMA Specialty and Service Society (SSS) and may apply for reinstatement in the HOD, through the SSS, when they believe they can comply with all of the current guidelines for representation in the HOD, in accordance with AMA Bylaw B-8.5.3.2.2.

## APPENDIX

### *Exhibit A - Summary Membership Information*

<b>Organization</b>	<b>AMA Membership of Organization's Total Eligible Membership</b>
Aerospace Medical Association	150 of 672 (22%)
American Academy of Dermatology	3748 of 14,539 (26%)
American Academy of Facial Plastic and Reconstructive Surgery, Inc.	162 of 616 (26%)
American Academy of Family Physicians	24,706 of 95,939 (26%)
American Academy of Hospice and Palliative Medicine	951 of 3922 (24%)
American Academy of Neurology	2460 of 16,007 (15%)
American Academy of Psychiatry and the Law	321 of 1149 (28%)
American Association for Hand Surgery	184 of 705 (26%)
American Association of Clinical Urologists, Inc.	1092 of 3439 (32%)
American Clinical Neurophysiology Society	101 of 322 (31%)
American College of Medical Quality	54 of 148 (36%)
American Dermatological Association, Inc.	171 of 440 (38%)
American Rhinologic Society	105 of 138 (76%)
American Society for Reconstructive Microsurgery	110 of 690 (16%)
American Society of Addiction Medicine	818 of 3763 (22%)
American Society of General Surgeons	No data submitted
American Society of Echocardiography	1140 of 5232 (22%)
American Society of Hematology	1025 of 6806 (15%)
American Society of Neuroimaging	38 of 116 (33%)
American Society of Ophthalmic Plastic and Reconstructive Surgery	154 of 684 (23%)
American Society of Transplant Surgeons	195 of 828 (24%)
Endocrine Society	1367 of 6879 (20%)
GLMA—Health Professionals Advancing LGBTQ+ Equality	46 of 143 (48%)
International Society for Hair Restoration Surgery	100 of 240 (42%)
North American Neuromodulation Society	247 of 1032 (26%)
North American Neuro-Ophthalmology Society	108 of 469 (23%)
Spine Intervention Society	625 of 2432 (26%)
United States and Canadian Academy of Pathology	900 of 4656 (19%)

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

Policy G-600.020

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

*Exhibit C*

**8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations.** Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

- 8.2.1** To cooperate with the AMA in increasing its AMA membership.
- 8.2.2** To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3** To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4** To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5** To provide information and data to the AMA when requested.

*Exhibit D – AMA Bylaws on Specialty Society Periodic Review*

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

**8.5 Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

- 8.5.1** If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.
- 8.5.2** If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.
- 8.5.3** Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.
  - 8.5.3.1** If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates

and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

**8.5.3.2** If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

**8.5.3.2.1** The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

**8.5.3.2.2** The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.