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REPORT OF THE BOARD OF TRUSTEES

B of T Report 03-A-25

Subject: 2024 Grants and Donations

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2024.

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2024
Amounts in thousands

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	$ 50
Centers for Disease Control and Prevention	Engaging Physicians to Strengthen the Public Health System and Improve the Nation's Public Health	488
Centers for Disease Control and Prevention	Improving Health Outcomes through Partnerships with Physicians to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats	23
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	112
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	81
Centers for Disease Control and Prevention	Physicians and Medical Students: Prevention Rx: Engaging Physicians to Enhance Public Health	20
Centers for Disease Control and Prevention	Protecting and Improving Health Globally: Building and Strengthening Public Health Impact, Systems, Capacity and Security	1,774
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medications for Opioid Use Disorders	11
Government Funding		**2,559**
American Chemical Society	International Congress On Peer Review and Scientific Publication	20
American College of Physicians, Inc.	International Congress On Peer Review and Scientific Publication	10
American Medical Association Foundation	Health Equity Acceleration Fund	341
American Medical Association Foundation (supported by Robert Wood Johnson Foundation funding)	The Truth, Reconciliation, Healing, and Transformation Project	520
Nonprofit Contributors		**891**
John Wiley & Sons, Inc.	International Congress On Peer Review and Scientific Publication	30
Contributors less than $5,000	International Medical Graduates Section Reception	5
Other Contributors		**35**
Total Grants and Donations		**$ 3,485**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-A-25

Subject: Update on Corporate Relationships

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2024. 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 AMA's 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 Meetings. AMA management is responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2024 RESULTS

In 2024, 102 activities were considered and approved through the Corporate Review process. Of the 102 activities recommended for approval, 52 were conferences or events, 11 were educational content or grants, 33 were collaborations or affiliations, four were member programs and two were business arrangements/licensing programs. 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 A

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 name and 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 2024

CONFERENCES/EVENTS

Project Number	Project Description	Corporations	Approval Date
48882	**Bryce Harlow Foundation 42nd Annual Awards Dinner** - Sponsorship with AMA name and logo.	Bryce Harlow Foundation	01/17/24
48561	**Anarcha, Lucy, Betsey Annual Conference** – Sponsorships with AMA name and logo.	The More Up Campus Faith Crusade Montgomery Rescue Mission	01/19/24
48398	**National Rx & Illicit Drug Summit** - Repeat sponsorship with AMA name and logo.	Healthcare Made Practical (HMP) Global	01/22/24
48956	**Becker's Collaborations** - CEO & CFO Roundtables, Annual Hospital Review, White paper and Webinar with AMA name and logo.	Becker's Hospital Review ASC Communications	01/24/24
49031	**National Independent Laboratory Association Annual Meeting** - Repeat sponsorship with AMA name and logo.	American Association of Bioanalysts AIMA Business and Medical Support LLC BacterioScan Lighthouse Lab Services BioPathogenix Credence Global Solutions	01/29/24

49012	**NAMSS 48th Annual Educational Virtual Conference and Exhibition** - Repeat sponsorship with AMA name and logo.	National Association of Medical Staff Services ABMS Solutions Medallion Qgenda HealthStream MD-Staff National Committee for Quality Assurance RLDatix Symplr Axuall Medicred PreCheck Santech Acorn Credentialing AOA Profiles Federation of State Medical Boards The Hardenbergh Group Verifiable Credentialing	01/31/24
49056	**March of Dimes Gourmet Gala -** Repeat sponsorship with AMA name and logo.	March of Dimes Blue Cross Blue Shield Association Pampers Comcast WalMart Abbott AdvaMed	02/01/24
48932	**South by Southwest Conference** - Sponsorship with AMA name and logo.	South by Southwest Johnson & Johnson	02/01/24
48908	**Machine Learning for Healthcare Conference** - Sponsorship with AMA name and logo.	Columbia University Johns Hopkins University Duke University Apple Microsoft	02/06/24
48795	**Ottawa Conference 2026** - Sponsorship of continuing medical education conference with AMA name and logo.	Association for Medical Education in Europe (AMEE)	02/06/24
48850	**ViVE Sponsorships** – Repeat sponsorships with AMA name and logo.	College of Healthcare Information Management Executives HLTH Inc.	02/06/24

48463	**AZARA User Conference** – Sponsorship with AMA name and logo.	Azara Healthcare	02/08/24
48958	**Art Institute of Chicago Exhibition –** Art exhibit featuring Journal of Ethics artwork and name and logo.	School of the Art Institute of Chicago	02/14/24
49206	**Chicago Cares Leadership Breakfast** – Repeat sponsorship with AMA name and logo.	Chicago Cares	02/19/24
49411	**International Association of Industrial Accident Boards and Commissions Convention -** Repeat sponsorship with AMA name and logo.	International Association of Industrial Accident Boards and Commissions National Council on Compensation Insurance Optum Aerie EDI Group The Black Car Fund Sedgwick Claims Management Service Concentra SFM Mutual Insurance Official Disability Guidelines by Milliman Care Guidelines Health Safety National Verisk	02/21/24
49259	**Medical Library Association Annual Meeting** – Sponsorship with JAMA Network name and logo.	Medical Library Association	02/23/24
49297	**ROCS Foundation Summit** – Repeat sponsorship with AMA name and logo.	ROCS Foundation John A. Hartford Foundation The Commonwealth Fund	02/26/24

49462	**Credentialing State Shows –** Repeat sponsorship with AMA name and logo.	Arizona Association of Medical Staff Services California Association of Medical Staff Services Illinois Association of Medical Staff Services Texas Society of Medical Services Specialists Florida Association of Medical Staff Services Massachusetts Association for Medical Staff Services New York State Association of Medical Staff Services Ohio Association Medical Staff Services Medical Staff Services Association of Pennsylvania Washington Association Medical Staff Services ABMS Solutions AMN Healthcare/Silversheet Barton Associates CIMRO Edge-U-Cate The Hardenbergh Group Hooper, Lundy & Bookman PC Lash & Goldberg MD Review MD Staff NAMSS PASS Polsinelli PreCheck Procopio PRS Credentialing Services Qgenda SkillSurvey Symplr VerityStream YS Credentialing	02/28/24

49453	**The Association of LGBTQ Journalists Annual Conference –** Repeat sponsorship with AMA name and logo.	The Association of LGBTQ Journalists Axios CBS News Fox News Hearst Corporation McClatchy Media Company DotDash Meredith Publishing Nexstar SAG-AFTRA Scripps Tegna The Athletic CNN TNT Sports	03/01/24
49458	**Asian American Journalists Association's Annual Convention** – Repeat sponsorship with AMA name and logo.	The Guardian Sinclair Broadcast Group IW Group Johnson & Johnson Pew Research Center	03/04/24
49483	**Healthcare Information Management Systems Society (HIMSS) Middle East Forum -** Sponsorship with AMA name and logo.	Healthcare Information Management Systems MWAN Events Gulf Cooperation Council eHealth ZIMAM Elsevier Dedalus	03/04/24
65938	**HIMSS Global Health Conference & Exhibition –** Sponsorship with AMA name and logo.	Healthcare Information Management Systems MWAN Events Gulf Cooperation Council eHealth ZIMAM Elsevier Dedalus	11/22/24
48811	**"Reckoning with Race and Racism in Academic Medicine" Conference –** Sponsorship with AMA name and logo.	Johns Hopkins School of Medicine American Association of Medical Colleges (AAMC) Molina Foundation Robert Wood Johnson Foundation National Institutes of Health	03/06/24

49096	**Bernard Lown Awards Dinner** – Sponsorship with AMA name and logo.	Lown Institute The Commonwealth Fund Robert Wood Johnson Foundation John A. Hartford Foundation Kaiser Permanente California Healthcare Foundation Gordon and Betty Moore Foundation Well-Being Trust Foundation Arnold. P. Gold Foundation	03/19/24
49253	**National Association of Black Journalists Convention** – Repeat sponsorship with AMA name and logo.	Bloomberg CBS Sports Climate Central Gannett Media Lumina National Association of Realtors	03/25/24
49214	**AMA International Medical Graduates Section Annual Meeting Desserts Reception –** Repeat sponsorship with AMA name and logo.	Association of Physicians of Pakistani Descent of North America Association of Haitian Physicians Abroad	03/29/24
50702	**Rock Health Summit –** Repeat sponsorship with AMA name and logo.	Rock Health Foundation California Health Care Foundation Google Tulsa Innovation Labs 1501 Health BioReference Laboratories Amazon Web Services Morgan Stanley Myovant Russell Reynolds	04/05/24
50519	**TruBridge National Client Conference** – Sponsorship with AMA name and logo.	TruBridge i2i Population Health Blockit SureScripts Wolters Kluwer	04/12/24

50589	**Southern Association of Workers' Compensation Administrators Convention and Luncheon** – Repeat sponsorship with AMA name and logo.	AKERA Claims Solutions American International Group Ametros CompTrust Mutual Insurance Company Concentra Enlyte FAIR Health Healthesystems Meridian Wealth Management National Council on Compensation Insurance Official Disability Guidelines by Milliman Care Guidelines Health Occupational Managed Care Alliance Optum Safety National Casualty Company Sedgwick Trean Corporation Verisk Workers' Compensation Institute	04/15/24
50575	**Essence Festival of Culture "Release the Pressure" Health Innovators Hub** – Repeat sponsorship with AMA and RTP name and logo.	Essence Festival New Voices Foundation	04/19/24
50586	**Greenway reENGAGE Client Summit** – Sponsorship with AMA name and logo.	Greenway Health Clearwave Phreesia Surescripts 3M Solventum HealthAsyst Relatient Instamed Vaytiv Updox	04/22/24

62721	**Project IMG (International Medical Graduate) Annual Conference** – Sponsorship with AMA name and logo.	Project IMG Palm Beach Atlantic University Brown University Intealth OET (Occupational English Test) mQ Mental Health Research Essen Healthcare UWorld Boards & Beyond American Medical Women's Association	06/06/24
62849	**Graphic Medicine Annual Conference** – Sponsorship with AMA Journal of Ethics name and logo.	Graphic Medicine International Collective Fáilte Ireland (National Tourism Authority) Meet in Ireland	06/21/24
62841	**American Society of Bioethics and Humanities Conference –** Sponsorship with AMA Journal of Ethics name and logo.	American Society of Bioethics and Humanities Hastings Center American Journal of Bioethics The Journal of Medicine and Philosophy Case Western Reserve University School of Medicine UCLA Health Ethics Center Sutter Health Belmont University Northwell Health Loyola University Bioethics Graduate Programs	06/26/24
62989	**Chief Medical Officer Exchange** – Repeat sponsorship with AMA name and logo.	Healthcare Compliance Professionals HealthLeaders Xtend Healthcare ShiftMed Solutions Vizient Inc. Optum R1 RCM Inc. Microsoft	07/05/24

63282	**Annual Convention and Scientific Assembly of the National Medical Association –** Repeat sponsorship with AMA name and logo.	National Medical Association Gilead Pfizer Hitachi Merck American College of Obstetricians and Gynecologists (ACOG) Glaxo Smith Kline Sutter Health ViiV Healthcare Regeneron Pharmaceuticals National Institutes of Health Centers for Disease Control and Prevention Morehouse School of Medicine Meharry Medical College Howard University College of Medicine University of Michigan University of Virginia The Ohio State University Harvard Medical School	07/10/24
63437	**Latino Medical Student Association National Conference** – Sponsorship with AMA Journal of Ethics name and logo.	Latino Medical Student Association	07/25/24
63241	**Facing Race: A National Conference** – Sponsorship with AMA, Rise to Health Coalition and Grand Rounds logos	Race Forward Accreditation Council for Graduate Medical Education RespectAbility National Center for Interprofessional Practice and Education Institute for Healthcare Improvement	07/26/24

63372	**Annual Princeton Conference** – Repeat sponsorship with AMA name and logo.	The Council on Health Care Economics and Policy at Brandeis University American Hospital Association Arnold Ventures Blue Cross Blue Shield of Massachusetts Foundation Blue Shield of California Foundation Booz Allen Hamilton California Health Benefits Review California Health Care Foundation Jewish Healthcare Foundation MAXIMUS Peterson Center on Healthcare The Health Industry Forum The John A. Hartford Foundation	07/29/24
64332	**Genetic Health Information Network Summit** - Repeat sponsorship with AMA name and logo.	Concert Genetics Illumina	08/07/24
64508	**Collaborative Family Healthcare Association Integrated Care Conference** – Repeat sponsorship with AMA name and logo.	Collaborative Family Healthcare Association The University of Texas Health Center of San Antonio American Psychological Association University of Nebraska Medical Center Munroe-Meyer Institute Area Health Education Centers EvolvedMD Health Federation of Philadelphia Merakey Mental Health Services National Register of Health Service Psychologists University of Houston Integrated Primary Care, Inc. The Foundation for Burnout Solutions Iris Telehealth	08/16/24
64665	**Southern College of Occupational and Environmental Medicine Conference** – Sponsorship with AMA name and logo.	Southern College of Occupational and Environmental Medicine Medlock Pfizer Psychemedics	09/03/24

65064	**MD-Staff Educational Conference -** Sponsorship with AMA name and logo.	MD-Staff PreCheck ABMS Solutions	09/20/24
65074	**Politico's Exchange Dinner** – Sponsorship with AMA name and logo.	Politico	09/26/24
65264	**HLTH Conference** - Repeat sponsorship with AMA name and logo.	HLTH Inc. HLTH Foundation	10/03/24
64748	**Association of American Medical Colleges Annual Meeting** – Repeat sponsorship with Journal of Ethics name and logo.	Association of American Medical Colleges	10/09/24
65537	**Women Business Leaders Annual Summit -** Repeat sponsorship with AMA name and logo.	Elevance Health Inc. Johnson & Johnson McKesson Corporation Tivity Health Amazon Web Services Epstein Becker & Green United Health Group Mintz Law Firm Newport Healthcare ProgenyHealth PYA Accounting Korn Ferry AArete Global Consulting Hello Heart Trustmark Medecision Morgan Health	10/18/24
65562	**College Art Association Annual Conference** – Sponsorship with AMA Journal of Ethics name and logo.	College Art Association JSTOR Digital Library Blick Art Materials University of California Press	10/29/24

66081	**Alliance for Continuing Education in the Health Professions Annual Conference** – Sponsorship with AMA EdHub name and logo.	Alliance for Continuing Education in the Health Professions Medlive/PlatformQ Conexiant PACE freeCME Medscape Partnership in International Management AcademicCME DKBmed Continuing Medical Education ReachMD Haymarket Media Talem Health NOVA Takeda Pharmaceuticals InfographEd CloudCME Med-IQ	11/18/24
66144	**AIDS Foundation of Chicago 40th Anniversary Gala –** Sponsorship with AMA name and logo.	BMO Harris Illinois Tool Works Kehoe Designs Morgan Stanley J&L Catering University of Illinois Health	11/25/24
66672	**Digital Health Innovation Ecosystems Forum** – Sponsorship with AMA name and logo.	MWAN Events OneSource Solutions International CHIME International HLTH Europe Scottish Developmental International MECOMED Invest Northern Ireland	12/27/24
66659	**Healthcare Burnout Symposium –** Sponsorship with AMA name and logo.	International Conference Development Events	01/02/25

EDUCATIONAL CONTENT OR GRANT

Project Number	Project Description	Corporations	Approval Date
50525	**OutCare Health Education** - AMA EdHub hosted content with AMA name and logo.	OutCare Health	04/24/24
49258	**Collaboration with National Association of County and City Health Officials** - AMA EdHub hosted content with AMA name and logo.	National Association of County and City Health Officials	03/12/24
49611	**Brain Health and Dementia Risk Reduction Collaboration** - AMA EdHub hosted continuing medical education with AMA name and logo.	Centers for Disease Control (CDC) Alzheimer's Association	03/19/24
62759	**Project Firstline Webinar - Building Blocks of Infection Prevention and Control -** AMA EdHub hosted continuing medical education with AMA name and logo.	CDC Project Firstline American Society of Nephrology	06/03/24
62924	**Measles: Stories from the Frontline** - AMA EdHub hosted content with AMA name and logo.	CDC Project Firstline Pediatric Pandemic Network American Academy of Pediatrics American Nurses Association	06/17/24
62981	**Language Equity Toolkit** – AMA EdHub hosted content with AMA name and logo.	Accreditation Council for Graduate Medical Education Association of American Medical Colleges National Council on Interpreting Health Care	07/05/24

64452	**American Health Information Management Association Workshop -** Training on clinical documentation coding with AMA name and logo.	American Health Information Management Association	08/14/24
64324	**MedCerts Collaboration** – MedCerts-hosted AMA content on improving BP measurements, with AMA name and logo.	MedCerts	08/16/24
64210	**Permanente Medical Group Collaboration** - AMA EdHub hosted content with AMA name and logo.	The Permanente Medical Group	08/29/24
64669	**Healthcare Webinar Series** - AMA sponsored segment on Medicare payment reform, with AMA name and logo.	WTOP Radio Federal News Network	09/03/24
65773	**Credentialing School Sponsorship** - Repeat sponsorship with AMA name and logo.	Edge-U-Cate Symplr The Hardenbergh Group	11/01/24

COLLABORATIONS/AFFILIATIONS

Project Number	**Project Description**	**Corporations**	**Approval Date**
48378	**Atlanta Hypertension Initiative –** Sponsorship of initiative improving hypertension in Atlanta area, with AMA name and logo.	Atlanta Hypertension Initiative Atlanta Regional Collaboration for Healthcare Improvement CDC Million Hearts American Heart Association National Association of Chronic Disease Directors	01/04/24

48723	**The Million Hearts Hypertension in Pregnancy Change Package** – Collaboration on resource to improve hypertension in pregnancy, with AMA name and logo.	Center for Disease Control and Prevention Million Hearts The Society for Maternal-Fetal Medicine The American College of Osteopathic Obstetricians and Gynecologists College of Nurse-Midwives The National Association of Nurse Practitioners in Women's Health	01/05/24
48617	**Chicago Area Public Affairs Group** – Repeat sponsorship with AMA name and logo.	Chicago Area Public Affairs Group Chicago Title Insurance Company BMO Bank JP Morgan Chase APCO Worldwide Boyce Possley The Clover Group	01/10/24
48870	**MAP Dashboards for Healthcare Organizations (HCOs)** – AMA co-branding with healthcare organizations for MAP blood pressure dashboard project.	Michigan Primary Care Association Hamilton Community Health Network Western Wayne Family Health Centers Grace Health Asian Human Services Family Health Center Concord Hospital Medical Group	01/16/24
49094	**Peterson Healthcare Technology Institute Digital Health Collaborative** – Collaboration researching benefits of digital health technology, with AMA name and logo.	Peterson Foundation AHIP National Alliance of HC Purchasers National Health Council National Partnership for Women and Families	02/02/24
49065	**Prevention Strategy Collaboration with Health Care Organizations –** Update to diabetes prevention program with AMA name and logo.	DePaul Community Health Centers Erie Family Health Centers Bedford-Stuyvesant Health Center Health Federation of Philadelphia AllianceChicago Hines VA Hospital Sparta Community Hospital University of Colorado Medicine Alabama Primary Health Care Association Hawaii Island Community Health Center East Central Mississippi Health Care Greater Philadelphia Health Action Health Partners of Western Ohio	02/07/24

		Colorado Community Managed Care Network Louisiana Primary Care Association Emplify Health Star Community Health Prosano Health Mass General Brigham Southwest Virginia Community Health Center	
49063	**American Telehealth Association Membership –** Repeat sponsorship with AMA name and logo.	American Telehealth Association	02/07/24
48981	**Access to Care Report** – Co-branded report on increasing access to care for pregnant patients with substance use disorder.	Manatt Health - Manatt, Phelps & Phillips, LLP	02/09/24
49541	**Physician Innovation Network (PIN) –** AMA PIN collaboration agreement with AMA name and logo.	RedCrow Healthcare Technology	03/08/24
49532	**AMA MAP Hypertension Quality Improvement Pilot** - Evaluation of AMA MAP program in a virtual care setting, with AMA name and logo.	KeyCare	03/14/24
49099	**Equitable Professional Societies Network Leadership Roundtables** – Health equity collaboration with healthcare leaders, with AMA name and logo.	Council of Medical Specialty Societies HealthBegins Race Forward	03/15/24
49432	**Digital Medicine Society Integrated Evidence Plans** – Toolkit collaboration with AMA name and logo.	Peterson Health Technology Institute Alliance of Community Health Plans American College of Cardiology Genentech Food & Drug Administration U.S. Department of Veterans Affairs	03/15/24

49097	**AMA Grand Rounds** – Health equity event and content collaboration with AMA and Grand Rounds name and logo.	Accreditation Council for Graduate Medical Education National Center for Interprofessional Practice and Education RespectAbility	03/18/24
49257	**Practice Transformation Survey Assessment** – AMA co-branding with healthcare organizations for physician burnout survey.	Advocate Health Care Allied Physician's Group of Riverhead Ballad Health Medical Associates Baystate Health Boulder Medical Center Carilion Clinic Cayuga Health Children's Hospital of The King's Daughters Medical Group Christus Health Cook Children's Hospital Dayton Children's Hospital Guthrie Health System Health Partners & Park Nicollet HealthONE Holland Hospital Huntington Health Jefferson Health Lahey Hospital & Medical Center Luminis Health MaineHealth Medical Group Memorial Health Ohio Methodist Mansfield Medical Center Methodist Medical Group MyMichigan Health Newark Beth Israel Medical Center Denver Health Northern Ohio Medical Specialists Northern Arizona Regional Behavioral Health Authority NYU Langone Family Health Centers Olive View, UCLA Medical Center ONCare Alliance OneHealth Saint Peter's University Hospital Schumacher Clinical Partners Health Sky Ridge Medical Center Sound Physicians South Shore Health St. Louis University SUNY Upstate Medical University Tapestry 360 Health The Guidance Center Trinity Health	03/25/24

		University of Michigan Health University of Missouri Healthcare Valley Children's Healthcare Virginia Center for Health Information Trusted Doctors Washington University School of Medicine West Virginia University Medicine Witham Hospital	
50700	**AI in Health – Navigating New Frontiers** – Working group collaboration and report on AI in Health, with AMA name and logo.	Alliance for Health Policy Kaiser Permanente Elevance Health Inc. MITRE Crowell & Moring Law The Patient-Centered Outcomes Research Institute Ostuka Pharmaceuticals Amazon Shields Health Solutions Association for Community Affiliated Plans	04/03/24
50609	**All In Campaign** – Repeat healthcare workforce wellbeing campaign with AMA name and logo.	Harvard TH Chan School of Public Health National Medical Association American Nurses Foundation AHIP Medicine Forward Institute for Healthcare Improvement American Foundation for Suicide Prevention American Society of Hospital Pharmacists	04/12/24
48927	**Validated Device Listing** – Update validatebp.org with language “a public health service supported by AMA."	National Opinion Research Center	04/13/24
62084	**Drug Shortage Task Force** - Coalition for policy recommendations to reduce drug shortage issues, with AMA name and logo.	United States Pharmacopeia Cancer Support Community Generics Access Project Association for Clinical Oncology Alliance for Aging Research Hemophilia Federation of American Friends of Cancer Research Howard University College of Pharmacy	05/28/24

		Arthritis Foundation National Consumers League National Psoriasis Foundation American Pharmacists Association Association of Health System Pharmacists Angels for Change Susan G. Komen Foundation American Cancer Society	
62184	**Release the Pressure Coalition** – Updated coalition for collaboration on reducing hypertension in minority women, with RTP name and logo.	AMA Foundation American Heart Association National Medical Association Association of Black Cardiologists Minority Health Institute	06/04/24
62977	**Joy in Medicine** – Repeat AMA recognition program on AMA website for outstanding healthcare organizations.	Catholic Health Columbus Regional Health Common Spirit CommonSpirit Mountain Region Community Health Network Veterans Integrated Service Network Intermountain Health Memorial Healthcare System MemorialCare Medical Group Novant Health Inc NYC Health + Hospitals TMCOne VA Illiana Health Care System Children's Healthcare of Atlanta Dana-Farber Cancer Institute Bellin and Gundersen Health System HealthPartners Kansas City VA Medical Center Naples Comprehensive Health Nuvance Health Trinity Health Hospital-Ann Arbor/Trinity Health IHA Medical Group UMass Chan Medical School Baystate and Baystate Health The University of Chicago Medicine University of Kentucky College of Medicine The University of Texas Health Science Center at San Antonio Bryan Medical Center Dayton Children's Hospital Denver Health	06/25/24

Endeavor Health Edward Hospital
Endeavor Health Elmhurst Hospital
El Rio Health
Medical College of Wisconsin Froedtert Hospital
Children's Wisconsin Hospital
Hartford HealthCare
Jefferson Health
Johns Hopkins Medicine
Mercy Health
Moffitt Cancer Center
MultiCare Health System
MyMichigan Health
Nemours Children's Health
Northwell Health
Oak Street Health
Olive View-UCLA Medical Center
Owensboro Health
Pediatric Physicians' Organization
Penn Medicine Lancaster General Health
Roper St. Francis Healthcare
Roswell Park Comprehensive Cancer Center
Samaritan Health Services
St. Luke's Health System
Stamford Health
Sutter Health
Sutter Independent Physicians
The Christ Hospital Health Network
UMass Memorial Health
University of California Irvine Health
University of Mississippi Medical Center
Atlantic Health System
Bayhealth
Hattiesburg Clinic
Henry Ford Health
Lehigh Valley Health Network
Mid-Atlantic Permanente Medical Group
Northwest Permanente
The Southeast Permanente Medical Group
Texas Children's Pediatrics

63251	**Rise to Health Coalition** – Updated health equity coalition focused resources for healthcare professionals, with AMA name and logo.	Encoding Equity Alliance National League for Nursing National Council of Asian Pacific Islander Physicians Student National Medical Association US Professional Association for Transgender Health	07/12/24
64628	**National Latino Physician Day** – Awareness Campaign with AMA name and logo.	National Latino Physician Day	08/29/24
64431	**Cardiovascular Disease Prevention Collaboration** – Heart disease prevention materials and training, with AMA name and logo.	Aledade Inc.	09/03/24
64783	**CPT & Value-Based Care Collaboration** - Co-branded issue brief, with AMA name and logo.	Manatt Health, Manatt, Phelps & Phillips, LLP	09/16/24
64838	**AMA Annual Research Challenge** – Repeat annual AMA branded competition with Laurel Road sponsored prize.	Laurel Road Bank	09/18/24
65068	**AMA STEPS Forward and Value-Based Care Collaboration** – Value-based care case studies and AI governance toolkit, with AMA name and logo.	Manatt Health, Manatt, Phelps & Phillips, LLP Geisinger Health System Hattiesburg Clinic	09/24/24
64957	**Athenahealth Co-Branded Collaboration** – "Fix Medicare Now" sponsorship with AMA name and logo.	Athenahealth	09/25/24
65073	**Keep Americans Covered Program** – Coalition to extend Affordable Care Act tax subsidies, with AMA name and logo.	AHIP American Cancer Society Cancer Action Network Blue Cross Blue Shield Association Leukemia & Lymphoma Society	09/27/24

		Federation of American Hospitals American Association of Retired Persons Alliance of Community Health Plans American Academy of Family Physicians The American College of Physicians American Heart Association American Lung Association Association for Community Affiliated Plans National Association of Pediatric Nurse Practitioners National Association of Community Health Centers Families USA National Rural Health Association Small Business for America's Future Susan G. Komen Foundation Unidos US United States of Care	
65613	**Mental Health Parity Collaboration –** Pilot for online tool comparing insurance mental health coverage, with AMA name and logo.	The Kennedy Forum Third Horizon Strategies	11/01/24
65577	**Physician Data Initiative** – Working group to establish data collection and categorization standards, with AMA name and logo.	MedBiquitous Association of American Medical Colleges Accreditation Council of Graduate Medical Education	11/04/24
66040	**Collaboration supporting CDC Million Hearts Project** – with AMA name and logo.	AllianceChicago CDC Million Hearts	11/103/24
66085	**Sponsorship supporting Physician Health Programs** – with AMA name and logo.	Federation Of State Physician Health Programs Coverys Insurance MedPro Group Medical Liability Mutual Insurance Company Physicians Insurance State Volunteer Mutual Insurance Company The Doctors Company	11/206/24

		Medical Professional Liability Association	
66163	***Academic Medicine:* Disability Supplement Collaboration** – with AMA name and logo.	Academic Medicine Association of American Medical Colleges Docs With Disabilities Initiative Robert Wood Johnson Foundation	12/18/24

MEMBER PROGRAMS

Project Number	Project Description	Corporations	Approval Date
65576	**Avid Traveling Update** - Travel affinity program with AMA name and logo.	AHI Travel Avid Traveling	10/24/24
49605	**Boards & Beyond Member Benefit** – Discount on medical student test prep materials, with AMA name and logo.	Boards & Beyond	03/12/24
66466	**AMBOSS Member Benefit** – Discount on medical student test prep materials, with AMA name and logo.	AMBOSS	12/12/24
66498	**UWorld Member Benefit** – Discount on medical student test prep materials, with AMA name and logo.	UWorld	12/16/24

BUSINESS ARRANGEMENTS/LICENSING PROGRAMS

Project Number	Project Description	Corporations	Approval Date
64865	**AMA MAP Hypertension Quality Improvement Program** - Business agreement with AMA name and logo.	Forward Health Group	10/09/24
64952	**Cadence Software Group** – AMA Guides content licensing agreement, with AMA Guides name and logo.	Cadence Software Group	12/12/24

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-A-25

Subject: AMA Performance, Activities and Status in 2024

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

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

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth 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.

Grounding our work in the Principles of Medical Ethics and the policies and wisdom of AMA House of Delegates, in 2024 the AMA was resolute in its fight to repair a broken health care system—one that is threatening the viability of physician practices and patient access to care, contributing to alarming rates of burnout and dissatisfaction, and placing enormous pressure on an already strained public health infrastructure.

Representing physicians with a unified voice

The AMA remained strongly focused on advocacy priorities critical to supporting and strengthening our nation's physician workforce and improving the lives of patients.

Thanks to the AMA's year-long push to reform an unsustainable Medicare reimbursement model that has cut physician payment by 33 percent since 2001, policymakers in Washington, D.C., now understand and acknowledge the crisis and are working in a bipartisan fashion on permanent solutions aligned with AMA recommendations.

The AMA's "Fix Medicare Now" grassroots campaign, which received widespread media attention, generated more than half-million contacts to members of Congress and helped secure introduction of two important pieces of federal legislation to reform the Medicare payment system.

- H.R. 2474, which would enact an annual, permanent inflationary payment update in Medicare that is tied to the Medicare Economic Index
- H.R. 6371, which would reform the budget neutrality policies that have been producing across-the-board payment cuts

Similarly, the AMA's advocacy campaign to reform the onerous prior authorization process, including its "Fix Prior Auth" grassroots campaign, resulted in important reforms both at the federal level and in more than a dozen states.

- The Centers for Medicare & Medicaid Services released final regulations to cut patient care delays and electronically streamline the prior authorization process for physicians—saving physicians an estimated $15 billion dollars.
- At the state level, over a dozen states enacted prior authorization reform laws—supported by the AMA and state medical associations.

In the courts, the AMA was a critical voice for physicians and organized medicine on a broad range of public health issues, including restricting access to e-cigarettes, tougher regulation of unlicensed and untraceable "ghost" guns, and expanding access to care. In addition to defending physicians from criminal and civil penalties for providing necessary care, the AMA was a plaintiff in a major antitrust case against MultiPlan, a data analytics company accused of creating a price-fixing conspiracy with the largest commercial health insurance companies in the country.

The AMA worked alongside state medical associations from across the country to oppose inappropriate scope expansions in more than 40 states. Much of the success was bolstered by the "AMA Scope of Practice Partnership" initiative that has provided more than $4 million in grants since its inception.

The AMA's efforts helped deliver concrete results in protecting patients from inappropriate scope of practice expansions, including the defeat of over 80 bills that would have allowed:

- Physician assistants and nurse practitioners to independently practice medicine
- Pharmacists to independently diagnose and prescribe medications to patients
- Naturopaths to prescribe legend drugs or perform surgical procedures
- Optometrists to perform surgery
- Nurse anesthetists to provide anesthesia services without physician supervision
- Psychologists to independently prescribe medications

Through proactive strategies and reactive opportunities, the AMA elevated the voice of physician leadership on critical issues of public health and our priority topics with media clips exceeding our three-year average. This includes the work to avert the Medicare payment cuts, as well as media and speech visibility throughout the year, leading to more than 3.8 billion media impressions (up from two billion in 2023 and a 10X increase from 2021). Meanwhile, our prior authorization legislation is on the precipice of passing, due to this sustained topic of visibility over the past decade, including 4.7 billion media impressions in 2024 (up from 2.3 billion in 2023)

Removing obstacles that interfere with patient care

Support for physician mental health and well-being expanded in 2024 as the AMA led, funded, or contributed to 38 research projects either to address burnout, promote digital health solutions or aid the long-term sustainability of physician practices. The AMA also recognized 62 health systems for implementing evidence-based strategies to improve physician and health provider well-being through the AMA's Joy in Medicine™ Health System Recognition Program.

Guided by the AMA and in support of physician well-being, a total of 34 licensure boards as of 2024—including 29 medical boards, and more than 425 hospitals and health systems—have revised their licensing or credentialing applications to remove intrusive mental health questions and stigmatizing language. This result is due to an ongoing advocacy effort by the AMA and our close partnerships with organizations like the Dr. Lorna Breen Heroes' Foundation.

AMA STEPS Forward® developed over 90 new or updated resources focused on preventing physician burnout, creating the organizational foundation for joy in medicine, and improving practice efficiency. The resources include toolkits, webinars, podcast episodes, and the new "Reducing Regulatory Burden and Value of Feeling Valued" playbooks.

To expand insight into burdensome electronic health record (EHR) systems, the AMA awarded grants to five organizations through the AMA Electronic Health Record Use Research Grant Program to study EHR usage and improve workflow and resource allocation at the practice and system-level.

The AMA conducted research to explore the role of Current Procedural Terminology (CPT®) in value-based care. Among other vital information, the research identified crucial ways that help ensure the CPT code set remains relevant as value-based care continues to evolve in health care delivery.

To help eliminate obstacles to patient care, the AMA launched VeriCre™, which streamlines the credentialing process, improves efficiency and reduces redundancy for physicians, hospitals, and health plans allowing patients to receive care sooner. VeriCre™ allows physicians to easily manage their credentials, career information and forms for efficient distribution and secure integration with third-party credentialing software.

Driving the future of medicine

To help physicians assess the risks and opportunities of augmented intelligence (AI) in medicine, the AMA continued to develop tools, resources, and support for AI study and implementation, and elevated the most pressing concerns of physicians to those shaping our digital health future.

Underscoring our commitment to ensure the physician voice is integrated into all aspects of health care technology, the AMA released an AI landscape report that provides an overview of current and future use cases, potential applications, and opportunities and risks of AI. The AMA also presented three webinars on future health topics including digital empathy, the human factor in solving problems, and navigating AI in health care.

JAMA® hosted the second annual *JAMA* Summit™, which convenes leaders from across sectors and around the world to discuss and debate critical issues in medicine, health, and health care. This year's event focused on the integration of AI in clinical medicine. *JAMA*® created and launched JAMA+ AI, a channel devoted as the first stop for authors and readers seeking the best science and commentary on AI and its application to medicine and public health.

The AMA, in partnership with the University of Michigan, developed a new seven-part online activity series "AI in Health Care**,**" which introduces learners to foundational principles of AI and machine-learning.

As a leader in the advancement of precision education, the AMA concluded the 2024 AMA ChangeMedEd® Innovation Grant Program that awarded 13 grants and focused on the application

of precision education across the medical education continuum—from medical school and residency to continuing medical education. The AMA continued to further define precision education as a critical way to develop an effective model of lifelong learning in medical education, one which produces a physician workforce capable of caring for our patients, families, and communities.

AMA Ed Hub™ partners with more than 60 organizations as a vital source of professional education for physicians by providing trusted, high-quality education to enable lifelong professional development. In 2024, AMA Ed Hub™ continued to experience high engagement.

- 8000+ education activities available
- 475,000+ registered users
- 4 million visitor sessions
- 600,000 courses completed

Leading the charge to confront public health crises

To address systemic inequities that have contributed to poorer health outcomes for historically marginalized communities, the AMA reaffirmed its commitment to health equity by extending our multi-faceted health equity strategic plan through 2025. This work spans state and federal advocacy, education and training for physicians, and community investments that target the root causes of inequities in medicine and help all people achieve their optimal health.

In collaboration with more than 20 organizations, the AMA hosted two National Health Equity Grand Rounds, which featured 14 national experts and reached over 24,000 viewers.

Building on its long legacy of advancing public health, 2024 saw the AMA develop a new strategic approach for promoting greater blood pressure control in targeting the number one cause of premature death in the U.S.: heart disease. By engaging more than 280 health care organizations the AMA helped reach more than 2.5 million hypertensive patients with solutions that assisted physicians and care teams in lowering their patients' blood pressure risks.

Amid the rising rates of sexually transmitted infections and viral hepatitis across the U.S., the AMA, in collaboration with the Centers for Disease Control and Prevention (CDC), launched a new online toolkit to help physicians and other health care professionals increase routine screenings for human immunodeficiency virus, sexually transmitted infections, viral hepatitis, and latent tuberculosis. We also hosted a series of educational webinars about best practices and strategies for routine screening.

The CDC's National Partners Cooperative Agreement awarded the AMA $2.45 million to support our efforts in advancing hypertension and cholesterol care in communities across the U.S.

The AMA's Enterprise Social Responsibility (ESR) program celebrated its fifth year of working to reduce health inequities in partnership with communities. AMA's ESR program aligns with the needs of the organizations through active partnerships, where AMA's activities are recognized as collaborative and add value to the community. In 2024, the ESR program recorded the most impactful year to date hosting over 40 events, supporting 85 organizations.

Membership

The AMA's advocacy and mission activities were again fueled by another year of strong financial performance and continued membership growth. AMA membership has increased more than 40 percent in the last 15 years with a 3.1 percent increase in dues paying members in 2024 alone as more physicians, medical students, and residents recognize our efforts and want to join the AMA in fighting on their behalf.

EVP Compensation

During 2024, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,400,311 in salary and $1,262,299 in incentive compensation, reduced by $2,902 in pre-tax deductions. Other taxable amounts per the contract are as follows: $168,999 distribution from a deferred compensation plan; $23,484 imputed costs for life insurance, $24,720 imputed costs for executive life insurance, $22,865 for legal fee reimbursement, $2,820 paid for parking and $2,500 paid for a fitness facility.

For additional information about AMA activities and accomplishments, please see the "AMA 2024 Annual Report."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-A-25

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2024 through February 2025

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

This report summarizes trends and news on tobacco usage, policies, and tobacco control advocacy activities from March 2024 through February 2025. The report is written pursuant to American Medical Association (AMA) Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE AT A GLANCE*

Adult smoking rates are at an all-time low of 11 percent and yet it is still the leading cause of preventable death in the United States. According to U.S. Surgeon General, one in five of all deaths are caused by smoking.[1] According to the Centers for Disease Control and Prevention (CDC) cigarette smoking accounts for more than 480,000 deaths every year, or about one in five deaths. Chronic diseases associated with cigarette smoking include respiratory and cardiovascular diseases, cancers, and diabetes. More than 16 million Americans live with a smoking-related disease.[2]

Despite large absolute differences in the numbers of smoking-attributable deaths by race and ethnicity, smoking accounts for a similar proportion of deaths among non-Hispanic Black (18 percent) and non-Hispanic White (20 percent) people and for approximately 10 percent of deaths among Hispanic people. In January 2025, Health and Human Services released the 35th United States Surgeon General's report on tobacco, Eliminating Tobacco-Related Disease and Death: Addressing Disparities. The report documents the persistence of disparities in tobacco product use and exposure to secondhand tobacco smoke and outlines recommendations that include marketing and manufacturing restrictions, funding for evidence-based programs and cessation inventions and eliminating menthol and flavorings in all tobacco products.[1]

Cigarettes remain the most commonly used type of tobacco product followed by e-cigarettes. Although cigarette smoking rates decreased, e-cigarette use increased from 3.7 percent in 2020 to 6.5 percent in 2023 according to National Health Interview Survey.[3] Men were more likely than women to use e-cigarettes. In 2019 3.5 percent of women and 5.5 percent of men reported using e-cigarettes. This increased to 5.5 percent and 7.6 percent in 2023. Examining usage by different age groups in 2023, e-cigarette usage was highest in adults ages 21-24 (15.5 percent), with usage decreasing with increased age among those 25 and older.

Current use of any tobacco product among middle and high school declined overall according to an analysis of the 2024 National Youth Tobacco Survey (NYTS) from 10 percent in 2023 to 8.1 percent in 2024. The analysis was published in the October 17, 2024, Morbidity and Mortality Weekly Report (MMWR).[4] The overall declines were largely driven by the decline in high school e-cigarette use that went from 1.56 million in 2023 to 1.2 million in 2024. But despite the declines one in 10 high school students and one in 20 middle school students reported current tobacco use of any product in 2024.

E-cigarette products were the most used tobacco product of middle and high school students with 5.9 percent reporting current e-cigarette use followed by nicotine pouches (1.8 percent), and cigarettes (1.4 percent). Among students who had ever used an e-cigarette, 43.6 percent reported current use. Tobacco use declined for Hispanic students and remained stable for other racial and ethnic groups but increased for non-Hispanic American Indian or Alaska Native. The continued disparities among youth tobacco users reported in the analysis highlights the need to continue to develop targeted prevention and control interventions.

NYTS is a cross-sectional, voluntary, school-based, self-administered, Internet survey of U.S. middle school (grades 6–8) and high school (grades 9–12) students. A stratified, three-stage cluster sampling procedure was used to generate a nationally representative sample of U.S. students attending private or public middle and high schools. Data were collected during January 22–May 22, 2024; 29,861 students from 283 schools participated, with an overall response rate of 33.4 percent.

EFFORTS TO ADDRESS TOBACCO CONTROL

Medicaid coverage improves for tobacco cessation, but barriers still exist

More than one in five adults enrolled in Medicaid smoke cigarettes which is higher than adults with private insurance. In 2021, prevalence in adults enrolled in Medicaid was 21.5 percent compared to 8.6 percent enrolled in private insurance. According to a report, State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Accessing Treatments — United States, 2018–2022, the number of states with comprehensive Medicaid coverage of tobacco cessation treatment increased from 15 to 20 states.[5]

The American Lung Association (ALA) authored the report that analyzed state-level information looking at coverage for nine tobacco cessation treatments and access barriers which include co-payments, prior authorization, treatment duration, annual and lifetime limits, and two others. The biggest improvement in removing barriers was for co-payments with nearly a third of the states without this requirement. The authors credit the enactment of the Families First Coronavirus Response Act which increased the federal share of Medicaid spending and required states to limit new cost-sharing for Medicaid enrollees.

Low-income populations are disproportionately affected by smoking-related diseases. Smoking cessation is one of the most effective interventions to prevent the health risks associated with chronic diseases.[6] Removing barriers to cessation services would improve quality of life as well as reduce the direct and indirect costs of tobacco-related diseases.

AMA Litigation Center joins with public health groups to protect tobacco regulation

In the courts, the AMA has continued to be very active in supporting efforts to further regulate and limit tobacco products and electronic nicotine delivery systems (ENDS). The AMA has joined numerous amicus briefs around the country in cases involving the federal government’s efforts to regulate and remove flavored ENDS from the market, which have contributed to favorable outcomes in several federal circuit courts. In addition, the AMA has supported state and local governments with amicus briefs after their laws banning flavored tobacco products and ENDS have been challenged by the tobacco and vaping industry.

Notably, the AMA Litigation Center joined two amicus briefs in the United States Supreme Court involving marketing denial orders of flavored products under the Tobacco Control Act. The two

cases, Federal and Drug Administration (FDA) v. Wages and Lion Investments and FDA v. R.J. Reynolds Vapor, have been briefed and argued and the Court is expected to rule before the end of June 2025.

In 2020, the AMA joined the African American Tobacco Control Leadership Council (AATCLC) as a plaintiff in its lawsuit against the Department of Health and Human Services and the FDA on account of the FDA's failure to prohibit the sale of menthol-flavored cigarettes. An FDA report found menthol cigarette use is associated with increased smoking initiation among youth and young adults, greater signs of nicotine dependence, and less success in smoking cessation. As of June 2024, the FDA had still not released rules for prohibiting the sale of menthol-flavored cigarettes. In January 2025, the Trump Administration withdrew the proposed federal rule banning menthol flavoring. This AMA/AATCLC lawsuit continues with Action on Smoking and Health and National Medical Association joining the suit.

California rolls back secondhand smoke protections

Public health and medical organizations were stunned when California Governor Gavin Newsom signed Assembly Bill 1775 (AB 1775) into law in September 2024. This law expands what is permitted at cannabis/marijuana retailers. Existing law gives California cities and counties the authority to decide if cannabis retailers are permitted in the jurisdiction, and to decide whether those cannabis retailers may allow onsite use, such as indoor cannabis smoking and/or vaping.

According to the Americans for Nonsmokers Rights the new law, which went into effect January 1, 2025, goes a step further by allowing jurisdictions to permit an additional element at cannabis retailers: the sale of food and non-alcoholic beverages and the sale of tickets to performances. This law, one of the first in the country, rolls back California's leadership in protecting workers from the health risks associated with secondhand smoke exposure which includes cannabis smoke. In fact, Governor Newsom had vetoed a similar law the previous year but succumbed to pressure from the rising influence of the cannabis lobby. [7,8,9]

Tobacco control advocates will continue to work at the local level to call for restrictions on cannabis retailers while working at the state level to overturn AB 1775.

American Lung Association Releases its 2025 State of Tobacco Report

The ALA released its 2025 "State of Tobacco Control" (https://www.lung.org/research/sotc) which reviews tobacco control activities at the state and federal levels and assigns grades based on laws and regulations designed to prevent and reduce tobacco use including e-cigarettes.[10] This is the 23rd edition of the ALA's State of Tobacco report which has served as a blueprint to public health organizations, and local, state and federal governments for enacting proven tobacco control policies. The 2025 report reveals the continued impact of tobacco use, including menthol cigarettes, on individuals and families across the country, and underscores the continued influence of the tobacco industry. These include tobacco industry efforts to stop former President Biden from ending the sale of menthol cigarettes and flavored cigars as well as industry efforts at the state level to stop proven-effective policies to prevent and reduce tobacco use.

Four states, Alabama, Georgia, Mississippi and Texas, received the worst grades in the nation. These states either did not advance any policies or weakened existing tobacco control efforts. Every state received an F for failing to pass any legislation or regulation prohibiting the sales of flavored tobacco products. The variety of flavors available for use in e-cigarettes has grown exponentially, especially among youth and young adults, according to a Tobacco Free Kids issue

brief.[11] The city of Denver passed a comprehensive flavored tobacco law, again demonstrating the leadership of local communities on this issue.

Maryland was lauded for increasing its cigarette tax by $1.25 per pack, making it the second highest state cigarette tax in the country at $5.00 per pack. Tobacco taxation, passed on to consumers in the form of higher cigarette prices, is one of the most effective population-based strategies for decreasing smoking and its adverse health consequences.[12]

Effective September 2024, 21 is the national tobacco sales age

After almost four years of delay, stricter requirements for tobacco retailers were finalized by the FDA in August 2024. In accordance with the 2019 passage of the Tobacco 21 legislation, the FDA issued final rules that became effective September 30, 2024, requiring retailers to use a photo ID to verify the age of anyone under the age of 30 trying to purchase any tobacco product including smokeless. In addition, the rules prohibit tobacco product vending machines in facilities where individuals under 21 are present or are permitted to enter. In 2019 Senators Tim Kaine (D-VA) and Mitch McConnell (R-KY) worked together to pass the Tobacco 21 law which also called for the FDA to issue guidance on implementation and enforcement. In 2022 they called on then FDA Commissioner Dr. Robert Califf to provide greater transparency on delays.[13] It is estimated that raising the minimum legal age to 21 years would reduce the smoking initiation rate among 15- to 17-year-olds by 25 percent, lead to 50 000 fewer cases of lung cancer and prevent 223 000 early deaths in the US.[14, 15]

*Note – at the time this report was prepared updated tobacco/smoking related data and reports were unavailable from trusted government sources. Due to the Trump Administration Executive Orders, CDC and other agencies were required to remove sources of public health surveillance data and reports.

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REPORT 10 OF THE BOARD OF TRUSTEES (A-25)
American Medical Association Health Equity Annual Report
(Informational)

EXECUTIVE SUMMARY

Background: At the 2018 Annual Meeting, the House of Delegates (HOD) adopted the recommendations of Policy D-180.981 directing our American Medical Association (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, the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021, and the successor 2024-2025 AMA Organizational Strategic Plan to Advance Health Equity in June 2024. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy." This report marks the sixth AMA Health Equity Report.

Discussion: The AMA has continued its efforts over recent years to further embed equity in our work. The 2024-2025 iteration of the Plan continues to serve as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2024, divided into the 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 updates on diversity and inclusion strategy updates are located within the Embed Equity section.

Conclusion: This report highlights only a portion of the work accomplished and lessons learned in 2024. AMA staff have devoted countless hours to learning how they can collaborate in advancing health equity and applying those insights within and beyond the organization. The AMA remains committed to driving progress toward health equity and embedding racial and social justice, making meaningful progress toward fulfilling the commitments outlined in both iterations of the Strategic Plan.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-25

Subject: American Medical Association Health Equity Annual Report

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates (HOD) adopted Policy D-180.981, directing our American Medical Association (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, the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021, and the successor 2024-2025 Plan in June 2024. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy." This report marks the sixth AMA Health Equity report.

DISCUSSION

Our AMA has committed to advancing health equity, advocating for racial and social justice, and embedding equity across the organization and beyond. In 2024, 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 2024, 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. Updates on diversity and inclusion strategy updates are included within the Embed Equity section.

Embed Equity

Ensuring a lasting commitment to health 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 2024:

- At the 2024 Annual and Interim House of Delegates Meetings, equity-focused reports, resolutions, and education sessions were presented, including Council on Ethical and Judicial Affairs reports: "Short Term Global Health Clinical Encounters" and "Expanding Access to Palliative Care." The Council on Science and Public Health presented 18 reports on topics such as: Sex and Gender Differences in Medical Research, Universal Screening for Substance Use and

Substance Use Disorders during Pregnancy, Stand Your Ground Laws, and Reducing Sodium Intake to Improve Public Health.

- The AMA Journal of Ethics published five equity-related issues such as Critical Pedagogies in Health Professions Education (Jan 2024); Global Medical Supply Chain Security (April 2024); Antimicrobial Stewardship (June 2024); Harm Reduction and Opioid Use Disorder (July 2024); and Sleep Stewardship (October 2024). The AMA released a podcast series, "Equity in our DNA: The Past and Promise of Genetics" in which experts discuss advances in modern medicine and provide insights into historical harms creating public mistrust. It provides an opportunity for viewers to understand how changes in precision medicine can reduce health equity gaps. Furthermore, the AMA, in collaboration with the U.S. Centers for Disease Control & Prevention (CDC), published seven episodes of the "Stories of Care" podcast series, resulting in 3,299 downloads and 1,405 continuing medical education completions. The AMA continued its campaign with the CDC and the Ad Council to promote flu vaccinations, focusing on Black and Hispanic/Latinx populations, reaching 1.6 million broadcast impressions and 404 million digital impressions.
- Diverse representation among AMA publications remained a goal. The AMA updated 29 images in the 2025 CPT Professional book to reflect diverse populations. Input was gathered from internal and external reviewers. This progress is contributing to AMA's four-year plan to update 75-100 CPT Professional book illustrations to depict authentic and diverse individuals.
- AMA content on health equity saw increased engagement in 2024, with 2.2 million website users, 23,200 referrals to the AMA Ed Hub, and 45 news articles. AMA expanded communication of equity initiatives through social media, newsletters including the Advocacy Update, Advocacy Insights webinar series, Center for Health Equity, CPT news email, and webinars. AMA social media had 343,000 views of health equity content with an average of one to two health equity related posts per week.
- On the AMA Ed Hub site, the AMA published 169 new equity-related activities and renewed 101, with engagements reaching 311,429 (vs. 189,721 in 2023) and completions increased to 68,700 (vs. 34,782 in 2023). The AMA partnered with medical schools to assign AMA health equity trainings, driving over 900 completions of health equity courses from medical student members. All four of the health equity foundational courses offered are in the top 15 percent of courses most utilized by medical students. Additionally, the AMA partnered with graduate medical education institutions to assign health equity courses to residents, resulting in more than 18,900 completions across more than 240 institutions. In 2024, there was an all-time high of foundations of health equity module completions seen in a year. Notably, in 2024, there were four newly uploaded quality improvement and patient safety (QIPS) courses and a new curriculum that centered on health equity focused patient scenarios. More than 4,000 resident members have enrolled in the curriculum since its launch in July 2024. Additionally, seven episodes of Prioritizing Equity were produced in 2024: Black Maternal Health; Voter Protections for During and After Incarceration; The Importance of Highlighting Historically Marginalized Physician's Journey Through Medicine; International Medical Graduates Experience in Medicine; Equitable Climate Action for Health; Culturally Responsive Communication Strategies for Equity; and Embedding Equity in Crisis Preparedness and Response in Health Systems Guide.
- The JAMA Network held quarterly diversity, equity, and inclusion (DEI) editor meetings to support DEI related concerns and share best practices. The JAMA fellowship welcomed eight early-career health equity scholars in the fully remote fellowship program, intended to foster accessibility and inclusivity of the program.
- In 2023-2024, the AMA evaluated external perceptions of its equity and social justice work and opportunities for strategic partnerships and allyships. There was a two-part analysis in support of these aims: a series of interviews with leaders within national equity and social justice organizations, and an analysis of social media conversations being had by the general public.

- Our AMA published playbooks and other educational resources for physicians, practices, and health systems, such as the health coaching toolkit to include the importance of community health workers, updated the Private Practice Playbook to include social determinants of health and health equity content, and developed virtual coaching options to help reach patients in traditionally remote and underserved communities. STEPS Forward® has continued to hold events, reaching a wider audience of attendees, while maintaining discounted attendance for federally qualified health centers (FQHCs) and safety-net providers. The bootcamps offer evidence-based time management and team-based care strategies to provide quality patient care. The Private Practice Simple Solutions learning collaboratives were created in support of practices in communities that may lack financial resources to engage with consultants or other external partners and continued to run through 2024, expanding to timely and relevant topics that are often complex in nature and that these practices may need support on, such as the implementation of virtual assistants or value-based care.

The AMA's employee life cycle and internal DEI framework helped to operationalize DEI initiatives across the enterprise. Within the embedding equity strategic approach, updates on the AMA's diversity and inclusion strategy included a number of efforts and initiatives:

- Our AMA supports DEI initiatives through nine Employee Resource Groups (ERGs), fostering inclusion and belonging across the organization. In 2024, the ERGs collectively had 640 staff who were members of their groups and hosted over 90 events designed to advance equity learning, cultivate community, and support the personal and professional development of their members.
- Staff are strongly encouraged to seek equity-focused learning opportunities, with minimum hours set in the organization's first year of internal enterprise-wide equity goals, and staff averaging over 16 hours in 2024. Among business units (BUs), staff have organized educational activities and events to strengthen community engagement and learning. As an example, AMA Insurance (AMAI) organically produced and presented a six-hour long Lunch and Learn training focused on equity and inclusion. Each AMAI staff is responsible for logging their required minimum of 7.5 hours of equity training/related programming participation.
- In addition, the Center for Health Equity and Human Resources have offered equity focused workshops to support staff completion of their equity learning goal. Staff participated in the Racial Equity Trainings offered by the Racial Equity Institute, the Diversity, Equity, Inclusion, and Belonging Foundation Course through Be More with Anu, and skill-based inclusion modules on Psychological Safety, Inclusive Communication, Identifying and Responding to Microaggressions, and Inclusive Facilitation. For the skills-based modules, 246 staff members completed 362 workshops, reflecting both a 36 percent increase in staff participation and a 41 percent increase in the number of completed workshops when compared to 2023. These trainings provided and/or helped refine actionable skills to promote inclusion across the employee lifecycle at the AMA.
- The AMA offered the staff management team, in partnership with Equity & Results, an in-person and virtual live workshop series on Antiracist Results-Based Accountability. Participants learned root cause analysis for inequities, strategy development to address "hot roots" and "pain points" that drive inequity, and operational plan and performance measurement development to enhance equitable impact internally and externally. A seven-session series (final four sessions in 2024) included 47 unique equity leads (including current and former business unit equity action team members) across all 18 BUs and one affiliate with 82 percent of the final session's survey respondents agreeing or strongly agreeing to knowledge gained. A three-session series, in support of enterprise-wide equity goals, included 57 directors and vice presidents from all business units,

with more than half agreeing or strongly agreeing they were confident about applying what they learned.

- Our AMA continues to work toward identifying and replacing offensive terminology across the enterprise. The AMA conducted a comprehensive search for outdated terms in our information technology (IT) systems and has embarked on instituting these updates starting in 2025 to replace harmful language.

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 people, expertise and knowledge, builds advocacy coalitions, participates in national networks, and establishes the foundation for true accountability and collaboration. The following are some of the relevant accomplishments during 2024:

- Our AMA launched the second iteration of the AMA's Strategic Plan to Embed Racial Justice and Advance Health Equity to advance health equity, with a viewpoint summarizing AMA's renewed commitment to the work and lessons learned from the original strategic plan.
- The AMA continued the Summer Health Law Internship and will continue in 2025, expanding from an eight-week to a ten-week paid summer internship for a rising third-year law student, with a focus on health disparities and the law.
- The AMA's Release the Pressure campaign, alongside the Henry Schein Cares Foundation, American Dental Association, National Medical Association, Care Quest Institute for Oral Health, and the Arnold Gold Foundation created the Prevention is Power Coalition. Educational materials including fact sheets, posters, and patient cards on hypertension for Federally Qualified Health Centers were created and reached over 800 organizational members and 65,000 health-focused followers through the National Association of Community Health Center's network.
- The AMA conducted a survey to understand physician perceptions of their health center-built environments and assess impact on their well-being. Of the 12,277 contacted, 526 responded and 281 agreed to follow-up interviews. The surveyed physicians included American Indian or Alaskan Native/Native Hawaiian or Pacific Islander, Hispanic or Latino, Black or African American, Middle Eastern or North African. The surveyed physicians are in the process of being connected with diverse learning communities such as Rise to Health and In Full Health resources.
- Seven new partners joined the AMA's Ed Hub in 2024, including Institute for Healthcare Improvement, Johns Hopkins University, National Association of County and City Health Officials, National Resources Defense Council, Oregon Health & Science University, OutCare Health, and The Permanente Medical Group. These organizations will be contributing to equity-related content on AMA Ed Hub site.
- Out AMA continued to follow the Enterprise Social Responsibility (ESR) team's health equity framework to build meaningful relationships with community organizations. In 2024, the ESR team hosted over 40 community engagement events with organizations including Erie Neighborhood House, Gardeneers, Nourishing Hope, Pilsen Food Pantry, and Project Linus. To highlight, AMA's ESR team partnered with MyBlock MyHood MyCity to co-design a weeklong service event. The weeklong service event celebrated the AMA ESR program's fifth year anniversary and provided volunteers with deeper engagement to build upon health equity work that is already happening in the community. The weeklong event impacted 423 residential homes and 12 neighborhood blocks.
- Additionally, there are increased efforts to contract with minority- and/or women-owned or led businesses for AMA projects, including local West Side vendors, which has led to successful

agreements. The AMA continues to participate in monthly West Side United (WSU) Anchor Partner meetings and attended a vendor summit event, meeting several WSU vendors in person.

- Our AMA's 2024 media sponsorships focused on reaching diverse audiences, supporting events with the National LGBTQ+ Journalists Association, the Asian American Journalists Association, and the National Association of Black Journalists, to name a few.
- In collaboration with the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, the AMA released recommended standards for collecting, reporting, and sharing race, ethnicity, and language data in health care. The standards represent a multi-year initiative around sociodemographic physician workforce data. Organizations, such as MedBiquitous, have agreed to adopt and promote these standards to the health care community.
- In 2024, our AMA continued collaborative research that leverages critical data from the AMA's Physician Professional Data aimed to study and evaluate the most pressing issues impacting equitable care.
- AMA has a goal to scale solutions to improve blood pressure control for five million patients diagnosed with hypertension (HTN) with a specific goal to impact one million patients identified as Black, Latina/e/o/x/Hispanic, Asian, Indigenous, and other historically marginalized groups. At the end of Q4 2024, approximately 2,589,155 patients were reached, and have impacted 774,261 patients with hypertension towards the goal of five million, with 38 percent from historically marginalized populations. AMA is embedding and advancing equity within its AMA MAP HTN™ program by evaluating program data, developing tools for health care professionals to identify inequities in blood pressure control rates, and creating inclusive patient education materials related to cardiovascular disease prevention that have been translated into over 15 languages.
- Across the enterprise, individual BUs sought out ways to embed equity within their departments. As an example, the AMA continued hosting students from historically marginalized backgrounds with the opportunity to visit the AMA, engage with AMA IT professionals, and learn about the organization's history and its role in promoting national health and wellbeing. Similarly, JAMA partnered with the Urban Alliance on a summer internship program to provide opportunities for Chicago students to explore Medical Editing and Publishing as a career path.
- The AMA contributed to revising the Declaration of Helsinki, supporting the creation of the new version that more effectively addresses health determinants and inequity. For example, the revision has a stronger emphasis on environmental considerations, for the first time requires post-clinical trial provisions (such as providing any intervention identified as beneficial and reasonably safe in the trial for participants who still need it) and discusses vulnerability in a more nuanced way.
- The AMA continued to partner with March of Dimes and Sinai Urban Health Institute to examine the impact of facility closures and loss of services on the South and West Sides of Chicago, publishing a final report in August 2024, titled "From Facilities to Outcomes: A Neighborhood-Level Examination of Maternal and Infant Care Access in Chicago."
- Our AMA conducted 32 burnout assessments at FQHCs and/or community health centers, all organizations serving patients from predominantly historically marginalized communities, including 23 organizations in the Arizona Alliance, a consortium of FQHCs. Several virtual workshops and reporting sessions to provide insight into interventions to reduce medical staff burnout were held.
- Several participating FQHCs were recognized through the AMA's Joy in Medicine™ Health System Recognition Program. AMA continued to work with FQHCs, and staff traveled to an FQHC located in Chicago's South Side, Alivio, and met with their leadership team to learn more about their needs and challenges.

- AMA staff continue to be present at minoritized and marginalized physician convenings to grow and foster relationships, as well as learn about health care priorities of these groups. Staff participated in various conferences to support building alliances, learning about the context necessary for restorative practice, and incorporating context into the AMA's own work. These conferences included: 8th Annual Urban Native Education Conference, National Hispanic Medical Association 30th Anniversary Celebration and Leadership Summit, Unidos US Annual Conference, Access in Medicine Summit, National Medical Association National Colloquium on African American Health and Annual Convention and Scientific Assembly, The Latino Medical Student Association National Conference, American Association of American Indian Physicians 52nd Annual Meeting and Health Conference, GLMA's 42nd Annual Conference on LGBTQ+ Health, and AAMC Annual Meeting. Staff gained insights into incorporating restorative practices and equity into AMA's work.

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 2024:

- Equity-related policy priorities can be seen throughout the AMA's engagement with Congress, the Administration, state legislatures and other policymakers, in the form of advocacy letters, presentations and testimony to state legislatures, national and medical organizations, and countless additional opportunities that engaged organized medicine and policymakers. In 2024, the AMA continued to actively voice support for:
    - International medical graduates;
    - Deferred Action for Childhood Arrivals recipients;
    - Migration and refugee population health and safety;
    - Nutrition programs expansion and culturally respectful dietary guidelines;
    - Medicaid coverage expansion;
    - Medicaid and Children's Health Insurance Program coverage extension;
    - Maternal and child health programs;
    - Protecting reproductive health;
    - Advancing data privacy principles and protecting the abuse/misuse of sensitive health data;
    - Enhanced revisions to the federal race and ethnicity data standards;
    - Mental health and substance use disorder parity laws;
    - Protections for physicians who seek care for wellness and burnout;
    - Evidence-based gender affirming care;
    - Prohibition of the so-called conversion therapy;
    - Fair student loan efforts;
    - Increased funding for graduate medical education;
    - Elimination of harmful race-based clinical algorithms;
    - Telehealth flexibilities in Medicare;
    - Reducing the prior authorization burden on patients; and
    - Addressing quality and administrative barriers in Medicare Advantage and other insurance plans.
- The AMA amplifies voices of historically marginalized individuals through its litigation efforts. Examples from this past year:
    - Reproductive health and gender-affirming care: The AMA has filed and joined dozens of amicus briefs across the country on these critical issues in state and federal courts,

including several briefs at the U.S. Supreme Court. The briefs have consistently emphasized the harm that government interference in the patient-physician relationship has on marginalized communities. The litigation team has also provided support to the AMA's Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted.
    - Anti-smoking: The AMA has continued to be a central voice in litigation on anti-smoking efforts, including serving as a named plaintiff in a case to ban the sale of menthol cigarettes. The AMA has also joined several amicus briefs supporting state and local restrictions on flavored tobacco and briefs supporting restrictions on flavored electronic nicotine delivery systems, including in the U.S. Supreme Court.
    - Affordable Care Act (ACA) Preventive Care: The AMA has been a leader in organizing amicus briefs supporting the ACA and opposing efforts to dismantle the preventive care provisions of the law. These briefs have included dozens of Federation members and have been filed at all levels of the case.
    - Medicare: The AMA has supported the federal government's efforts to support health equity in Medicare through the use of anti-racism plans under the MIPS program.
    - Internal and External Communication: The litigation team routinely communicates with state and specialty societies about possible collaboration efforts in order to support health equity in the courts.
- The AMA proposed revisions adopted into World Medical Association policy, advocating against anti-LGBTQ+ legislation worldwide. AMA also supported and facilitated World Medical Association policies addressing humanitarian issues in Gaza and Turkey. Additionally, the AMA facilitated an opportunity for Jesse Ehrenfeld, MD, MPH, to speak and participate in a panel at the World Medical Association General Assembly on the opportunities and risks of innovation in health equity.
- The AMA hosted the first two hybrid National Health Equity Grand Rounds: Advancing Health Equity Through Resistance: A State of the Union on Threats and Opportunities in New York City, with 990 live attendees, and Rewrite the Script: Narrative Transformation for Equity in Health at the Facing Race conference in St. Louis, Missouri, with 1,044 live attendees. Overall, 90 percent of Grand Rounds viewers reported that they were satisfied or very satisfied with the 2024 events.
- In its second year, the Health Equity in Organized Medicine (HEIOM) survey was distributed to the AMA Federation of Medicine in January 2024. The survey seeks to understand the current state of organized medicine’s efforts in advancing health equity and developing a shared understanding of equity initiatives across states and specialties. Despite an increasingly complex political landscape and efforts to discredit diversity, equity, and inclusion initiatives, the 2024 HEIOM survey found continued engagement around equity and inclusion efforts across various sectors. Notably, 74.1 percent of organizations reported taking at least one action to make equity a strategic priority. Among organizations that completed both 2023 to 2024 surveys, 51.9 percent reported completing or sustaining the majority of their actions, and no organization reported stopping or canceling the effort they had underway in 2023.
- In response to AMA HOD policy D-405.970: Racism – A Threat to Public Health, the AMA submitted new ICD-10 codes focused on the conditions related to the experience of racism to the National Center for Health Statistics in 2024. The AMA supported the successful implementation of Gravity Project’s social determinants of health terminology and Fast Healthcare Interoperability Resources exchange standards across the state of New York (NY) to provide the data standards necessary to more effectively identify and address the health-related social needs of 6.9 million Medicaid beneficiaries. The use of these standards in NY, and across the country, also enables the stories of marginalized populations to be more accurately told in a way that was not possible before the Gravity Project. When aggregated, this data will help local, state, and

federal officials to make more informed decisions about the needs of these marginalized populations and the impact of addressing these needs on health care outcomes and spending.

- The AMA has worked to close coverage gaps in Medicaid programs so that beneficiaries have coverage for a blood pressure (BP) monitoring device and cuff. AMA has also worked to increase Medicaid coverage for clinical services related to self-measured blood pressure.
- In Atlanta, the AMA collaborated with the CDC, local American Heart Association (AHA) representatives, and a local collaborative on health improvement to convene more than 75 organizations and align solutions to social drivers of health to improve blood pressure for Black adults. Notably in Atlanta, the Medical Association of Georgia and Medical Association of Atlanta are engaging their membership locally. The AMA has deployed AMA MAP™ resources, tools, and educational content to health care organizations in the Atlanta area.
- New STEPS Forward® content helped address determinants of health and inequities. For example, 2024 STEPS Forward® podcast content included episodes focused on (1) Integrating a Community Health Worker into Team-based Care, (2) Connecting the Dots Between Social Determinants of Health and Climate Change, (3) Frontline Connect: Eliminating Barriers to Mental Health Services for the Health Care Workforce, and (4) I felt such a shame to be me: How One Medical Educator is Working to End Mental Health Stigma in Medicine.
- As part of The AMA Foundation's Health Equity Accelerator fund, the AMA was awarded a two-year $2.3 million collaborative grant to focus on promoting equitable practices and diversity in the admissions process after the 2023 U.S. Supreme Court (SCOTUS) decision on affirmative action. The proposal was written to supplement ongoing efforts, including a separate set of roundtable discussions, the completion of the book *Remaining Medical Education: The Future of Health Equity and Racial Justice*, and broader Medical Education strategies. The grant-funded initiative, referred to as Equity and Justice in Medical Education, is convening key stakeholders most affected by the SCOTUS decision to collect their reflections on the challenges and opportunities of the changing landscape. The participating organizations include the National Medical Association, National Hispanic Medical Association, Association of American Indian Physicians, National Council of Asian Pacific Islander Physicians, Asian Pacific American Medical Student Association, Latino Medical Student Association, Association of Native American Medical Students, Student National Medical Association, American Association of College of Osteopathic Medicine, and the Association of American Medical Colleges. A total of six convenings will be held during the grant period. These convenings aim to foster collaboration between participants with the hope of developing common approaches that will leverage collective influence while not countermanding efforts of any one organization over another.

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 2024:

- The new Health Solutions Innovation Framework now includes Equity Impact as a mandated quadrant of the Product Lean Canvas (a one-page business plan to help determine if a product is worth moving forward) and continues to propagate across the additional stages through product development and delivery.
- The AMA hosted an expert convening on postpartum HTN to identify best practices for postpartum blood pressure monitoring and management. Specifically, convening participants highlighted that policy change, further research, and practice tools and resources are needed to support broad improvements in postpartum HTN care.

- The AMA worked with external organizations, health innovation and technology companies to encourage organizations that support health care delivery, such as health technology, payers, and others, to use an equity lens to understand population representation within their studies and programs, investment and removal of barriers for those who have been historically marginalized, and transparency for specific populations. Additionally, the US Validated Blood Pressure Device Listing has continued to grow in number and variety of devices, including broader cuff sizes and lower price points to reach a broader population in need.
- The AMA continued to strive toward the adoption, optimization, and sustainability of responsible, impactful and equitable digitally enabled innovations. This included highlighting organizations that are championing and implementing health equity via the Physician Innovation Network (PIN) and providing a place through PIN to engage in important conversations centering the Principles of Equitable Innovation. The AMA connected stakeholders and fostered collaboration to improve the development, evidence base, and quality of digital health solutions.
- The AMA provided Innovation Grants to twelve organizations and developed a community of practice where grantees meet monthly. As part of the AMA "Innovation in Medical Education Series" with Elsevier, the recently published *Reimagining Medical Education: The Future of Health Equity and Social Justice* illuminates multiple aspects and points of view connected to this important and evolving topic. This externally commissioned publication was written in response to a 2021 report by the AMA Council on Medical Education. The AMA Council on Medical Education report included a directive to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce and ameliorating inequitable outcomes among minoritized and marginalized patient populations. The book was published in November 2024 after an extensive process of selecting an editorial panel and facilitating dialogs on developing a common vision for the book. The book envisions medical education's many concrete and potential contributions to social justice and racial equity. The AMA contracted with the Social Mission Alliance to review the book and identify their recommendations of which parts of the book may be most important and feasible to enact quickly. A report with those recommendations was submitted in October 2024 and it will be used with other analyses to help build a strategy on enacting recommendations from the book.

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 2024:

- Presented the restorative justice framework and community engagement plan for conversation at the Association of American Indian Physician's 52nd Annual Meeting and Health Conference, entitled "A Pathway and Journey Toward Truth and Reconciliation;" at the GLMA Health Professionals Advancing LGBTQ+ Equity (GLMA) 42nd Annual Conference on LGBTQ+ Health in a Lunch Plenary and Discussion on Restorative Justice and Representation; and at the GLMA Workshop, "Restorative Justice in Medicine Workshop."

- A cross-enterprise, cross-functional staff team has been supporting the Truth, Reconciliation, Healing and Transformation (TRHT) Task Force that was established by HOD policy.
    - Facilitated, supported and worked closely with two TRHT Task Force sub-groups (Writing and Narrative), including creation of recommendations and guidance to plan collection of testimonies from physicians, advocates and patient populations on historical harms in medicine, and implementation of the plan to collect physician narratives for the report to the Board.
    - Planned and implemented educational opportunities for TRHT task force members, staff, and minoritized physician groups including three asynchronous learnings in October on the History of Medical Harms in the Asian and Pacific Islander American community (Winston Wong, MD, MS), The AMA and Harms Arising from Exclusionary Training (Harriet Washington, MA) and Research on Race and Health in the US: Some Historical Background (David R. Williams, PhD, MPH, MA).
    - Planned and supported the TRHT Task Force Meeting with two panel presentations: (1) The Legacy of Medical Experimentation and Maternal Health featuring Michelle Browder and Lee Sharma, MD and (2) Developing Responsive Policies and Practices to Maternal and Reproductive Health Inequities in the Region featuring Tom Ellison, MD, PhD; Natalie Hernandez, PhD, MPH; and Yolanda Lawson, MD.
- The AMA partnered with the Institutional Antiracism and Accountability (IARA) Project, funded by a Robert Wood Johnson Foundation grant, subgranted by the AMA Foundation. IARA's Truth, Reconciliation, Healing, and Transformation Archival Research Project is using their specially granted access to AMA archival materials to examine the historical roots of health inequities in the U.S. and will use this work to inform actionable strategies for advancing health equity.
- The AMA continues its work of revising the AMA Guides to the Evaluation of Permanent Impairment, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine. Specifically, a race-neutral approach to pulmonary function test interpretation algorithms is being implemented by reporting and interpreting results using average reference equations rather than using race-based calculations.
- The AMA and Association of American Medical Colleges (AAMC) were invited by one of the partners of The REParations and Anti-Institutional Racism (REPAIR) Project to co-sponsor an event for May 2024 on their campus. The REPAIR Project is a three-year initiative designed to address anti-racism and better incorporate structural competency in science and medicine. The project recognizes that long-standing racial inequities in health, health care institutions and scholarship are a result of systemic race-based violence and racism in society as a whole and seeks to open conversation and promote efforts to rectify and eliminate these problems. It also recognizes the need to support a strategy of maximizing the effect of the Liaison Committee on Medical Education standard on structural competency to accelerate health equity.

Challenges & Opportunities

Across the AMA, several challenges have been identified in advancing health equity goals. Time constraints and the lack of prioritization for equity-focused projects amid competing demands remain significant hurdles. Smaller teams struggle to allocate time for participation in events and for equity action team meetings. Additionally, some BUs report limited access to subject matter experts, further complicating efforts to develop equitable internal strategies.

A recurring challenge is ensuring leadership elevates marginalized perspectives, staff, collaborators, contractors, and patients and communities most impacted by inequities. The same individuals have often

been driving equity initiatives for years, leading to fatigue within equity action teams. Equity-related work often takes a backseat to other organizational priorities, leaving staff feeling overwhelmed by the magnitude of inequities and the limited time to address them. There is difficulty in embedding equity into team practices in places where direct leadership support and involvement is less robust.

The cross-enterprise antiracist results-based accountability training course has provided an opportunity for equity champions and leadership to identify opportunities and strategies to embed equitable principles throughout AMA systems and structures. However, there remain varying levels of understanding of root causes of inequities and confidence in applying equity strategies among staff and varying degrees of commitment to integrating equitable approaches (e.g., data transparency, inclusive decision-making) among leadership.

CONCLUSION

This report highlights only a portion of the work accomplished and lessons learned in 2024. AMA staff have devoted countless hours to learning how they can collaborate in advancing health equity and applying those insights within and beyond the organization. The AMA remains committed to driving progress toward health equity and embedding racial and social justice, making meaningful progress toward fulfilling the commitments outlined in both iterations of the Strategic Plan.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-25

Subject: AMA Efforts on Medicare Payment Reform

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

At the 2023 American Medical Association (AMA) Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-385.945, "Advocacy and Action for a Sustainable Medical Care System" and amended Policy D-390.922, "Physician Payment Reform and Equity." Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until a predictable, sustainable, fair physician payment system is achieved. The Board has prepared the following report to provide an update on AMA activities for the year to date. (Note: This report was prepared in March based on approval deadlines, so more recent developments may not be reflected in it.)

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA's Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the "Characteristics of a Rational Medicare Payment System" that was endorsed by 124 state medical associations and national medical specialty societies. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System; and
- Greater opportunities for physician practices wanting to transition to advanced alternative payment models (APMs).

At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy; regulatory advocacy; federation engagement; and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus

within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

The AMA shares its members' deep frustration over the persistent cuts to Medicare payments. While Congress mitigated approximately half of the 2024 Medicare physician payment cuts that were initially implemented in January 2024, physicians continue to sound the alarm about how two decades of annual cuts are jeopardizing practice viability and limiting patient access to care. Unfortunately, the final 2025 Physician Payment Rule imposed an additional 2.83 percent cut.

An early draft of a year-end legislative package in December included a proposal to address 2.5 percent of the scheduled cut. However, this proposal collapsed under political pressure, and the scaled-down spending package that ultimately passed failed to address the payment cuts. As a result, physicians are now facing Medicare cuts for the fifth consecutive year, which went into effect on January 1, 2025. Meanwhile, CMS projects that the MEI will increase by 3.5 percent in 2025, further widening the gap between what Medicare pays physicians and the actual cost of delivering quality patient care.

The financial stability of physician practices and the long-term sustainability of the nation's entire health care system are at serious risk. Medicare physician payment rates have effectively plummeted 33 percent from 2001 to 2025 when adjusted for inflation in practice costs. Addressing this widening gap is essential to ensure physicians can continue providing high-quality care to Medicare patients.

Fixing our unsustainable Medicare payment system will remain an urgent advocacy and legislative priority for our AMA until meaningful reform is achieved. The need to stop the annual cycle of pay cuts and patches and enact permanent Medicare payment reforms could not be clearer. Because of Congress' failure to reverse these cuts, millions of seniors will find it more difficult to access high quality care and physicians will find it more difficult to accept new Medicare patients. The impact of sustained, year-over-year Medicare payment cuts will become noticeable first in rural and underserved areas and with small, independent physician practices which will be highly detrimental for some of our nation's most vulnerable patients.

As a result of the continued advocacy efforts of the AMA and larger physician community and direct engagement with Congress, a collection of influential Dear Colleague letters were circulated and commonsense legislation introduced to address the broken Medicare physician payment system and build upon "Characteristics of a Rational Medicare Physician Payment System" including:

Medicare Reform: Automatic Annual Inflation-based Updates

- The AMA and our Federation partners continue to advocate for an inflation update to Medicare payments, on top of reversing the new round of 2.83 percent cuts that began on January 1.
- The 118th Congress took an important first step toward Medicare reform with the introduction of H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," a bill that would provide automatic, annual payment updates to account for practice cost inflation as reflected in the MEI. We will advocate for the introduction of similar legislation in 2025.

- Tying annual payment updates to the MEI has long been supported by the AMA to promote the financial viability of physician practices and place physicians on equal ground with other health care providers. Federation groups have joined forces in seeking bipartisan cosponsors for this legislation and to educate Congress on why it is needed.

Medicare Payment Reform: Budget Neutrality

- A bill that was strongly supported by the AMA was introduced in the House last year by the co-chairs of the GOP Doctors Caucus (H.R. 6371), based on AMA recommendations, that would reform the budget neutrality policies that have been producing across-the-board payment cuts. The bill would have:
  - Required CMS to review actual claims data and correct flawed utilization projections that cause inappropriate conversation factor cuts or increases; and
  - Raised the spending threshold that triggers a budget neutrality adjustment from $20 million to $53 million.
- The AMA is advocating for the introduction of similar legislation in 2025.

Medicare Payment Reform: Revising the Medicare Merit-based Incentive Payment System (MIPS)

- Together with Federation groups, the AMA has developed legislative language to improve the MIPS program. The AMA draft would:
  - Address steep penalties that are distributed unevenly and disproportionately impact small, rural, and independent practices;
  - Hold CMS accountable for providing physicians with timely and actionable data; and
  - Reform MIPS so that it is more clinically relevant and less burdensome.
- We will work to advance these MIPS reforms with the new Administration and Congress.

Summary of Recent AMA Advocacy Efforts at the end of the 118th Congress and beginning of the 119th

- On September 10, the AMA joined more than 120 organizations representing more than one million health care providers and their patients in a sign-on letter calling on Congress to take action to address the unsustainable Medicare physician payment system. The letter specifically mentioned three pieces of bipartisan legislation that were introduced in the 118th Congress to address systemic flaws to the Medicare physician payment system, all of which the AMA has advocated in support of:
  - The Strengthening Medicare for Patients and Providers Act (H.R. 2474) which would enact an annual, permanent inflationary payment update in Medicare that is tied to the MEI;
  - The Physician Fee Stabilization Act (S. 4935), which would increase the budget neutrality threshold under the Medicare physician Fee Schedule and provide regular indexing to the MEI; and
  - The Provider Reimbursement Stability Act (H.R. 6371), which would build upon the provisions in S. 4935 through its inclusion of additional key components to reform budget neutrality laws.

- In October, Representatives Mariannette Miller-Meeks, MD (R-IA) and Jimmy Panetta (D-CA), along with 233 bipartisan members of Congress sent a “Dear Colleague” letter urging House leadership to take immediate action to not only stop the 2.8 percent cut, but also provide

physicians with a much-needed payment update that reflects the inflationary pressure they are facing running a medical practice.

- As a direct result of AMA advocacy efforts, Reps. Greg Murphy (R-NC), and Jimmy Panetta, (D-CA) introduced in October, H.R. 10073, the "Medicare Patient Access and Practice Stabilization Act of 2024" to eliminate the 2.83 percent Medicare cuts and provide physicians with a 1.8 percent payment increase.

- On November 15, an AMA-led letter co-signed by 128 national medical societies and state medical associations was sent in support of Congress expeditiously passing H.R. 10073 before January 1, 2025.

- On November 21, a bipartisan, Senate "Dear Colleague" letter led by Sens. John Boozman, (R-AR) and Peter Welch, (D-VT) with 41 signors was sent to Senate leadership warning the cuts would interfere with the ability of physicians to provide high-quality care supporting efforts to prevent a pending 2.8 percent cut in Medicare physician payments that went into effect on January 1.

- As a result of AMA advocacy efforts, Reps. Greg Murphy, MD (R-NC) and Jimmy Panetta (D-CA), along with a bipartisan group of legislators, introduced in January the Medicare Patient Access and Practice Stabilization Act of 2025 (H.R. 879). This legislation, with more than 120 co-sponsors, would prospectively cancel the 2.83 percent payment cut that went into effect on January 1, while also providing a 2.0 percent payment update, helping to stabilize physician practices and protect patients' access to care.

- In February, an AMA-led sign-on letter was sent to Congressional leadership with 80 medical specialty societies and all 50 state medical societies urging Congress to reverse the 2.83 percent Medicare payment cuts and provide physicians with a meaningful payment increase that reflects ongoing inflationary pressures and to pass H.R. 879, the Medicare Patient Access and Practice Stabilization Act.

- In March, the AMA signed onto a letter with several other physician groups to Congressional leadership calling on Congress to include H.R. 879 in the March continuing resolution appropriations legislation. Unfortunately, H.R. 879 or provisions reversing the 2.83 Medicare cuts were not included in the March appropriations legislation.

Physician Call to Take Action

The AMA will continue to work with Congress to build bipartisan support for a proposal that will put an end to the annual cycle of Medicare cuts that threaten seniors' access to care. Bipartisan support for the aforementioned legislative proposals continues to grow among rank-and-file Members of Congress. However, the need for further advocacy remains to push the relevant Committees and Congressional leadership to make Medicare physician payment reform a top priority.

AMA National Advocacy Conference - February 2025, Washington, DC

The Advocacy team successfully hosted several members of Congress during the AMA National Advocacy Conference (NAC) at the "Fix Medicare Now" Kick Off event, held at the Cannon House Office Building. Notable attendees included Reps. Greg Murphy, MD (R-NC), Jimmy Panetta,

(D-CA), Kimberly Schrier, MD (D-WA), Mariannette Miller-Meeks, MD (R-IA), John Joyce, MD (R-PA), Raul Ruiz, MD (D-CA), Ami Bera, MD (D-CA), and Mike Kennedy, MD (R-UT). These legislators addressed the physician attendees and voiced their support for H.R. 879, emphasizing the urgent need to reverse Medicare payment cuts to protect patient access to care and stabilize physician practices.

The "Fix Medicare Now" Kick Off event was a powerful visual statement of physician unity against the payment cuts, with hundreds of physicians dressed in white coats rallying together. Physicians participated in over 350 visits with House members and senators, urging them to support H.R. 879 and introduce companion legislation in the Senate.

Additionally, physicians at the NAC were equipped with an AMA action kit that focused solely on Medicare physician payment, including compelling facts and figures demonstrating the adverse effects of the Medicare payment cuts, including the statistic that physicians are now being paid 33 percent less for Medicare services (adjusted for inflation) than they were in 2001.

The AMA also took out a full-page advertisement in The Hill, advocating for passage of H.R. 879. The ad included a QR code directing viewers to more information about the legislation.

The AMA NAC further featured presentations by several congressional members at the Grand Hyatt, including Herb Conaway, MD (D-NJ), Robert Onder, MD (R-MO), Raja Krishnamoorthi, (D-IL), Maxine Dexter, MD (D-OR), Kelly Morrison, MD (D-MN), Diana DeGette, (D-CO), and Rich McCormick, MD (R-GA). All these Members expressed the need to stop the Medicare cuts and to reform the payment system.

Our AMA President opened the conference by highlighting the unsustainable financial pressures physicians face and the urgent need to fix the broken Medicare payment system.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network, Patients Advocacy Network, and its Very Influential Physicians program. Op-eds have been placed in various publications from AMA leaders, as well as from "grasstops" contacts in local newspapers. Digital advertisements are running, targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments.

The AMA has a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics and a new "Medicare basics" series of papers describing in plain language specific challenges presented by current Medicare payment policies and recommendations for reform.

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following 2025 statistics result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 50+ million in earned media and ad impressions,
- 2 million+ media and ad engagements,
- 292,000+ pageviews,

- 276,000+ site users,
- 52,000+ contacts to Congress, and
- A combined 150+ third-party media placements and grass top contacts made in key Congressional districts.

Continuing Advocacy Amidst Legislative Challenges

We do not expect quick action in Congress in the near term to advance legislation to reform the Medicare physician payment system and include permanent MEI payment updates given its potential to cost more than $300 billion over a 10-year period. The Republican majority in the House and Senate is currently focused primarily on adopting a final budget resolution that would allow for "reconciliation" legislation to extend expiring tax cuts and significantly reduce federal spending while bypassing Senate filibuster rules. Achieving consensus on tax, spending, and budgetary matters has always been very challenging in Congress.

Despite these hurdles, the AMA advocacy team has made substantial progress in laying the groundwork for Medicare physician payment reform. This report has highlighted the team's efforts, including:

- Aggressively advocating to replace the 2.83 percent Medicare physician payment cut that took effect on January 1, 2025, with a payment update that better reflects practice costs;
- Pushing for reforms to the budget neutrality process, the MIPS program, and modifications to APMs;
- Strengthening coalitions by partnering with allied professions and the patient community, both of whom are negatively impacted by the broken Medicare payment system;
- Organizing grassroots efforts and ensuring continuous physician engagement through initiatives like the Physicians Grassroots Network; and
- Equipping physicians with advocacy tools and resources to effectively communicate their concerns and solutions to lawmakers.

The journey toward comprehensive Medicare physician payment reform will not be easy, but the AMA remains unwavering in its commitment to this cause. By building on each incremental reform, the AMA is establishing a strong foundation for eventual success.

As physicians across the country continue to share their stories and advocate for reform, there is hope that our united efforts will eventually break through the political and financial barriers that have hindered progress. The AMA will continue to fight tirelessly until a sustainable, fair, and effective Medicare physician payment system is achieved.

CONCLUSION

The AMA will continue to engage the federation and press Congress to develop long-term solutions to the systematic problems with the Medicare physician payment system and preserve patient access to quality care. Despite the aforementioned challenges, the continued engagement of the physician community is crucial. It is vital to continue advocating for reform, engaging with legislators, and highlighting the real-world impacts of the current, broken system on patient care and physician practices. Please follow Advocacy Update, join the Physicians Grassroots Network, visit www.FixMedicareNow often for updated material and alerts, and follow other AMA communications vehicles to stay up to date and engaged on this topic.

REPORT 12 OF THE BOARD OF TRUSTEES (A-25)
Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," instructs the AMA to establish a task force to, "help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources." AMA Policy D-605.982 entitled, "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance," requires the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (Task Force) provide an annual report to the House of Delegates (HOD) at each Annual Meeting. Accordingly, this report highlights the Task Force's activities to date.

In 2024, the Task Force was formed by the AMA Board of Trustees and began work to carry out the directives adopted by the HOD. There are 29 physician members serving on the Task Force, 11 representing national medical specialty societies, 10 representing AMA Councils, seven representing state medical associations, and one representing the AMA Board of Trustees. Staff from the respective medical associations are also invited to support their assigned physician members in Task Force activities.

To date (the date of this writing), the Task Force held virtual meetings in May 2024, December 2024, and January 2025; in-person meetings in July 2024 and February 2025; and an informational session at the 2024 AMA Interim Meeting. The discussions at these meetings have generated ideas for numerous projects, including a web-based resource hub, research and resources on workforce impact, messaging and strategy research, and the development of state law guides.

The July in-person meeting examined legal issues related to abortion care, including abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act, and shield law protections for abortion care providers. Task Force members discussed each issue and raised items for further action. In accordance with policy and in preparation for a new website that will serve as a resource hub for physicians and others navigating abortion restrictions, the Task Force also reviewed implementation-focused practice and advocacy resources on a range of issues, such as, health disparities, practice management, medical education, privacy, and legal issues, as well as identified resource gaps and options to fill the gaps.

In accordance with the amendment to Policy G-605.009 adopted at the 2023 Interim Meeting, the Task Force formed a subcommittee to focus on payment issues in gender-affirming care for adults and held an in-person meeting in February 2025 focused on these issues. Presentations and discussions covered the legislative and litigation landscape, coding issues, Medicaid, and insurance regulations all pertaining to gender-affirming care for adults and raised solutions to address barriers to care.

The Task Force will host informational sessions at the 2025 Annual and Interim Meetings of the HOD, and in-person meetings in July 2025 and February 2026 to discuss the impact of abortion restrictions on education, training, and workforce and the intersection of abortion care, health equity, and public health, respectively. Virtual calls will be scheduled as needed.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-25

Subject: Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

This report provides an update on the activities of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (Task Force) in accordance with Policies G-605.009, D-5.998, and D-605.982. (Note: Because of approval deadlines, this report was prepared in February and may not include more recent developments.)

BACKGROUND

American Medical Association (AMA) Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," was adopted at the 2022 Annual Meeting of the AMA House of Delegates (HOD). Policy G-605.009 instructs that:

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Adopted during the AMA 2022 Interim Meeting, Policy D-5.998, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," added a requirement for an annual report of the Task Force. Policy D-5.998(1) instructs that:

1. Our AMA Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.

At the AMA 2023 Interim Meeting, the HOD amended Policy G-605.009, adding the creation of an ad hoc committee on payment and reimbursement issues in gender affirming care to the Task Force's directives. Specifically, the amendment instructs that:

1. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

At the AMA 2024 Interim Meeting, the HOD amended Policy G-605.009, adding that the Task Force:

h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.

Also at the AMA 2024 Interim Meeting, the HOD adopted Policy D-605.982, "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance," which states:

1. Our American Medical Association's Task Force, to Preserve the Patient-Physician Relationship, will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed.

DISCUSSION OF TASK FORCE ACTIVITIES

Task Force Formation

As directed by the HOD and in response to the U.S. Supreme Court's landmark 2022 decision in *Dobbs v. Jackson Women's Health Organization*, which held that the U.S. Constitution does not

confer a constitutional right to abortion and returned the authority to regulate abortion to the states and the subsequent enactment of abortion bans in half the states, the AMA Board of Trustees' (Board) formed the Task Force in June of 2023. With the formation of the Task Force and consistent with AMA Policies G-605.009 and D-5.998, as noted above, the Board envisioned that the Task Force would advise the Board of new and emerging threats to the provision of evidenced-based medical care and appropriate and innovative responses to protect access to care and to preserve the role of the patient-physician relationship as a central element in medical decision-making.

In accordance with the specific language of AMA Policies G-605.009 and D-5.998, in September 2023, the Chairs of the Councils on Legislation, Medical Service, Medical Education, Science and Public Health, and Ethics and Judicial Affairs each appointed two Council members to serve on the Task Force. As a result, 10 Council representatives serve on the Task Force. The Immediate Past Chair of the Board, Willie Underwood III, MD, MSc, MPH, appointed Madelyn E. Butler, MD, AMA Trustee, and Maryanne C. Bombaugh, MD, MBA, MSc, member of the Executive Committee for the AMA Council on Legislation, to serve as Co-Chairs of the Task Force.

In addition, and in accordance with the underlying policy, in the spring of 2024, AMA invited 10 state medical associations and 13 national medical specialty societies to appoint a physician representative to serve on the Task Force. The organizations were selected based on their expertise, experience, and response to an AMA survey fielded in November 2022 (which was described in detail in the 2023 report of the Task Force) that asked about priorities and capacity to engage on the issues identified in AMA Policy G-605.009.

Seven state medical associations and 11 national medical specialty societies nominated a physician representative to serve on the Task Force. The participating national medical specialty societies include:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Emergency Physicians
- American College of Obstetricians & Gynecologists
- American College of Physicians
- American Psychiatric Association
- American Society for Reproductive Medicine
- American Society of Clinical Oncology
- The Endocrine Society

The participating state medical associations include:

- California Medical Association
- Idaho Medical Association
- The Maryland State Medical Society (MedChi)
- Massachusetts Medical Society
- Pennsylvania Medical Society
- Texas Medical Association
- Medical Society of Virginia

In total, there are 29 physician members on the Task Force.

Task Force Meetings

As the Task Force formed, staff across the AMA conducted environmental scans and gaps analyses of the issues identified in Policy G-605.009. These landscape analyses identify implementation-focused practice and advocacy resources on issues including health equity, practice management, medical education, privacy, and legal issues and identify potential resource gaps. The landscape analyses were presented to Council representatives monthly, beginning in January of 2024 and concluding in May of 2024. The landscape analyses were used (and will continue to be used) to identify key topics of discussion for meetings of the Task Force and were distributed to all Task Force members prior to the first in-person meeting of the Task Force.

Since its inception in spring of 2024, the Task Force has held three virtual meetings, two in-person meetings, and one informational session. The virtual meetings were held in May 2024, December 2024, and January 2025. In-person meetings were held in July 2024 and February 2025. The informational session was held at the AMA 2024 Interim Meeting of the HOD in November 2024.

The Task Force held a virtual kick-off meeting on May 2024, in which the Task Force Co-Chairs laid out the Task Force's scope, deliverables, and calendar for upcoming meetings. In December 2024, the Task Force held a meeting to discuss the remarks given at the informational session at the 2024 Interim Meeting of the HOD and discuss ongoing Task Force projects. Then in January 2025, the Task Force met to review research conducted into strategy and messaging. (Note: Additional details about the research discussed in the January meeting is provided later in this report.) The Task Force will continue to schedule virtual meetings as necessary.

The Task Force held its first in-person meeting in July 2024 in Chicago. The in-person meeting focused on legal issues in abortion care and featured a range of speakers and presenters on topics all relating to legal issues in abortion care including, abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act (EMTALA), and shield law protections for abortion care providers. Following each presentation, Task Force members asked questions and discussed issues and concerns. During a working lunch, Task Force members were asked to strategize and identify resource gaps and potential deliverables for the Task Force regarding advocacy, health equity, medical education and workforce, legal issues, practice issues, and public health. The exercise generated numerous ideas for action. At the conclusion of the day, as directed by the Board and in accordance with Policies G-605.009 and D-5.998, which instruct the Task Force to identify and create implementation-focused practice and advocacy resources, the Task Force discussed existing resources and limitations of those resources, and identified gaps where resources need to be developed.

Following its July meeting, the Task Force hosted an informational session at the AMA's 2024 Interim Meeting to engage with AMA Delegates, Alternate Delegates, and representatives from the AMA Sections. This session was an opportunity to elevate important voices that are not members of the Task Force. At the session, the Task Force co-chairs presented on the Task Force's directives, scope, and activities in 2024. Following the presentation, selected representatives from the AMA's Sections were invited to provide remarks about their experience with laws restricting or banning reproductive health care. The representatives' remarks focused on state laws' impacts on patient care, career and family decisions, educational opportunities, fears for patient outcomes, and, overall, increased physician stress and anxiety. The selected speakers from the AMA Sections represented:

- Women Physicians Section
- Medical Student Section

- Resident and Fellow Section
- Young Physicians Section
- Minority Affairs Section
- LGBTQ+ Section
- Private Practice Physician Section
- Organized Medicine Staff Section
- Academic Physicians Section
- International Medical Graduates Section
- Senior Physician Section

After the representatives from AMA's Sections spoke, other interested parties were invited to ask questions or provide remarks on issues being considered by the Task Force that had not been addressed by previous speakers. These speakers focused their remarks on requests for more communication about the Task Force's work and opportunities for future engagement with the Task Force. To foster continued communication with AMA Delegates, Alternate Delegates, representatives from AMA Sections, and other interested parties, the Task Force plans to host informational sessions at the 2025 Annual and Interim Meetings of the HOD. The Board encourages all interested members to participate in the informational sessions in June and November. In addition to the informational sessions, AMA staff expect to conduct outreach with Sections and specialty groups in the lead up to the HOD meetings and will meet with them at their request.

In accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim Meeting, in summer of 2024 the Task Force formed a subcommittee to focus on payment and reimbursement issues in gender-affirming care for adults. Members of the subcommittee represent the following nine organizations:

- AMA Board of Trustees
- AMA Council on Legislation
- AMA Council on Ethical and Judicial Affairs
- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Psychiatric Association
- American Society for Reproductive Medicine
- The Endocrine Society
- Idaho Medical Association

AMA staff conducted a landscape analysis on payment and reimbursement issues that hinder access to gender-affirming care in adults, which, like the landscape analyses on abortion, identified existing resources and gaps in those resources and helped inform discussion during in-person meetings. The subcommittee met in August 2024 to identify issues in payment and reimbursement for gender-affirming care in adults and plan the topics, structure, and agenda for the Task Force's meeting in February 2025 dedicated to these issues.

One of the issues identified by the subcommittee was challenges arising from CPT® coding for gender-affirming care in adults. As such, the subcommittee collaborated with the LGBTQ+ Section to field a survey to better understand these coding challenges. The input from this survey aided the Task Force's discussion of coding issues during its February 2025 meeting.

As directed by AMA Policy, the Task Force met in February of 2025 in Chicago to "identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to

address these barriers to care." The meeting featured a range of speakers on topics all involving payment and reimbursement limitations and administrative challenges that impede access to gender-affirming care for adults, including challenges stemming from outdated or inadequate billing codes, inadequate provider networks, low reimbursement rates, discriminatory laws and policies, and state and federal efforts restrict or criminalize access to gender-affirming care. Speakers included physicians who provide gender-affirming care to adult patients, attorneys, coding experts, a state insurance regulator, and a Medicaid expert. The meeting was structured to allow ample time after each presentation for Task Force members to ask questions of the presenters and discuss barriers to care with one another. These discussions focused on the current landscape and highlighted potential pain points for physicians and patients. Much of the discussion also centered around recent federal executive orders to prohibit federal funding of services for minors and the impact those policies could have on care for other populations. In the last session of the meeting, as directed by the Board and consistent with Policy G-605.009, which instructs the Task Force to recommend solutions to these barriers to care, the Task Force members discussed opportunities and strategies for improving access to care and alleviating administrative burden, including working towards updating CPT® codes, continuing to advocate against criminalization, and supporting physicians who care for transgender and gender diverse patients. This discussion was informed by Task Force member's perspectives as clinicians, the speaker's presentations, and discussions throughout the meeting. Work related to the payment and coding issues raised in this meeting and by the Task Force subcommittee, as it relates to the adult patient population, is ongoing.

Ongoing Projects of the Task Force

As a result of reproductive care resource gaps identified by the Task Force during its July 2024 meeting, AMA, at the direction of the Board, has undertaken a series of projects to fill those gaps, including the development of a resource hub, strategy and message development, research and resources on workforce impact, and development of state law guides.

First, AMA is developing a website to serve as a resource hub for physicians navigating abortion restrictions. The website will exist separately from the AMA's website and will be available to the public. The website will house resources created and developed by the Task Force, as well as resources created and provided by Federation partners and other external organizations. At this time, AMA staff has secured the funding for the website's creation and contracted with a vendor, and creation of the website is in process. The Task Force will inform the HOD when the website is available later this year.

Second, to further refine AMA's advocacy strategy and messaging around abortion restrictions, AMA staff collaborated with a research consulting firm to conduct qualitative research using surveys, in-depth interviews, and focus groups. The research helped explain how different messages, language, and tone resonate across key constituent audiences and build a more compelling narrative for reproductive health advocacy grounded in a strategic messaging foundation. The research provided insight for Task Force members and their organizations on physicians' and the public's perception of the current reproductive health care landscape and will inform strategy for the Task Force going forward. The Task Force met in January 2025 to review the research findings and discuss their implication for Task Force messaging strategy.

To better understand how abortion bans and restrictions impact the physician workforce, AMA staff has initiated a research project examining the impact of abortion restrictions on the physician workforce and where physicians choose to practice. The research and mapping project is scheduled to be completed in spring 2025.

Because of the Task Force's discussions surrounding the need for legal resources for physicians, the AMA has supported the Abortion Defense Network (ADN) and their network of attorneys and law firms that provide legal advice and representation to physicians navigating the post-*Roe* legal landscape. Their resources include 16 in-depth "Know Your State's Abortion Laws" guides for medical professionals, which aim to provide clarification on what conduct is permitted and what the law requires in states with abortion restrictions. The guides cover state laws and professional guidelines on numerous facets of reproductive health care, including medication abortion, contraception, and obligations under EMTALA. In addition to their written legal resources, ADN provides physicians with personalized legal advice and assistance through their hotline. All of these resources are available to physicians and other health care providers at www.abortiondefensenetwork.org, and the AMA is exploring opportunities to support creation of additional ADN resources and further publicize existing resources.

Prompted by the discussions at the Task Force's February meeting, AMA staff is exploring potential next steps related to payment and reimbursement in gender-affirming care in adults, including reviewing and updating existing resources, following up on coding issues, continuing collaboration with state medical associations where appropriate, and supporting physician wellness for physicians navigating challenges in providing gender-affirming care. (Note: Because of approval deadlines, this report was prepared in February 2025 and may not include more recent developments about the Task Force's activities. The Board urges all interested members to participate in the informational session at the 2025 Annual Meeting.)

In addition to these activities, due to the timeliness and prioritization of the issues, the AMA State Advocacy Summit held in January 2025 included a panel of leading staff from state attorneys general offices across the country to highlight ongoing work to protect and promote reproductive health care. The panelists discussed shield laws, programs to link physicians with legal support, and ways state attorneys general can work directly with health care professionals to resolve complaints and mitigate barriers to care. The AMA State Advocacy Summit is held annually to elevate state legislative and regulatory issues and strategies in advance of the upcoming state legislative sessions. Attendees include physician leadership from the AMA, national, state, and specialty medical associations, including the members of the Board, Council members, delegates, and alternate delegates to the HOD, as well executive, health policy, and government affairs staff from organized medicine.

The Task Force continues to consider additional deliverables to support physicians navigating state laws restricting or banning abortion and experiencing challenges related to payment and reimbursement for gender-affirming care. In particular, in accordance with AMA policy passed at the 2024 Interim Meeting, AMA is continuing to meet and collaborate with American College of Obstetricians and Gynecologists on a project to facilitate institutional guidance in states with abortion restrictions. The Task Force is also receiving quarterly updates on litigation activity from the AMA Office of the General Counsel. Additionally, throughout the Spring of 2025, the co-chairs of the Task Force have reached out to and are meeting with various AMA Sections in an effort to continue dialogue, hear concerns, and take back recommendations to the larger Task Force.

Upcoming Meetings of the Task Force

The Task Force will host an informational session at the AMA 2025 Annual Meeting to continue to engage AMA Delegates, Alternate Delegates, and representatives from AMA Sections. This session is an opportunity to elevate important voices that are not members of the Task Force. Attendees of the informational session will hear about the activities of the Task Force and are

invited to share their perspective on the issues being considered by the Task Force. The Board encourages all interested members to participate in this informational session.

The Task Force will also host an in-person meeting in July 2025 to discuss the impact of abortion restrictions on education, training, and workforce; an informational session at the 2025 Interim Meeting of the HOD; and an in-person meeting in February 2026 to discuss the intersection of abortion care, health equity, and public health.

CONCLUSION

The Board, through the Task Force, will continue to implement Policies G-605.009 and D-5.998, monitor and prepare for new and emerging threats to the provision of evidenced-based medical care, and work to protect access to care and preserve the role of the patient-physician relationship as a central element in medical decision-making.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-25

Subject: Physician Assistants and Nurse Practitioner Movement Between Specialties

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

INTRODUCTION

At the 2024 Annual Meeting, Board of Trustees Report 14 was adopted as amended creating Policy H-35.960, "Physician Assistant and Nurse Practitioner Movement Between Specialties" and the remainder of the report was filed.

1. Our American Medical Association encourages hospitals and other health care entities employing nurse practitioners and physician assistants to ensure that the practitioner's certification aligns with the specialty in which they will practice.
2. Our AMA will continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching.
3. Our AMA will continue to support research into the cost and quality of primary care delivered by nurse practitioners and physician assistants.
4. Our AMA will continue to support research into the distribution and impact of nurse practitioners and physician assistants on primary care in underserved areas.
5. Our AMA will continue to support the expansion of access to physicians in under-resourced areas.

Two additional recommendations from this report were referred for further study:

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)

This Board of Trustees Informational Report summarizes data on this topic to date and discusses our AMA's ongoing research to fill the remaining gaps in the data. This research will inform our AMA's next steps and will also address the referred items as more information is obtained.

BACKGROUND

Existing data from the American Association of Nurse Practitioners (AANP), American Association of Physician Assistants (AAPA), and National Commission on Certification of

Physician Assistants (NCCPA) provide insight into which specialties nurse practitioners and physician assistants are practicing, as well as nurse practitioner and physician assistant certifications, including optional specialty certifications. The AAPA and NCCPA data also provide details on specialty switching by physician assistants.

Nurse Practitioners

The AANP, the largest professional organization and leading advocate for nurse practitioners, conducts an annual workforce survey of nurse practitioners practicing in the United States. Per AANP, 385,000 nurse practitioners are currently licensed in the United States. The AANP nurse practitioner workforce survey was sent to all AANP members and nonmembers in the AANP National NP database, excluding individuals without a valid email address, individuals not currently practicing in the United States, and individuals who opted out of receiving AANP surveys. The final sampling group for the information published in the *2024 Nurse Practitioner Practice Report (Practice Report)* and included in this report represents a sample of 10,275 nurse practitioners. The *Practice Report* includes relevant information on the top clinical areas of focus in which nurse practitioners practice, nurse practitioner certification, and optional specialty certifications that are held by nurse practitioners.

The *Practice Report* shares the top 10 clinical areas in which nurse practitioners practice. These clinical focus areas presumably align with the specialty in which the individual is practicing; however, the type of setting in which the nurse practitioner practices may vary. Based on this information, 36.8 percent of nurse practitioners are practicing in a primary care specialty, which the *Practice Report* defines as family practice, primary care, internal medicine, geriatrics, and OBGYN women's health.

Table 1. Top 10 clinical focus areas[1]	(percent)
Family practice	16.9
Primary care	9.4
Psychiatry/mental health	5.9
Urgent care	5.8
Cardiology	4.2
Internal medicine	4.2
Geriatrics	3.3
OBGYN women's health	3.0
Oncology/hematology	2.7
Pediatrics/general	2.6

The *Practice Report* also provides information on nurse practitioners by population certification area; the certification obtained following graduation and typically required for state licensure as a nurse practitioner. Population certifications may be obtained from a variety of certifying bodies, such as the American Academy of Nurse Practitioner Certification Board or the American Nurses Credentialing Center. Each certifying body offers their own certification and administers their own examination which are generally aligned with the population foci of the nurse practitioner's training. Certification is typically required for state licensure as a nurse practitioner. Most nurse practitioners are certified as Family Nurse Practitioners (FNP-C or FNP-BC). As some nurse practitioners hold multiple certifications the sum of all percentages in the table below is greater than 100 percent.

Table 2. Nurse Practitioners by population certification area[2]	(percent)
Family	68.7
Adult-gerontology primary care	7.9
Psychiatric/mental health	7.1
Adult	7.0
Adult-gerontology acute care	6.1
Acute care	3.9
Pediatric-primary care	2.9
Women's health	2.0
Gerontology	0.9
Neonatal	0.9
Pediatric-Acute Care	0.7
No certification	0.6

Finally, the *Practice Report* shares the percentage of nurse practitioners with additional specialty practice certifications. Nurse practitioners may pursue optional certification(s) in various specialties/subspecialties after initial certification in their role and population focus, as shown in the previous table. An array of certifying boards issue "specialty" certifications for nurse practitioners—typically these certifications are based on hours of practice experience in a specialty and passage of an exam. Customarily, the certifying boards are specific to nursing and specific to a single specialty. Of note, 92.8 percent of nurse practitioners obtain no optional specialty certification.

Table 3. Nurse practitioners with additional specialty practice certifications[3]	(percent)
Wound care	1.3
Hospice and palliative care	1.3
Emergency	1.1
Oncology	0.9
Diabetes management-advanced	0.7
Addictions advanced practice	0.7
Pediatric-primary care mental health	0.4
Occupational health	0.3
Dermatology	0.3
Orthopaedics	0.3
Nephrology	0.2
Genetics advanced nurse	0.1
School health	0.1
No advanced certifications	92.8

Physician Assistants

The NCCPA, which is the only certifying organization for physician assistants in the United States, conducts similar workforce surveys of physician assistants, including the *Statistical Profile of Board Certified Physician Assistants (General Report)*, and *Statistical Profile of Board Certified Physician Assistants by Specialty (Specialty Report)*.[4,5] The latest NCCPA reports are based on data collected from all physician assistants who are board certified as of December 31, 2023 and have made updates to their profile maintained by NCCPA. Of these physician assistants, 149,909 provided responses for at least a portion of their profile which informed the reports. These reports

provide data on physician assistants by their principal clinical specialty, relevant specialty certifications, as well as specialty switching.

The *Specialty Report* includes detailed data on the number of physician assistants practicing in 68 specialties. According to the *General Report*, 75.3 percent of physician assistants practice in one of the top 10 specialties, as follows:

Table 4. Physician Assistants by specialty[6]	Number (percent)
Family medicine/general practice	20,940 (16.5)
Other	14,208 (11.2)
Emergency medicine	13,727 (10.8)
Surgery – orthopaedic	13,534 (10.7)
Dermatology	5,449 (4.3)
Internal medicine/general practice	5,073 (4)
Hospital medicine (hospitalist)	4,548 (3.6)
Surgery – general	3,895 (3.1)
Internal medicine – cardiology	3,705 (2.9)
Surgery - cardiothoracic	3,056 (2.4)

The *General Report* analyzes changes in physician assistants' primary practice areas between 2019 and 2023. For example, the *General Report* shows that 18.7 percent of physician assistants practiced in a surgical specialty (e.g., orthopaedic surgery, cardiovascular surgery, and neurosurgery) in 2023.[7] This is the largest practice area for physician assistants and has remained the same since 2019. By contrast, the number of physician assistants practicing in family medicine/general practice has declined from 18.6 percent in 2019 to 16.5 percent in 2023. The number of physician assistants in emergency medicine has also declined slightly from 12.8 percent in 2019 to 10.8 percent in 2023.

The *Specialty Report* includes information on the percentage of board-certified physician assistants who completed a postgraduate program (fellowship or residency) in a specialty, including primary care. The five highest specialties in which physician assistants completed a postgraduate program are: critical care medicine (16.1 percent), emergency medicine (10.4 percent), dermatology (9.0 percent), cardiothoracic and vascular surgery (8.4 percent), and psychiatry (8.1 percent).[8] The *Specialty Report* also highlights the relationship between the postgraduate program and the specialty in which the physician assistant is currently practicing, as shown in the table below. The likelihood of physician assistants practicing in the same specialty in which they completed a postgraduate program varies considerably. For example, of the physician assistants who completed a postgraduate program in emergency medicine, 85.7 percent are currently practicing in emergency medicine, while only 11.1 percent of physician assistants who completed a post graduate program in gerontology are currently practicing in gerontology.[9]

Table 5[10]		
Physician Assistants postgraduate program by specialty practice area	Complete postgraduate program (residency or fellowship) (percent)	Practice area of postgraduate program same as current principal practice area (percent)
Primary care	3.3	47.6
Cardiology	2.9	27.4
Cardiothoracic and vascular surgery	8.4	33.7
Critical care medicine	16.1	69.9
Dermatology	9.0	84.1

Emergency medicine	10.4	85.7
Family medicine/general practice	3.4	44.7
Gastroenterology	2.8	33.3
General surgery	6.7	72.3
Geriatrics	2.9	11.1
Hospital medicine	5.0	65.9
Internal medicine-general practice	2.9	27.6
Neurology	3.7	54.0
Neurosurgery	4.3	27.0
Obstetrics and gynecology	4.1	73.0
Occupational medicine	5.9	21.3
Oncology	3.9	53.1
Orthopaedic surgery	5.0	68.5
Otolaryngology	4.3	40.7
Pain medicine	3.5	15.4
Pediatrics-general	2.9	47.7
Physical medicine/rehabilitation	1.8	23.1
Plastic surgery	6.6	13.0
Psychiatry	8.1	74.4
Urology	3.8	31.4

The *Specialty Report* also elucidates on specialty switching. As part of the data gathering by NCCPA, physician assistants were asked "how many times they changed specialties throughout their career thus far."[11] The rate of those who have not changed specialties varied from a high of 60.3 percent for physician assistants practicing in orthopaedic surgery to a low of 19.2 percent for those practicing in occupational medicine.[12] A separate report by AAPA, *PAs and Specialty Change*, provides some additional data on the preparation, motivation, and timing of specialty switching by physician assistants.[13] Per this report, 20 percent of physician assistants have changed their specialty at some point in their career.[14] Overall physician assistants with less than five years of experience were most likely to change specialties.[15] The report also found that physician assistants who switched specialties once were more likely to switch multiple times. In terms of preparation by physician assistants prior to switching specialties, 79.9 percent stated they prepared through on-the-job training while 77.3 percent identified self-study.[16] Finally, the report examined the type of support physician assistants receive after they have switched specialties, finding that 88 percent of physician assistants who have switched specialties in 2021 received onboarding support for six months or less.[17]

Table 6. Physician Assistants Specialty Switching[18]

Specialty	Have not changed specialties (percent)	1 time (percent)	2 to 3 times (percent)	4 to 5 times (percent)	6 to 10 times (percent)	Over 10 times (percent)
Primary care	54.0	19.4	20.0	5.1	1.4	0.1
Cardiology	46.3	26.4	22.2	4.0	1.1	<0.1
Cardiothoracic and vascular surgery	52.1	23.4	19.8	3.9	0.8	0.1
Critical care medicine	47.1	24.3	22.6	4.9	1.0	0.1
Dermatology	50.2	26.1	19.2	3.7	0.9	<0.1
Emergency medicine	52.9	22.6	19.6	3.9	1.0	0.1

Family medicine/general practice	56.3	18.4	19.2	4.8	1.3	0.1
Gastroenterology	41.9	27.4	23.8	5.2	1.7	0.1
General surgery	45.8	23.1	23.4	6.0	1.7	0.1
Geriatrics	32.0	22.7	30.2	11.4	3.4	0.4
Hospital medicine	52.2	19.2	21.5	5.7	1.3	<0.1
Internal medicine-general practice	45.3	22.2	23.6	6.9	2.0	0.1
Neurology	42.2	25.5	23.4	7.3	1.4	0.2
Neurosurgery	50.5	20.7	23.4	4.2	1.2	0.0
Obstetrics and gynecology	50.0	23.9	20.0	5.2	0.9	0.1
Occupational medicine	19.2	22.1	36.6	17.0	4.8	0.2
Oncology	44.8	25.6	21.8	6.7	1.1	0.0
Orthopaedic surgery	60.3	19.7	16.2	3.2	0.6	<0.1
Otolaryngology	42.4	27.4	24.0	4.5	1.8	0.0
Pain medicine	29.8	26.9	29.7	10.9	2.7	0.1
Pediatrics-general	52.5	22.6	20.4	3.8	0.6	0.1
Physical medicine/rehabilitation	31.6	23.1	32.9	9.5	2.9	0.0
Plastic surgery	33.9	29.5	27.9	7.4	1.4	0.0
Psychiatry	45.6	23.8	21.1	7.2	2.2	0.1
Urology	46.0	22.0	22.8	7.4	1.7	0.0

DISCUSSION

The AANP, NCCPA, and AAPA reports provide some useful data on nurse practitioner and physician assistant certifications and the specialties in which they practice. For example, the data show that while 68.7 percent of nurse practitioners are certified in primary care, only 36.8 percent practice in primary care. Additionally, a shockingly low number of nurse practitioners receive any optional advanced certifications in specialties, suggesting that most nurse practitioners practicing in specialties have no training in that specialty. Similarly, the NCCPA data shows that only a small percentage of physician assistants receive any specialty specific postgraduate training, yet the majority of physician assistants practice in specialties and over half switch specialties at least once during their career. This also suggests that physician assistants practicing in specialties often have no formal training in that specialty.

CONCLUSION

While the AANP, NCCPA, and AAPA reports provide some useful data, gaps in data remain necessitating additional research to provide a full response to the first two resolves of BOT 14-A-24. To fill these gaps, our AMA has engaged with a trusted vendor to conduct additional research. This research is currently underway and will be shared with the HOD in a subsequent Report at I-25.

REFERENCES

[1] American Association of Nurse Practitioners. *2024 Nurse Practitioner Practice Report*. 2024, at 14.
[2] *Id*., at 13.
[3] *Id*., at 13.
[4] National Commission on Certification of Physician Assistants. *Statistical Profile of Board Certified Physician Assistants: Annual Report*. 2023.
[5] National Commission on Certification of Physician Assistants. *Statistical Profile of Board Certified PAs by Specialty: Annual Report*. 2023.
[6] Id., at 6-7.
[7] National Commission on Certification of Physician Assistants. *Statistical Profile of Board Certified Physician Assistants: Annual Report*. 2023, at 18.
[8] National Commission on Certification of Physician Assistants. *Statistical Profile of Board Certified PAs by Specialty: Annual Report*. 2023, at 17.
[9] *Id*.
[10] *Id*.
[11] *Id*., at 57.
[12] *Id*., at 57.
[13] American Academy of Physician Assistants. *PAs and Specialty Change: Preparation, Motivation, and Scope*. 2024.
[14] *Id.* at 5.
[15] *Id*.
[16] *Id*. at 11.
[17] *Id*. at 12.
[18] National Commission on Certification of Physician Assistants. Statistical Profile of Board Certified PAs by Specialty: Annual Report. 2023, at 57.

REPORT 25 OF THE BOARD OF TRUSTEES (A-25)
AMA Public Health Strategy Update

EXECUTIVE SUMMARY

BACKGROUND: Policy D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems," adopted by House of Delegates 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-145.992, "Further Action to Respond to the Gun Violence Public Health Crisis" has 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. This informational report is an effort to provide regular updates on the status of the AMA's mission critical public health work to the HOD.

DISCUSSION

In recent months there have been a number of proposed policies that threaten to weaken our public health infrastructure, undermine science and evidence-based practice, and weaken protections for underserved and marginalized communities, which will result in increasing health inequities. The intent of this report is not to outline those proposed policies and their potential impacts, but rather to share the work that the AMA has done to advance our current public health priorities, which are as follows:

1. Promote evidence-based clinical and community preventive services.
2. Respond to public health crises impacting physicians, patients, and the public. This includes addressing the threat of climate change, preventing firearm injuries and deaths, being prepared for emerging and remerging infectious disease threats, and ending the nation's drug overdose epidemic.
3. Strengthen the health system through improved collaboration between medicine and public health.
4. Combat the spread of misinformation and disinformation.

CONCLUSION

The AMA continues to advance its mission, to promote the art and science of medicine and the betterment of public health. The highlighted accomplishments in this report capture the work accomplished from March of 2024 – March of 2025 related to the AMA's current public health priorities. In the current environment, AMA may need to increase efforts in these areas to maintain the organization as a trusted source of information for physicians and the public and to help protect the nation's public health infrastructure.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 25-A-25

Subject: AMA Public Health Strategy Update

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

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-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.

In recent months there have been a number of concerning policies that threaten to weaken our public health infrastructure, undermine science and evidence-based practice, and weaken protections for underserved and marginalized communities, which will result in increasing health inequities. This informational report is an effort to provide regular updates on the status of the AMA's mission critical public health work to the HOD.

DISCUSSION

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." According to the Centers for Disease Control and Prevention (CDC), public health is "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals."[1] Public health promotes and protects the health of people and the communities where they live, learn, work and play.[2] Public health practice is a different field than clinical medicine with different motivating values, responsibilities, and goals.[3] 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 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.[4] The AMA develops an annual report on health equity activities. Progress towards the health equity strategy is reported in the Board of Trustees (BOT) annual health equity report. (See BOT Report 10, "Center for Health Equity Annual Report.")

AMA PUBLIC HEALTH AND PREVENTION ACTIVITIES

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

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.

In addition to representing the AMA at meetings of these committees and task forces over the last year, the AMA continues to disseminate information on evidence-based preventive services. Examples include:

USPSTF

- The Journal of the American Medical Association (JAMA) continues to publish the recommendations of the USPSTF. These recommendations are also featured in the AMA *Morning Rounds* newsletter.
- The AMA submitted comments on the USPSTF recommendation related to food insecurity.
- The AMA has submitted amicus briefs in the case of *Braidwood Management v. Becerra*, a case that challenges the Affordable Care Act's requirement for private health plans to provide people with access to preventive services. The U.S. Supreme Court is scheduled to hear oral arguments in April of 2025, on whether the structure of the USPSTF violates the Constitution's appointments clause and in declining to sever the statutory provision that it found to unduly insulate the task force from the Health & Human Services (HHS) secretary's supervision.

ACIP

- The AMA's ACIP Liaison joined the AMA Update podcast throughout the year to provide updates to physicians.
    - The March 8, 2024, episode covered the latest ACIP COVID vaccine recommendations, which include an additional dose of the updated vaccine for those 65 and reviewed CDC's new isolation guidelines after testing positive for COVID.
    - The July 8, 2024, episode covered recommendations for RSV, COVID-19, and pneumococcal vaccines as well as updated information on flu vaccines.
    - The September 4, 2024, episode covered the new COVID vaccine coming out in Fall 2024.
    - The November 6, 2024, episode covered what physicians need to know about the new recommendations from CDC's ACIP for COVID vaccine frequency for seniors as well as updates on the RSV vaccine.

- The February 26-28, 2025, ACIP meeting was postponed. The AMA joined a letter to the Secretary of HHS, the Interim Director of the Centers for Disease Control and Prevention (CDC), and U.S. Senator Bill Cassidy calling for the rescheduling of this critical meeting and the reconciling of the absent portal for public remarks to ensure Americans receive the information needed to protect themselves against vaccine-preventable illnesses, confirming immunization's importance in the mission to make America healthier.

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

The AMA is committed to improving the health of the nation and reducing the burden of chronic diseases. Our primary focus is preventing cardiovascular disease (CVD), the leading cause of death in the U.S., accounting for one in four deaths among adults.[5] Two major risk factors for CVD are hypertension and type 2 diabetes.

- To prevent CVD and address related health inequities, the AMA is developing and disseminating CVD prevention solutions in collaboration with health care and public health leaders. These solutions educate clinical care teams and patients, guide health care organizations (HCOs) in clinical quality improvement and promote policy changes to remove barriers to care. The AMA disseminates these solutions through strategic alliances with various organizations including the CDC, the American Heart Association (AHA), and West Side United in Chicago.
- The AMA MAP ™ Hypertension clinical quality improvement program was designed to improve hypertension management and control. The free program has demonstrated effectiveness in a variety of health care settings from large health care organizations (HCO) to community health centers. Participating HCOs are provided with clinical based practice facilitation and a personalized dashboard with performance metrics.[6] The AMA MAP ™ set of solutions is expanding to include management for other cardiovascular disease risk factors, including cholesterol, prediabetes, and post-partum hypertension.
- In 2024, the AMA was awarded a multi-year CDC grant to implement three projects aimed at improving the quality of cardiovascular disease-related preventive care in Community Health Centers/Federally Qualified Health Centers. The funding will allow AMA to scale its existing quality improvement program. The goal is to help 500,000 patients achieve blood pressure control.
- AMA MAP™ houses a suite of tools and resources designed to help organizations build and integrate diabetes prevention strategies into their organizations. AMA has worked with more than 80 health care organizations across the country to increase identification and management of patients with prediabetes. In 2024, the AMA submitted one of its prediabetes quality measures to the Centers for Medicare & Medicaid Services (CMS) for consideration for inclusion in the Merit-based Incentive Payment System (MIPS) Program. In January 2025, the measure, Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes, was recommended for adoption and the approval vote was unanimous.
- Additionally, the AMA, in collaboration with the AHA, developed Target: BP™, which recognizes organizations that have achieved milestones in their commitments to improving blood pressure control. In 2024, Target: BP ™ Achievement Awards recognized 1,812 HCOs for efforts to prioritize control of their patients' blood pressure (BP) through attested evidence-based blood pressure measurement practices, like using the US Validated Blood Pressure Device Listing (VDL™). Participants came from 47 states or U.S. territories and served about 34 million patients, including 9 million with hypertension. Nearly half of

participating organizations are nonprofit health centers that receive federal funding to reach medically underserved populations, known as federally qualified health centers, reflecting the associations' shared commitment to improving health equity.

- One in three adults enrolled in Medicaid have hypertension and since 2022, the AMA has worked to increase Medicaid coverage to ensure that beneficiaries receive home blood pressure devices and have their condition monitored by physician-led care teams. As of October 2024, 22 states have coverage for self-measured blood pressure clinical services and home BP devices.
- Another cardiovascular disease risk factor is obesity, which is linked to cardiovascular disease mortality, independent of other risk factors. The AMA is collaborating with Federation members, including the American College of Physicians and the Obesity Medicine Association, to explore opportunities for improving access to evidence-based obesity treatments.

C. Screening and Reducing Risk for Dementia

Under the Navigating Brain Health and Dementia Project, the AMA reviewed available materials on the AMA Ed Hub addressing Brain Health and Dementia to determine potential gaps, developed three CME webinars, seven short videos, and one podcast, and continued collaboration and relationship building with the Alzheimer's Association and other partners. The webinars were developed in collaboration with CDC and the Alzheimer's Association, and focused on (1) the Screening and Diagnosis of Alzheimer's Disease and Related Dementias (ADRD), (2) Reducing Risk of ADRD, and (3) Treatment of ADRD. The seven YouTube short videos addressed the growing impact of the disease, key considerations around screening, addressing risk factors, as well as addressing cardiovascular risk factors, blood pressure control, and loneliness. For the webinars, there have been a total of 4,541 views; for the short videos, there have been a total of 7,962 views on YouTube.

With recently awarded funding from the CDC, this important work will continue through the convening of a workgroup comprised of clinicians and/or researchers with expertise in ADRD research, clinical care, and/or education. The workgroup will inform the design of a needs assessment to better understand the current knowledge, daily practices, challenges, and training needs of physicians and other health care professionals in the prevention, screening, diagnosis, and treatment of ADRD. The workgroup and needs assessment findings will inform the development of education opportunities, training, communication strategies, and resources for health care professionals involved in the assessment and management of ADRD.

D. 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 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 LTBI. The toolkit contains two different sets of strategies – one targeted to community health centers (CHCs) and a second to emergency departments (EDs). The toolkit was launched to the public with a press release on March 6, 2024.[7]

- In conjunction with the launch of the toolkit, we hosted a three-part webinar series that highlights key strategies to improve routine screening including opt-out testing, care team training and forming a strong referral network.[8] Since its launch, the toolkit has had over

22,000 pageviews, over 18,000 views of the launch series webinars and over 220 downloads of the PDF toolkit (as of January 31, 2025).

- In April 2024, we concluded a pilot of the routine screening toolkit with four EDs. The ED pilot cohort included: Harris Health Ben Taub Hospital (staffed by Baylor College of Medicine physicians and residents), Mayo Clinic, University of Colorado and Valleywise Health. Each pilot site selected 2-3 of the quality improvement strategies outlined in the toolkit to implement in their emergency department to provide tangible feedback to the AMA on the effectiveness of these strategies and ease of implementation in addition to providing input overall on the toolkit itself.
- The pilot activities with the EDs, as well as our pilot in 2023 with CHCs, demonstrated that implementing programs to screen, diagnose, and connect patients to care for multiple infections is possible in EDs and CHCs. The AMA toolkit can help organizations implement screening programs successfully. Sites with leadership support, strong community ties, and efficient workflows succeeded in implementing the AMA toolkit, while technical and resource limitations posed implementation challenges.
- In September 2024, the AMA was awarded additional funding from the CDC to continue to increase awareness of and engagement with the HIV, STIs, Viral Hepatitis and LTBI Routine Screening Toolkit by hosting a Community of Practice to convene CHC and ED facilities interested in implementing strategies outlined in the toolkit to increase screening.
- The AMA has identified a group of approximately 20 CHCs and EDs from across the country to participate in this 6-month Community of Practice which is planned to take place in 2025. The AMA has also identified a group of national organizations who serve CHCs and EDs who are committed to helping promote the routine screening toolkit to their members during 2025.
- In addition to the work on the routine screening toolkit, the AMA has also received funding from the CDC to explore barriers in accessing preventive medications including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for HIV and doxycycline post-exposure prophylaxis (doxy PEP) for STIs. The findings will inform the development of targeted education and resources to help improve access to these interventions.

E. 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, while recognizing that we must prioritize our efforts and that engagement in these campaigns alone is not feasible due to cost.

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. This year's campaign features a new PSA titled "Play Defense Against Flu" that leverages comedy to highlight how antibodies that develop after getting a flu vaccination work hard to protect oneself, loved ones and the community at large from the flu. Audiences are encouraged to gear up with a flu shot. The Get My Flu Shot campaign PSAs were 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. PSAs are available to run in English and Spanish across all platforms, in donated time and space throughout flu season. The campaign ads direct audiences to GetMyFluShot.org for more information, including where to get a flu vaccine in their area. Some highlights from the 2024-25 flu campaign are as follows:

- The donated media value for the current Flu season reached $2.4 million. The most support has come from out of home (OOH – $1,103,913), closely followed by TV support ($1,017,100).
- A media tour was held on October 10, 2024, in English and Spanish, featuring spokespeople from the AMA and representatives from the CDC. Over 40 placements were secured across TV, radio, and digital, with a reach of 404 million digital impressions and 1.6 million broadcast impressions.
- A second media tour was held on December 9, 2024, in English and Spanish, with spokespeople from the AMA and representatives from the CDC. Over 90 placements across TV, radio, and digital were secured with a reach of 206.9 million digital impressions and 6.5 million broadcast impressions.
- We partnered with Influential for our trusted messenger activation on social media. The concepts include athletes showing how they keep themselves in top shape by prepping for flu. Data is incoming for the total impressions and estimated reach.
- PSA awareness is now 57 percent in Black and Hispanic respondents based off our most recent December 2024 tracking study.

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

The AMA's public health work has also been focused on 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 is 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 the 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." Since the A-24 meeting, AMA has accomplished the following activities and developed a strategy to address climate change and health which was adopted at the I-24 HOD meeting:[9]

- The AMA has made climate change and sustainability education available via the Ed Hub™ from a variety of sources including the UC Center for Climate, Health, and Equity, Stanford Medicine, AMA Journal of Ethics, the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA). For example:
    - In July 2024, the JAMA Network developed a short film on how operating rooms can be cleaner, featuring physician experts working to make operating rooms more sustainable.
    - On October 29, 2024, Clinically Significant™, an AMA Continuing Medical Education (CME) podcast covered the climate impacts of metered-dose inhalers.[10]

    - In February 2025, the AMA STEPS Forward® podcast released an episode presented the benefits of going green and effective strategies to implement sustainability throughout medical practices.
- AMA's Center for Health Equity released an episode as part of the Prioritizing Equity series featuring physicians and scholarly leaders advocating for equitable climate action to remedy the disproportionate burden of health harms climate crisis puts on historically marginalized communities (summer 2024).[11]
- The AMA is in the process of developing a new CME module for physicians and trainees on climate change and health which is anticipated to be available in early summer 2025. The focus of the module is to bring awareness to physicians about the impact of climate change on the nation's health and to empower physicians to begin conversations with their patients about how climate change is affecting their health and what they can do about it.
- The *AMA Update* podcast featured topics related to climate change impacts throughout the year to provide updates to physicians, including:
    - May 1, 2024, covered the recently released CDC heat risk initiative.
    - June 19, 2024, delved into the symptoms of heat stroke versus heat exhaustion that physicians should watch out for during 2024 heat waves.
    - June 26, 2024, focused on heat-related illnesses as many states across the country were experiencing record breaking heatwaves.
    - July 26, 2024, covered how the Earth was experiencing its hottest day (and year) on record.
    - January 15, 2025, discussed California wildfire smoke and how to improve air quality during wildfires.
- AMA developed and distributed a survey to physicians to assess perceptions on climate change and health, including the level of importance and relevance of climate change to physicians, understanding day-to-day effects of climate change that physicians may be experiencing or anticipating experiencing in the future, and exploring what the AMA's role should be in supporting physicians on climate change. Data analysis of survey results is ongoing.
- The AMA submitted an abstract to the APHA annual conference to be held in November 2025 to present findings from the survey distributed to physicians in December 2024 and will identify other avenues of dissemination for this information.
- The AMA continues to engage in the Medical Society Consortium on Climate and Health (MCSSH), which brings together associations representing over 600,000 clinical practitioners.[12] The AMA sits on the executive committee of this group. Additionally, the AMA was a sponsor of the MSCCH Annual Convention, held in March 2025 in Washington, DC.
- The AMA is a member and sponsor 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 Health Care Delivery Workgroup has been focused on three deliverables:
    - The *Building Momentum to Act on Health Care Decarbonization* webinar Series;
    - The *Clinical Environmental Sustainability Journey Map* to provide health care leaders and clinicians with actions they can implement to enable sustainable health care transformation of their organizations and practices.
    - A *Clinicians Key Actions Shortlist* on decarbonization that will pull key actions clinicians in the U.S. can take modeled after Choosing Wisely Canada's Climate-Conscious Recommendations designed to mobilize clinicians to stop or reduce low-value practices that harm the environment without compromising patient care.

- The AMA is represented on the APHA Center for Climate, Health, and Equity Advisory Board, which meets regularly to guide the overall strategic direction of APHA's Center for Climate, Health and Equity.
- Additionally, the AMA participates in 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.[13] 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.
- In terms of advocacy efforts, the AMA joined with partners or submitted comments separately on the following:
    - AMA joined 85 other medical and public health organizations on January 25, 2025 in a letter to the Occupational Health and Safety Administration in support of their proposed standard on heat injury and illness prevention in outdoor and indoor work settings.[14]
    - AMA submitted a comment letter to CMS on June 10, 2024, in support of the Transforming Episode Accountability Model Decarbonization and Resilience Initiative, a voluntary effort designed to address threats posed by climate change to the nation's health and health care system by collecting, monitoring, and assessing, hospital carbon emissions and their effects on health outcomes, costs, and quality.

B. Prevent firearm injuries and deaths.

In the 1980's the AMA recognized firearms as a serious threat to the public's health as 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.[15]

- The AMA continues to convene its Firearm Injury Prevention task force, which is charged with advising the AMA Board of Trustees on the role of organized medicine in firearm injury prevention and developing resources for physicians and trainees on firearm injury prevention to increase counseling of high-risk patients and awareness of available interventions.
- On June 10, 2024, the Firearm Injury Prevention task force hosted an educational session on *Health Care Strategies for Firearm Injury Prevention* at the House of Delegates meeting. Representatives from the Health Alliance for Violence Intervention, American Geriatric Society, Society of Critical Care Medicine, and American Pediatric Surgical Association. The session was recorded and shared on the AMA Ed Hub and YouTube channel.
- Task force members have participated in *AMA Update* video and podcast episodes on safe and secure firearm storage (featuring the American Academy of Pediatrics representative); the health system role in firearm injury prevention (featuring the American Pediatric Surgical Association representative), and Extreme Risk Protection Orders (featuring the Society of Critical Care Medicine representative and the Johns Hopkins Center for Gun Violence Solutions).
- The task force will be working to inform the development of resources for health care professionals to be featured on an expanded digital resource hub being developed with the Ad Council.

- On June 25, 2024, the AMA released a statement applauding the Surgeon General advisory on firearm violence as a public health crisis.
- On February 27, 2025, the Ad Council launched a new youth gun violence prevention initiative in collaboration with a coalition of health care and business leaders, including the AMA. This new effort is the first national cross-sector youth gun violence prevention campaign that aims to address the fact that firearm injuries have been the leading cause of death for children ages 1 to 17 for three consecutive years in the United States. The new public service announcement (PSA) is focused on parents and those with youth in their lives and encourages them to take action by visiting AgreeToAgree.org, where individuals can learn about gun violence and how to have conversations with their communities supported by conversations guides and resources.
- In conjunction with the Ad Council campaign launch on February 27th, 2025, Children's Hospital Association President and CEO Matthew Cook and American Medical Association CEO and EVP James L. Madara, MD authored an opinion piece published in Becker's Hospital Review titled, "*Hospitals and healthcare professionals must lead on firearm injury prevention to keep children and communities safe*."
- The AMA also partnered with the Ad Council on a video content series, featuring health care professionals speaking directly to other health care professionals on the responsibility and unique role they hold to help prevent firearm injuries through supportive conversations with their patients. The video series directs audiences to AgreeToAgree.org/HealthCare to learn more.
- On Thursday, March 6, 2025, AMA participated in a Washington Post Live conversation about how gun violence has impacted communities around the country, initiatives to find common ground, and efforts to bolster public safety and health.
- The AMA is also participating in the Health Professional Education and Advocacy/Policy committees of the Healthcare Coalition for Firearm Injury Prevention, which is being led by American Academy of Pediatrics, American College of Emergency Physicians , American College of Physicians, American College of Surgeons, and the Council of Medical Specialty Societies.[16]
- In terms of advocacy, the AMA wrote a letter to the leadership of the Maine Judiciary Committee on April 4, 2024, expressing our support for LD 2283, legislation to establish crisis intervention orders to temporarily remove firearms from individuals deemed at high risk to themselves or others.

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

Infectious diseases continue to evolve and advance throughout the U.S. Pathogens that were once geographically limited are now advancing beyond traditional borders. Blastomycosis, Histoplasmosis and Coccidioidomycosis are all fungal infections that have pushed through expected boundaries. In addition to organisms known to be found in the U.S., tropical diseases like malaria, dengue and Leishmaniasis have all been found in the U.S. in nontravelers. Re-emerging pathogens like measles continue to find footholds across the country. Currently, H5N1 (avian influenza) is spreading through poultry and dairy farms with sporadic human cases and one death.[17] In addition, Clade I mpox (a more severe strain than was seen here in 2022) is spreading in part of Africa with a few cases occurring in the U.S. so far.[18] As the AMA is relied upon as a source of information by physicians and patients, the AMA must maintain the ability to respond and share information and advocate for physicians, patients, and the public in line with AMA policies.

- The AMA is currently maintaining resources pages on mpox, H5N1, and COVID-19. We are working to create additional infectious disease related resources for physicians to be available on the AMA website to help ensure the continued availability of information should other sources not remain available.
- The AMA continues to release weekly *AMA Update* video and podcast episodes focused on public health topics, including the latest outbreak information. AMA YouTube subscribers have increased from 42,000 to 255,000 since the beginning of 2025.
- 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.[19]
- Over the last year, AMA has developed 7 *Stories of Care* podcast episodes exploring inequalities in infection prevention and control (IPC). The podcast series has featured episodes on improving hand hygiene compliance, IPC challenges within long-term acute care hospitals, how nurse-driven protocols can reduce HAIs, challenges with burnout in IPC teams, pediatrics and IPC challenges, how fostering resiliency improves retention in medical teams, and the importance of IPC research in medical training.
- The AMA funded seven state and specialty medical societies to develop training and IPC content for its membership and disseminate Project Firstline content with over 69,000 impressions in the first 6 months.
- In 2024, the AMA partnered with the CDC on two webinars addressing the measles resurgence and lower vaccine rates. The first, *Be on Alert for Travel-Related Measles*, featured a discussion on current measles epidemiology trends, measles recognition, travel-associated risks, core health care infection prevention measures and the importance of vaccination. The second webinar, *Measles: Stories From the Frontlines* featured speakers from the CDC, the Pediatric Pandemic Network, American Nurses Association, and American Academy of Pediatrics to bring their experiences caring for patients with measles.
- On August 6, 2024, AMA hosted a webinar to provide information on preparing for viral respiratory season including vaccination updates. Participants included CDC Director Mandy Cohen, MD, MPH and Demetre Daskalakis, MD, MPH.
- A six-part, ECHO-style tele-mentoring series ran from April through June of 2024 that explored the nuances of infection prevention in facility types outside of the acute care hospital. Settings included acute rehabilitation hospitals, ambulatory surgery centers, behavioral health units, post-acute long-term care facilities, dialysis facilities, and pediatric units.
- A CME module was published in 2024 that presents patient cases in a choose-your-own-adventure format outlining transmission-based precautions so that physicians and other health care professionals can recognize how to protect themselves in any situation.
- AMA is working with the American Society of Nephrology (ASN) to reach clinicians working in dialysis facilities. ASN is producing three hour-long webinars looking at preventing dialysis-related infections and how health care professionals can use social determinants of health to meet patients where they are. The first webinar was hosted in February 2025.
- On November 21, 2024, the AMA participated in a webinar with the CDC on *Leading the Way to a Healthier Winter: A Conversation for Clinicians on Flu, COVID-19, & RSV Vaccine.* The briefing covered new updates to vaccine recommendations for common respiratory viruses, the latest trends in respiratory illness, what to know about vaccination among health care professionals.

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.

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 to meet regulatory requirements. Courses are 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.[20] The following summarizes the numerous resources created and work done on this topic:

- In 2024 the AMA completed the content and resource update for the physician education series module *Practical Guidance for Pain Management*. This content was made available to help physicians meet the DEA's MATE Act requirements, effective as of June 27, 2023.
- The AMA continues to convene the Substance Use and Pain Care Task Force, which supports and guides the development of the annual Overdose Epidemic Report on the overdose epidemic outlining current data, policy, updates, clinical accomplishments and what still needs to be done.[21]
- In 2024, the AMA developed additional episodes of the physician education podcast series on *The Opioid Overdose Epidemic*. Podcast episodes feature experts who shared relevant research, insights, and experience to help physicians of all specialties in addressing the opioid overdose epidemic. The four additional episodes include: *Opioid Use Disorder and Pregnancy, Opioid Utilization in Hospice and Palliative Care, Disparities in Access to Medication for Opioid Use Disorder, and Opioid Use a Prevention Approach.* As of December 2024, podcast engagement has risen annually from 7,930 downloads to 27,133 downloads, with a high interest in the following topics: *Opioid Prescribing and Appropriate Pain Management, Opioid Overdose Prevention, and Opioid Use Disorder Treatment.*
- In 2024, the AMA was awarded funding from the CDC to develop and implement a clinician toolkit focused on the recommendations and guiding principles of the 2022 Clinical Practice Guideline for Prescribing Opioids for Pain that is specifically tailored to community health centers (CHCs). During the two-year project period the AMA will partner with the National Association of Community Health Centers to develop an actionable toolkit resource for clinicians and will implement the toolkit resource in CHCs. The toolkit will provide an extensive, multidisciplinary, evidence-based educational experience for clinicians working in CHCs that is unique and sensitive to the needs of CHCs while also preparing them to serve as content experts and agents of change for their local healthcare communities regarding pain care.
- In November of 2024, the AMA released its 2024 Overdose Epidemic Report, showing progress in harm reduction services and policy promoting evidence-based care, but underscoring ongoing challenges as the nation's drug overdose epidemic continues.
- The AMA continues to participate as a member of the National Academy of Medicine Action Collaborative on Countering the U.S. Opioid Epidemic. 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 AMA's Cannabis task force was established to inform and develop evidence-based education on cannabis. In 2024, the AMA developed and disseminated a podcast series on *Cannabis Education.* Episodes feature expert discussions and insights that can help physicians of all specialties understand cannabis and the health effects of cannabis use. Initial podcast episode course completions demonstrate a high interest in the topic *Cannabis and Pain Management.* Additional episodes with substantial engagement include *Cannabis Use and Psychiatric Disorders, Cannabis Pharmacology, How Addictive in Cannabis, Cannabis Use among Pregnant Persons, Preventing Cannabis Use among Minors, and What to Know about FDA-approved Cannabis-derived Products.*

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

The AMA is collaborating with leading health care organizations to strengthen the interface between public health and health care. In November 2023, AMA and health care partners announced the Common Health Coalition: Together for Public Health, a partnership between AMA and four other leading healthcare organizations, including: AHIP (formerly America's Health Insurance Plans), Alliance of Community Health Plans, American Hospital Association , and Kaiser Permanente.[22] The Common Health Coalition is focused on translating the hard-won lessons and successes of the COVID-19 pandemic response into actionable strategies that will strengthen the partnership between our health care and public health systems.

- The Coalition's founding members have called on health care and public health organizations across the country to consider joining this effort. Interested organizations can learn more and take steps to join us by visiting the website, https://commonhealthcoalition.org/.
- On December 9, 2024, the Coalition announced its launch of the Inaugural Common Health Challenge to Champion Catalysts for Change, which will focus on Community Health Workers. As part of this initiative, the Common Health Coalition aims to advance meaningful Community Health Worker initiatives across the U.S. through partnership between health care and public health.[23]

In addition, the AMA took the following actions:

- In April of 2024, the AMA joined a letter to Congress urging the Labor, Health and Human Services, Education and Related Agencies appropriations bill for Fiscal Year (FY) 2025 to include funding to modernize and sustain our public health data infrastructure. The letter specifically requested at least $340 million annually for Public Health Data Modernization at the CDC.
- AMA released a leadership viewpoint in November of 2024, titled, *Building a robust public health system will benefit us all*.
- In March of 2025, the AMA joined a letter to the National Institutes of Health (NIH) expressing our appreciation for their longstanding commitment to funding scientific research that advances medical breakthroughs but noting that we are deeply concerned about the recently announced policy imposing a 15 percent cap on indirect cost recovery for NIH grants. The letter urges NIH to rescind this directive and instead work collaboratively to develop a solution that balances transparency, efficiency, and sustainability.

4. Combat the spread of misinformation and disinformation.

The AMA remains engaged in external collaborations to address mis- and disinformation, such as the Coalition for Trust in Health & Science and the recently rebranded physician-focused coalition, Mitigating Medical Misinformation Workgroup.

- The Coalition for Trust in Health and Science's vision is for all people to have equitable access to accurate, understandable, and relevant information to make personally appropriate health choices and decisions. The AMA is an active member, engaging with leadership and participating in programming. The AMA also made a financial contribution in 2024 to support the Coalition's work.
- The AMA is also an active participant in the Mitigating Medical Misinformation Workgroup and supported its recent research that found primary care physicians were viewed as the most trusted source for medical information. The AMA will work with this group to disseminate these findings to a broader audience and will continue to coordinate efforts internally to ensure alignment.
- The AMA filed an amicus brief with the U.S. Supreme Court in the case of *Murthy v. Missouri.* The brief focuses on how disinformation diminished uptake of COVID-19 vaccines, which then limited the vaccines' ability to save lives by controlling the spread of disease—thereby creating a compelling interest for the government to act. The court ruled that the plaintiffs did not have standing to bring the lawsuit as they could not show a substantial risk that, in the near future, at least one platform will restrict their speech in response to the actions of a government defendant.

CONCLUSION

The current environment has elevated the critical importance of AMA's role of promoting and disseminating evidence-based public health policy and content. The AMA continues to advance its mission, to promote the art and science of medicine and the betterment of public health. The highlighted accomplishments in this report capture a fraction of the work accomplished from March of 2024 – March of 2025 related to the AMA's public health strategy. The AMA will likely need to increase efforts in these areas to maintain the organization as a trusted source of information for physicians and the public and to help protect the nation's public health infrastructure.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 27-A-25

Subject: AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

At the 2024 Interim Meeting, the House of Delegates adopted the following recommendations in Board of Trustees Report 16, AMA Reimbursement of Necessary Business Meeting Expenses for Delegates and Alternates (Policy D-600.951):

1. Our American Medical Association will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program.
2. Our AMA will provide the House of Delegates with reports on a regular cadence detailing ongoing work regarding House of Delegates meetings to mitigate costs, explore solutions, and maintain participation while reducing the financial burden on all parties over the long term.
3. Our AMA will not reduce by one day the 2025 Annual and Interim Meetings and will issue a report for consideration at the 2025 Annual Meeting outlining details for potential changes to the length and format of future House of Delegates meetings.

This report is presented as information to the House of Delegates.

In November 2024, the Board of Trustees established an Emergency Assistance Pilot Program (EAP) to support state medical associations and national medical specialty societies experiencing financial hardship. The program, limited to meetings of the House of Delegates (HOD), will be in effect for the Annual and Interim meetings in 2025 and 2026. Information on applying and qualifying for the program, including data about delegate apportionment was sent to the Chief Executive Officer/Executive Director of each organization seated in the House of Delegates. Societies must apply annually; if approved, the emergency assistance grant will apply to both the Annual and Interim meetings for that calendar year.

In its initial cycle, twenty-four societies inquired about the program, and twenty-one submitted applications. Two societies did not meet the two percent of revenue threshold for delegate and alternate delegate expenses, and one was unable to provide the necessary tax documentation. Ultimately, 18 societies qualified for assistance, covering approximately 300 delegates and alternates -- including some regional medical student delegates and sectional resident and fellow delegates. The AMA will disburse 50 percent of the emergency grant assistance in advance of the meetings with the remainder paid after attendance has been confirmed.

While the AMA has restored the original meeting schedule for the HOD and opted not to shorten the 2025 Annual and Interim Meetings by one day, the Board has tasked the Council on Long Range Planning and Development with preparing a comprehensive report. This report will explore potential changes to the length, format, and structure of future HOD meetings and will be submitted to the Board for review and further consideration.

The Board of Trustees will provide the House of Delegates with a future report summarizing these ongoing efforts to mitigate meeting-related expenses, ensure broad participation, and responsibly steward AMA resources over the long term.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 03-A-25

Subject: Reconsidering Terminology to Describe Physician Assisted Suicide

Presented by: Jeremy A. Lazarus, MD, Chair

At the 2023 Interim meeting, Resolution 004-Reconsideration of Medical Aid in Dying (MAID) was referred and asked, "that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal." This informational report provides supplemental background and analysis to support Board of Trustees Report 18-A-25, which responds to the referred resolution.

BACKGROUND

The AMA *Code of Medical Ethics* defines physician assisted suicide (PAS) (Opinion 5.7 "Physician-Assisted Suicide") as the practice of a physician facilitating "a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act". In companion 1997 cases, the US Supreme Court held that there is no Constitutional right to PAS, and, therefore, permissibility should rest with the states [1]. Over the nearly three decades since, 10 states and the District of Columbia have legalized the practice [2].

ETHICAL ISSUE

Resolution 004 directed the Council on Ethical and Judicial Affairs (CEJA) to study whether current research, practice, or policy changes warrant reconsideration of CEJA's ethical analysis and/or position on PAS.

ETHICAL ANALYSIS

At the 2019 Annual meeting, the AMA House of Delegates adopted CEJA Report 02-A-19 entitled "Physician-Assisted Suicide" and upheld AMA *Code of Medical Ethics* Opinion 5.7 which opposes PAS as a practice that is "fundamentally incompatible with the physician's role as a healer." CEJA Report 02-A-19 also recognized, in an Appendix, that "morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide." This Appendix noted that the AMA *Code* preserves the opportunity as articulated in Opinion 1.1.7, "Physician Exercise of Conscience," for individual physicians "to act (or refrain from acting) in accordance with the dictates of conscience in their professional practice." AMA's position on physician assisted suicide is not a position of neutrality, establishing that the profession of medicine should not support the practice of physician assisted suicide or see it as part of a physician's role. The aim of the Appendix to CEJA Report 02-A-19, however, is to reassure individual physicians that those who, after due moral consideration, decide to participate in the practice, will be judged to have acted conscientiously, consistent with the AMA *Code*.
In developing CEJA Report 02-A-19, the Council's analyses and deliberations were informed by available data and research. However, its decision was not an empirically dictated one, but rather, it was driven by the core values of medicine preserved within the *Code of Medical Ethics*. The

Council has reviewed legislative developments since 2019 and has also reviewed recent government data, health services research and clinical practices in US and international jurisdictions where PAS and/or euthanasia are legal. The Council noted that these empirical data are subject to varied interpretations and concluded that, as a matter of ethical reasoning, the data do not settle the ethical issue. The relevant core ethical values at stake have not changed since the adoption of CEJA Report 02-A-19. As such, the AMA's position on physician assisted suicide remains unchanged.

Fiscal Note: Less than $500

REFERENCES

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 04-A-25

Subject: Reconsideration of Physician Assisted Suicide

Presented by: Jeremy A. Lazarus, MD, Chair

At the 2023 Interim meeting of the AMA House of Delegates, Resolution 004-Reconsideration of Medical Aid in Dying (MAID) was referred and asked, "that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal." This informational report provides supplemental background and analysis to support Board of Trustees Report 18-A-25, which responds to the referred resolution.

BACKGROUND

The AMA *Code of Medical Ethics* defines physician assisted suicide (PAS) as the practice of a physician facilitating "a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act" (1). In companion 1997 cases, the US Supreme Court held that there is no Constitutional right to PAS, and, therefore, permissibility should rest with the states (2). Over the nearly three decades since, 10 states and the District of Columbia have legalized the practice (3).

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AMA's position on physician assisted suicide is not a position of neutrality, establishing that the profession of medicine should not support the practice of physician assisted suicide or see it as part of a physician's role. The aim of the Appendix to CEJA Report 02-A-19, however, is to reassure individual physicians that those who, after due moral consideration, decide to participate in the practice, that they will be judged to have acted conscientiously, consistent with the AMA *Code*. In developing CEJA Report 02-A-19, the Council's analyses and deliberations were informed by available data and research. However, its decision was not an empirically dictated one, but rather, it was driven by the core values of medicine preserved within the *Code of Medical Ethics*. The

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Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 12-A-25

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

Presented by: Jeremy A. Lazarus, MD, Chair

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

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

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

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

APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2024 – MARCH 31, 2025

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

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
13	No sanction or other type of action
0	Monitoring
5	Probation
0	Revocation
5	Suspension
0	Denied
0	Suspension lifted
10	Censure
1	Reprimand[1]

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

[1] Sanction no longer in use.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 01-A-25

Subject: Palliative Care

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-I-24, "Expanding Access to Palliative Care." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-5.10 – Palliative Care

Physicians have clinical ethical responsibilities to address the pain and suffering occasioned by illness and injury and to respect their patients as whole persons. These duties require physicians to assure the provision of effective palliative care whenever a patient is experiencing serious, chronic, complex, or critical illness, regardless of prognosis. Palliative care is sound medical treatment that includes the comprehensive management and coordination of care for pain and other distressing symptoms including physical, psychological, intellectual, social, spiritual, and existential distress from serious illness. Evaluation and treatment are patient-centered but with an additional focus on the needs, values, beliefs, and culture of patients and those who love and care for them in decision-making accordingly.

Palliative care is widely acknowledged to be appropriate for patients who are close to death, but persons who have chronic, progressive, and/or eventually fatal illnesses often have symptoms and experience suffering early in the disease course. The clinical ethical responsibilities to address symptoms and suffering may therefore sometimes entail a need for palliative care before the terminal phase of disease. Moreover, the duty to respect patients as whole persons should lead physicians to encourage patients with chronic, progressive, and/or eventually fatal conditions to identify surrogate medical decision makers, given the likelihood of a loss of decisional capacity during medical treatment.

When caring for patients' physicians should:

(a) Integrate palliative care into treatment.

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

(b) Seek and/or provide palliative care, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness.

(c) Offer palliative care simultaneously with disease modifying interventions, including attempts for cure or remission.

(d) Be aware of, and where needed, engage palliative care expertise in care.

Physicians as a profession should:

(e) Advocate that palliative care be accessible for all patients, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness. (I, V, VIII)

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 3-A-25

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

Presented by: Michelle Berger, MD, Chair

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

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

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

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

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

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

DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of House of Delegates (HOD) Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect year-end 2024 delegation rosters. AMA council rosters as well as listings for the

governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of U.S. medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2024 Masterfile after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the number allotted at the 2024 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. Race and ethnicity information, which is provided directly by physicians, is missing for nearly one-fourth of AMA members (24.0 percent) and the total U.S. physician population (23.6 percent), limiting the ability to draw firm conclusions.

Readers are reminded that most AMA leadership groups considered herein designate seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of age-related groups, namely the student, resident, and young physician sections. To provide further clarity on this point, an additional table has been included in the appendix illustrating demographic characteristics and career stage breakdowns of section governing councils.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 displays the basic demographic characteristics of AMA leadership, AMA members, and all physicians and medical students. Raw counts for Tables 1 and 2 can be found in Appendix A. Upward- and downward-pointing arrows indicate an increase or decrease of at least two percentage points compared to CLRPD Report 1-A-23, “Demographic Characteristics of the House of Delegates and AMA Leadership”; the following observations refer to changes since CLRPD Report 1-A-23. Changes are not highlighted for the BOT due to the small number of Board members. Between year-end 2022 and year-end 2024, AMA membership increased by 16,080 members, a 5.9 percent increase.

- Among alternate delegates, an increase of 3.9 percentage points was observed in the 40-49 age group, while a decrease of 2.3 percentage points was observed in the 60-69 age group. Among leadership of AMA councils, sections and special groups, an increase of 3.0 percentage points was seen in the under 40 age group, while representatives aged 50-59 and 70 and over decreased by 2.0 and 2.2 percentage points respectively.

- Female representation in the HOD increased once again, a continuation of a steady trend of more than a decade. Delegates identifying as female made up 37.2 percent of delegates (a 2.9 percentage point increase since 2022) and 49.5 percent of alternate delegates (a 5.8 percentage point increase). Likewise, female representation among all AMA members increased by 2.1 percentage points.

- Delegates, alternate delegates, and CSSG identifying as white non-Hispanic declined by 2.1 percentage points, 4.5 percentage points and 3.8 percentage points, respectively. Asian/Asian American representation increased among alternate delegates by 3.4 percentage points.

Table 1. Demographic Characteristics of AMA Leadership, December 2024

	Delegates[1]	Alternate Delegates[1]	Board of Trustees[2]	Councils and Leadership of Sections and Special Groups[3]	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Mean age (years)[4]	56.5	50.2	55.5	49.9	46.5	52.9
Age Distribution						
Under age 40	14.7%	28.6%	10.0%	33.5%↑	53.1%	30.7%
40-49 years	16.2%	21.6%↑	15.0%	14.0%	11.5%	17.1%
50-59 years	21.5%	18.4%	35.0%	19.6%↓	9.5%	15.5%
60-69 years	26.3%	20.0%↓	35.0%	20.1%	8.6%	15.2%
70 or more	21.3%	11.4%	5.0%	12.8%↓	17.3%	21.5%
Gender						
Male	62.8%↓	50.2%↓	50.0%	52.5%	57.7%↓	61.4%
Female	37.2%↑	49.5%↑	50.0%	47.5%	41.6%↑	37.8%
Unknown	0.0%	0.2%	0.0%	0.0%	0.7%	0.8%
Race/Ethnicity						
White non-Hispanic	63.7%↓	52.8%↓	45.0%	53.1%↓	47.7%	49.0%
Black non-Hispanic	5.9%	6.3%	10.0%	5.0%	5.2%	4.5%
Hispanic	3.1%	4.2%	5.0%	6.1%	4.0%	4.4%
Asian/Asian American	13.5%	19.3%↑	30.0%	20.1%	17.1%	16.6%
Native American	0.3%	0.5%	0.0%	0.6%	0.2%	0.2%
Other[5]	1.8%	1.6%↓	0.0%	1.7%↓	1.8%↓	1.7%
Unknown	11.8%	15.3%↑	10.0%	13.4%↑	24.0%↑	23.6%↑
Education						
US or Canada	90.3%	88.8%	95.0%	87.7%	80.8%	77.2%
IMG	9.7%	11.2%	5.0%	12.3%	19.2%	22.8%

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

- Limited changes were observed to the life stage, employment, and specialty characteristics of delegates to the HOD. Among delegates, an increase of 2.3 percentage points was observed among established physicians, and the share of group practice physicians decreased by 2.2 percentage points. Among alternate delegates, representation of internal

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

medicine specialists increased by 4.2 percentage points.

- Among CSSG, increases were observed among students (2.1 percentage points), group practice physicians (4.4 percentage points), and radiologists (2.6 percentage points), while decreases were observed among established physicians (-2.8 percentage points), self-employed solo practice physicians (-2.4 percentage points), retired/inactive physicians (2.7 percentage points) and internal medicine specialists (-4.9 percentage points).

- The percentage of intern/resident/fellow AMA members increased by 3.0 percentage points.

Table 2. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership, December 2024

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Life Stage						
Student[6]	4.4%	10.0%	5.0%	11.7%↑	18.2%	7.9%
Resident[6]	6.3%	8.4%	5.0%	12.3%	29.2%↑	11.5%
Young (Under age 40 or first eight years of practice)[7]	6.0%	15.1%	0.0%	12.8%	10.2%	15.4%
Established (Age 40-64)[7]	47.4%↑	45.3%	65.0%	38.5%↓	20.9%	36.1%
Senior (Age 65 or more)[7]	35.9%	21.2%	25.0%	24.6%	21.5%	29.1%
Present Employment						
Self-employed solo practice	11.9%	7.2%	30.0%	8.4%↓	5.4%	6.8%
Two physician practice	1.6%	1.6%	0.0%	0.6%	1.3%	1.7%
Group practice	37.6%↓	38.1%	30.0%	39.1%↑	23.9%	38.7%
Non-government hospital	8.8%	8.4%	10.0%	7.3%	3.0%	4.3%
State or local government hospital	9.7%	9.3%	10.0%	7.8%	3.2%	5.3%
HMO	1.0%	0.7%	0.0%	0.6%	0.2%	0.1%
Medical School	4.0%	2.6%	5.0%	2.8%	0.8%	1.2%
U.S. Government	2.6%	1.4%	5.0%	1.7%	0.7%	1.4%
Locum Tenens	0.3%	0.2%	0.0%	1.7%	0.1%	0.2%
Retired/Inactive	9.6%	5.8%	0.0%	3.9%↓	10.7%	12.9%
Resident/Intern/Fellow	6.3%	8.4%	5.0%	12.3%	29.2%↑	11.5%
Student	4.4%	10.0%	5.0%	11.7%↑	18.2%	7.9%

[6] Students and residents are so categorized without regard to age.
[7] Reflects section/group definition of its membership.

Other/Unknown	2.2%	6.3%	0.0%	2.2%	3.3%	8.0%
Self-designated Specialty[8]						
Family Medicine	12.9%	9.8%	0.0%	10.1%	8.8%	11.3%
Internal Medicine	21.8%	19.3%↑	10.0%	17.3%↓	21.4%	23.0%
Surgery	21.3%	17.7%	40.0%	15.1%	13.0%	13.0%
Pediatrics	4.0%	5.3%	5.0%	6.7%	5.8%	8.6%
OB/GYN	6.3%	7.0%	15.0%	8.9%	4.9%	4.4%
Radiology	5.3%	3.7%	10.0%	5.0%↑	3.5%	4.3%
Psychiatry	3.7%	5.6%	0.0%	5.6%	4.4%	5.2%
Anesthesiology	3.5%	3.3%	5.0%	2.8%	4.1%	4.9%
Pathology	1.6%	4.0%	0.0%	0.6%	1.7%	2.1%
Other specialty	15.2%	14.4%	10.0%	16.2%	14.2%	15.3%
Student	4.4%	10.0%	5.0%	11.7%↑	18.2%	7.9%

For further data, including information on state medical associations and national medical specialty societies, raw counts of the above tables, and detailed state and specialty society data, please see the appendices.

This year, the Council added another metric to the report with the inclusion of a diversity index. The index provides a balanced and robust assessment of diversity and has been widely applied across demographic and clinical research contexts. The Council utilized the Gini-Simpson Diversity Index (GSI) which measures the probability that two individuals selected at random will represent different identities; it is measured from 0 to 1, where 0 represents an absence of diversity and 1 represents the greatest possible diversity. CLRPD assessed diversity trends within the AMA HOD and AMA leadership from 2014 to 2024, specifically focusing on member age, gender, and race/ethnicity. The Council intends to include this metric in future reports on the demographic characteristics of the HOD and AMA leadership as another means of encouraging greater awareness and responsiveness to diversity. To view data on the GSI of the HOD and AMA leadership, please view graphics 1-3 in Appendix A.

PROMOTING DIVERSITY AMONG DELEGATIONS

Policy G-600.035 stipulates that "(f)uture reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote diversity within state and specialty society delegations."

In 2024, the AMA Center for Health Equity (CHE) surveyed the AMA Federation of Medicine for its annual Health Equity in Organized Medicine (HEIOM) survey, which queried members of the Federation with the goal of developing a shared understanding of health equity initiatives. This report highlights some key findings of that survey related to diversity among delegations, but the Council encourages members of the HOD to access the report in its entirety to view the breadth of efforts being undertaken by organizations within the Federation to improve health equity and increase organizational diversity. The Council plans to collaborate with CHE to include queries about best practices to increase diversity among state and specialty delegations in future HEIOM surveys to improve collaboration and knowledge sharing, and to avoid duplication of effort.

Of the 81 organizations that responded, the HEIOM survey found that nearly one in four had taken at least one action to identify opportunities for improvement. Approximately half of responding

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

organizations said that they had achieved or were working toward collecting and stratifying quantitative data regarding organizational leadership and staff to identify inequities, and a similar number said they had undertaken or were in the process of undertaking similar efforts about their organization's membership. Additionally, nearly three in four had taken at least one action to make equity a strategic priority which included ensuring that senior leadership and board members reflected the diversity of the community served by the organization.

The report highlighted an illustrative initiative undertaken by the Tennessee Medical Association (TMA), which recognized the need for younger and more diverse members to better reflect the state's physician demographics. To work toward this goal, TMA created a leadership portfolio to assess diversity in leadership across various demographics, environments, and experiences to develop an understanding of diversity within the organization. The Association built on this work by developing a "leadership scorecard," which defines representation and tracks progress on diversity in leadership roles, including its AMA delegation. The initiative aims to identify key areas lacking diversity and guide the nominating committee when selecting candidates for leadership roles.

Another initiative highlighted in the report came from the American Academy of Orthopaedic Surgeons (AAOS), which developed a publicly shared Governance Diversity Report to provide an analysis of the composition of the organization's volunteer structure, member engagement and applicant selection. The report has helped AAOS understand baseline diversity within its governance, raise awareness of diversity with councils and committees, and increase the number of female and underrepresented minority members holding positions within the AAOS governance structure. Additionally, public sharing of the report has allowed for increased transparency, trust-building, and accountability

APPENDIX A

Table 3. Demographic Characteristics of AMA Leadership, December 2024

	Delegates[1]	Alternate Delegates[1]	Board of Trustees[2]	Councils and Leadership of Sections and Special Groups[3]	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Mean age (years)[4]	56.5	50.2	55.5	49.9	46.5	52.9
Age Distribution						
Under age 40	100	123	2	60	154413	476983
40-49 years	110	93	3	25	33442	265681
50-59 years	146	79	7	35	27626	240822
60-69 years	179	86	7	36	25008	236161
70 or more	145	49	1	23	50308	334043
Gender						
Male	427	216	10	94	167789	953966
Female	253	213	10	85	120971	587295
Unknown	0	1	0	0	2036	12430
Race/Ethnicity						
White non-Hispanic	433	227	9	95	138710	761308
Black non-Hispanic	40	27	2	9	15121	69916
Hispanic	21	18	1	11	11632	68362
Asian/Asian American	92	83	6	36	49726	257913
Native American	2	2	0	1	582	3107
Other[5]	12	7	0	3	5234	26413
Unknown	80	66	2	24	69791	366671
Education						
US or Canada	614	382	19	157	234963	1199449
IMG	66	48	1	22	55833	354241

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

Table 4. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership, December 2024

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Life Stage						
Student[6]	30	43	1	21	52925	122742
Resident[1]	43	36	1	22	84912	178674
Young (Under age 40 or first eight years of practice)[7]	41	65	0	23	29661	239268
Established (Age 40-64)[2]	322	195	13	69	60776	560882
Senior (Age 65 or more)[2]	244	91	5	44	62521	452124
Present Employment						
Self-employed solo practice	81	31	6	15	15703	105651
Two physician practice	11	7	0	1	3780	26413
Group practice	256	164	6	70	69500	601278
Non-government hospital	60	36	2	13	8724	66809
State or local government hospital	66	40	2	14	9305	82346
HMO	7	3	0	1	582	1554
Medical School	27	11	1	5	2326	18644
U.S. Government	18	6	1	3	2036	21752
Locum Tenens	2	1	0	3	291	3107
Retired/Inactive	65	25	0	7	31115	200426
Intern/Resident/Fellow	43	36	1	22	84912	178674
Student	30	43	1	21	52925	122742
Other/Unknown	15	27	0	4	9596	124295
Self-designated Specialty[8]						
Family Medicine	88	42	0	18	25590	175567
Internal Medicine	148	83	2	31	62230	357349
Surgery	145	76	8	27	37803	201980
Pediatrics	27	23	1	12	16866	133617
OB/GYN	43	30	3	16	14249	68362
Radiology	36	16	2	9	10178	66809
Psychiatry	25	24	0	10	12795	80792

[6] Students and residents are so categorized without regard to age.
[7] Reflects section/group definition of its membership.
[8] See Appendix B for a listing of specialty classifications.

Anesthesiology	24	14	1	5	11923	76131
Pathology	11	17	0	1	4944	32627
Other specialty	103	62	2	29	41293	237715
Student	30	43	1	21	52925	122742

Table 5. Demographic Characteristic Cross Sections of AMA Members, December 2024

	White non-Hispanic	Black non-Hispanic	Hispanic	Asian/Asian American	Native American	Other[9]
Count	138,771	15,016	11,703	49,758	466	75,084
Mean age (years)[10]	51.2	42.0	46.4	41.0	41.9	42.5
Under age 40	44.1%↑	57.0%	47.8%	60.7%	49.1%↓	64.8%
40-49 years	10.8%	15.5%	13.6%	15.0%	19.3%↓	9.3%
50-59 years	10.1%	12.2%	15.8%↑	11.6%	23.0%↑	5.5%
60-69 years	10.9%	8.1%	10.0%	5.3%	7.5%↑	6.1%
70 or more	24.0%	7.1%	12.9%	7.5%	1.1%	14.3%
Male	63.5%	43.6%	58.0%	51.5%	50.0%↓	54.0%↑
Female	36.4%	56.3%	41.9%	48.3%	50.0%↑	43.6%↓
Unknown	0.0%	0.0%	0.1%	0.1%	0.0%	2.4%
Student[11]	13.0%↓	19.4%↓	17.9%↓	16.9%↓	17.8%↓	28.4%↑
Resident[3]	24.4%↑	33.3%↓	24.6%	35.3%↑	24.5%↓	34.0%↓
Young (Under age 40 or first eight years of practice)[12]	10.4%	11.8%	7.9%↑	13.2%	13.5%↑	8.0%
Mature (Age 40-64)[4]	22.8%	25.0%	31.9%	25.2%	40.3%	12.0%
Senior (Age 65 or more)[4]	29.5%	10.4%	17.7%	9.5%	3.9%↑	17.6%
US or Canada	91.2%	80.6%↓	75.8%↑	65.7%↓	92.9%	72.5%
IMG	8.8%	19.4%↑	24.2%↓	34.3%↑	7.1%	27.5%

[9] Includes other self-reported racial and ethnic groups.
[10] Age as of December 31. Mean age is the arithmetic average.
[11] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[12] Reflects section/group definition of its membership.

Table 6. Demographic Characteristics of AMA Section Governing Councils, December 2024

	APS	IPPS	IMGS	LGBTQ+	MSS	MAS	OMSS	PPPS	RFS	SPS	WPS	YPS
Mean Age (years)	60.2	53.4	42.5	38.1	26.7	49.9	64.6	53.8	31.4	72.0	40.8	38.4
Student	0.0%	0.0%	0.0%	22.2%	100.0%	12.5%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%
Resident	0.0%	0.0%	12.5%	11.1%	0.0%	25.0%	0.0%	0.0%	100.0%	0.0%	25.0%	0.0%
Young (Under age 40 or first eight years of practice)[1]	11.1%	12.5%	62.5%	33.3%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	25.0%	85.7%
Mature (Age 40-64)[1]	44.4%	75.0%	25.0%	33.3%	0.0%	50.0%	50.0%	37.5%	0.0%	14.3%	25.0%	14.3%
Senior (Age 65 or over)[1]	44.4%	12.5%	0.0%	0.0%	0.0%	12.5%	50.0%	37.5%	0.0%	85.7%	12.5%	0.0%
Male	77.8%	75.0%	37.5%	55.6%	33.3%	25.0%	50.0%	25.0%	62.5%	71.4%	0.0%	57.1%
Female	22.2%	25.0%	62.5%	44.4%	66.7%	75.0%	50.0%	75.0%	37.5%	28.6%	100.0%	42.9%
Unknown	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
White non-Hispanic	55.6%	62.5%	37.5%	66.7%	11.1%	0.0%	75.0%	62.5%	75.0%	71.4%	12.5%	85.7%
Black non-Hispanic	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%
Hispanic	11.1%	12.5%	12.5%	11.1%	0.0%	37.5%	12.5%	0.0%	12.5%	0.0%	0.0%	0.0%
Asian/Asian American	33.3%	25.0%	37.5%	22.2%	55.6%	0.0%	12.5%	12.5%	12.5%	14.3%	37.5%	14.3%
Native American	0.0%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other[2]	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown	0.0%	0.0%	12.5%	0.0%	33.3%	25.0%	0.0%	25.0%	0.0%	14.3%	25.0%	0.0%
US or Canada	66.7%	62.5%	0.0%	100.0%	100.0%	100.0%	87.5%	75.0%	100.0%	100.0%	100.0%	100.0%
IMG	33.3%	37.5%	100.0%	0.0%	0.0%	0.0%	12.5%	25.0%	0.0%	0.0%	0.0%	0.0%

[1] Reflects section/group definition of its membership.
[2] Includes other self-reported racial and ethnic groups.

Table 7. Characteristics of Specialty Society Delegations, December 2024

	Mean Age[1]	Median Age[1]	% Female	% IMG	% Resident
AMA Members (n = 290,796)	46.5	38	41.6%	19.2%	29.2%
Specialty Society Delegates and Alternates (n = 433)	55.1	54	44.3%	9.7%	2.3%
Family Medicine Delegations (n = 28)	54.9	54	53.6%	10.7%	0.0%
Internal Medicine Delegations (n = 106)	58.4	59	44.3%	17.0%	1.9%
Surgery Delegations (n = 99)	53.7	52	35.4%	8.1%	4.0%
Pediatrics Delegations (n = 11)	52.1	45	81.8%	0.0%	0.0%
OB/GYN Delegations (n = 29)	57.3	58	65.5%	6.9%	0.0%
Radiology Delegations (n = 30)	57.1	60	36.7%	6.7%	0.0%
Psychiatry Delegations (n = 26)	53.4	54	53.8%	3.8%	0.0%
Anesthesiology Delegations (n = 17)	50.9	52	17.6%	5.9%	11.8%
Pathology Delegations (n = 19)	53.5	53	52.6%	10.5%	0.0%
Other specialty Delegations (n = 66)	54.0	52	42.4%	7.6%	3.0%

The specialty delegations listed above contain the following delegations:

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

[1] The mean age is the arithmetic average age. The median age is the age at which 50% of the group is older and 50% is younger

Table 8. Mean and Median Age of AMA Members and Delegations by State, December 2024

State	Total AMA Members in State	Mean Age of AMA Members	Median Age of AMA Members	Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates	Median Age of Delegates and Alternate Delegates
Alabama	3,838	43.7	34	7	62.1	68
Alaska	327	55.2	53	0	0.0	0
Arizona	4,136	48.7	39	9	63.1	65
Arkansas	1,926	46.2	37	4	69.3	70
California	36,006	50.6	46	63	55.2	55
Colorado	5,152	45.6	40	9	61.7	67
Connecticut	3,098	47.9	38	9	61.2	67
Delaware	855	54.9	53	2	†	†
District of Columbia	1,843	40.8	32	2	†	†
Florida	15,970	49.2	40	37	60.1	62
Georgia	6,098	47.8	42	10	57.6	57
Guam	19	59.7	58	0	0.0	0
Hawaii	1,081	53.7	48	3	†	†
Idaho	844	47.8	41	3	†	†
Illinois	11,110	48.8	37	21	62.4	66
Indiana	4,950	43.8	33	9	61.0	68
Iowa	3,224	46.8	40	6	60.0	60
Kansas	2,821	43.4	32	7	63.1	66
Kentucky	4,282	44.1	36	9	62.9	64
Louisiana	5,988	41.2	35	9	55.6	57
Maine	1,250	44.3	34	3	†	†
Maryland	5,267	52.1	48	13	59.5	61
Massachusetts	12,806	38.9	32	16	57.6	61
Michigan	13,136	44.4	35	24	57.7	59
Minnesota	4,683	48.5	40	9	61.8	62
Mississippi	2,748	45.2	36	6	58.5	58
Missouri	5,369	41.4	32	7	58.9	63
Montana	620	49.3	40	2	†	†
Nebraska	1,684	42.3	32	3	†	†
Nevada	1,896	44.9	35	4	67.8	66
New Hampshire	853	52.1	50	3	†	†
New Jersey	8,440	49.0	42	14	64.3	68
New Mexico	1,254	51.0	44	3	†	†
New York	22,864	44.9	34	38	58.4	62
North Carolina	5,395	48.4	40	10	57.9	58
North Dakota	1,315	44.1	41	2	†	†
Ohio	10,750	44.0	33	20	52.5	49

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

State	Total AMA Members in State	Mean Age of AMA Members	Median Age of AMA Members	Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates	Median Age of Delegates and Alternate Delegates
Oklahoma	3,393	42.7	32	7	59.4	56
Oregon	3,294	50.6	46	7	57.0	58
Other	786	81.3	89	1	†	†
Pennsylvania	14,059	48.7	40	26	57.2	61
Puerto Rico	1,460	44.5	31	2	†	†
Rhode Island	1,070	44.6	34	5	59.4	62
South Carolina	3,392	44.0	34	8	62.9	67
South Dakota	1,316	44.4	40	4	61.5	61
Tennessee	5,132	44.7	34	8	63.3	64
Texas	21,053	43.3	34	31	59.3	60
Utah	2,093	45.0	36	3	†	†
Vermont	522	48.0	37	1	†	†
Virgin Islands	28	73.5	73	1	†	†
Virginia	6,776	47.0	40	15	56.5	57
Washington	5,779	51.7	48	10	49.9	45
West Virginia	1,820	42.0	33	2	†	†
Wisconsin	4,733	47.2	38	10	57.9	55
Wyoming	192	60.5	58	2	†	†
TOTAL	290,796	46.5	38	539	58.9	60

Table 9. Women and International Medical Graduates on State Association Delegations, December 2024

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Women AMA Members in State	Number of Women Delegates and Alternate Delegates	Total IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	3,838	7	1,532	2	563	0
Alaska	327	0	130	0	39	0
Arizona	4,136	9	1,557	3	685	1
Arkansas	1,926	4	729	0	277	0
California	36,006	63	15,575	25	6,983	5
Colorado	5,152	9	2,362	5	292	0
Connecticut	3,098	9	1,293	4	778	2
Delaware	855	2	295	1	252	0
District of Columbia	1,843	2	953	0	242	0
Florida	15,970	37	5,926	12	4,732	6
Georgia	6,098	10	2,671	3	1,208	1
Guam	19	0	5	0	11	0
Hawaii	1,081	3	406	2	155	0
Idaho	844	3	261	2	45	1
Illinois	11,110	21	4,588	8	2,425	4
Indiana	4,950	9	1,955	5	714	2
Iowa	3,224	6	1,266	3	561	1
Kansas	2,821	7	1,126	3	276	0
Kentucky	4,282	9	1,717	2	603	0
Louisiana	5,988	9	2,643	3	967	2
Maine	1,250	3	618	1	102	0
Maryland	5,267	13	2,346	6	1,338	4
Massachusetts	12,806	16	6,438	5	1,981	1
Michigan	13,136	24	5,277	8	3,027	3
Minnesota	4,683	9	1,835	4	780	0
Mississippi	2,748	6	988	2	333	1
Missouri	5,369	7	2,265	3	720	2
Montana	620	2	236	1	29	0
Nebraska	1,684	3	702	1	143	0
Nevada	1,896	4	699	1	391	1
New Hampshire	853	3	322	1	151	0
New Jersey	8,440	14	3,387	5	2,528	4
New Mexico	1,254	3	525	2	185	0
New York	22,864	38	9,750	13	6,712	6
North Carolina	5,395	10	2,093	6	734	0
North Dakota	1,315	2	510	1	264	0
Ohio	10,750	20	4,429	8	1,855	4
Oklahoma	3,393	7	1,354	3	387	0
Other	786	1	124	1	425	0
Oregon	3,294	7	1,475	2	297	0
Pennsylvania	14,059	26	5,428	4	2,666	5

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Women AMA Members in State	Number of Women Delegates and Alternate Delegates	Total IMG Members in State	Number of IMG Delegates and Alternate Delegates
Puerto Rico	1,460	2	660	0	284	1
Rhode Island	1,070	5	491	2	205	0
South Carolina	3,392	8	1,449	1	325	0
South Dakota	1,316	4	543	1	187	0
Tennessee	5,132	8	2,055	2	562	2
Texas	21,053	31	9,085	10	3,787	3
Utah	2,093	3	610	1	101	0
Vermont	522	1	242	0	45	0
Virgin Islands	28	1	9	1	8	0
Virginia	6,776	15	2,911	7	1,219	1
Washington	5,779	10	2,428	6	942	2
West Virginia	1,820	2	707	0	389	0
Wisconsin	4,733	10	1,939	5	797	1
Wyoming	192	2	57	0	20	0
TOTAL	290,796	539	120,977	197	55,727	66

Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2024

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
Alabama	3,838	7	606	2	2	1,644	0	0
Alaska	327	0	6	0	0	24	0	0
Arizona	4,136	9	858	0	0	1,052	1	0
Arkansas	1,926	4	531	1	1	403	0	0
California	36,006	63	3,231	7	5	7,485	6	4
Colorado	5,152	9	1,523	1	1	691	1	1
Connecticut	3,098	9	474	6	6	963	1	1
Delaware	855	2	21	0	0	128	0	0
District of Columbia	1,843	2	613	0	0	515	0	0
Florida	15,970	37	2,397	3	3	5,098	1	1
Georgia	6,098	10	1,076	0	0	1,430	0	0
Guam	19	0	0	0	0	1	0	0
Hawaii	1,081	3	148	0	0	237	0	0
Idaho	844	3	162	0	0	209	0	0
Illinois	11,110	21	2,462	2	1	2,872	5	4
Indiana	4,950	9	1,037	2	2	1,733	0	0
Iowa	3,224	6	403	1	1	948	0	0
Kansas	2,821	7	1,140	2	2	476	0	0
Kentucky	4,282	9	945	0	0	1,144	0	0
Louisiana	5,988	9	1,225	0	0	1,957	0	0
Maine	1,250	3	481	0	0	200	0	0
Maryland	5,267	13	421	1	1	1,036	1	0
Massachusetts	12,806	16	3,362	3	2	5,778	3	2
Michigan	13,136	24	1,775	2	1	5,267	3	3

[1] The Medical Student Section elects AMA delegates and alternate delegates from Medical Student Regions. There are seven Medical Student Regions defined for the purposes of electing AMA Delegates from Medical Student Regions. Each Region is entitled to delegate and alternate delegate representation based on the number of seats allocated to it by apportionment. A delegate is seated with the state delegation in which his or her medical school resides.

[2] Resident sectional delegates and alternate delegates endorsed by specialty societies were not included in this table. The following specialty societies endorsed sectional resident delegates and alternate delegates: American Academy of Dermatology Association, American Academy of Neurology, American Academy of Ophthalmology, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, American College of Chest Physicians (CHEST), American College of Emergency Physicians, American College of Nuclear Medicine, American College of Obstetricians and Gynecologists, American College of Radiology, American College of Surgeons, American Psychiatric Association, American Society of Anesthesiologists, American Urological Association, Association for Clinical Oncology, College of American Pathologists, Society of Interventional Radiology, and Undersea and Hyperbaric Medical Society.

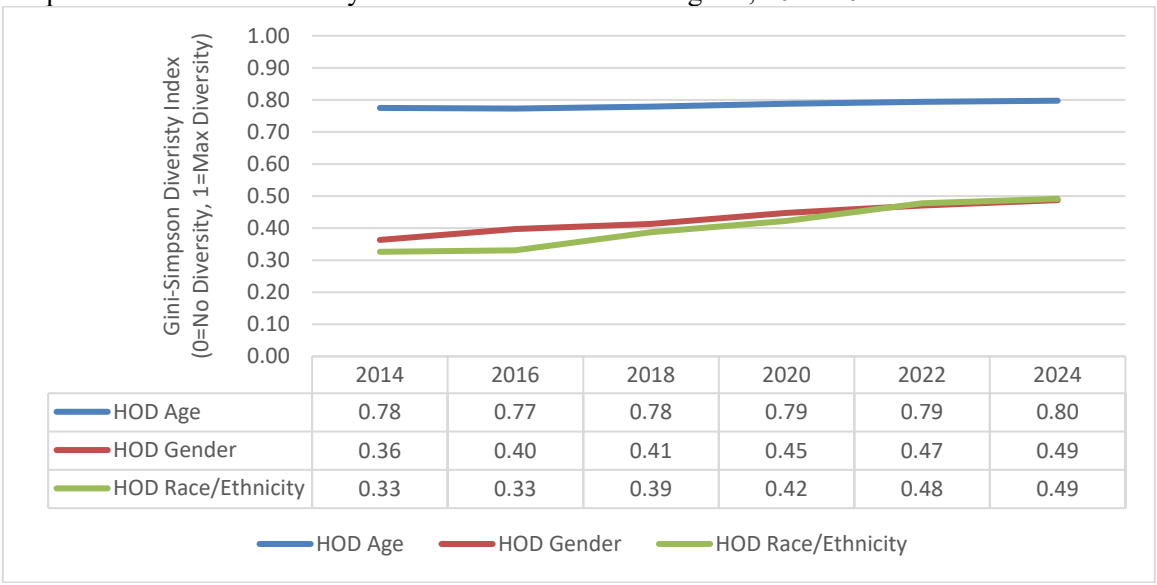
State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
Minnesota	4,683	9	388	0	0	1,563	0	0
Mississippi	2,748	6	640	1	1	771	1	1
Missouri	5,369	7	1,541	2	1	1,757	1	1
Montana	620	2	239	0	0	34	0	0
Nebraska	1,684	3	704	1	1	231	1	1
Nevada	1,896	4	401	1	1	620	0	0
New Hampshire	853	3	96	0	0	170	0	0
New Jersey	8,440	14	1,172	2	2	2,275	1	1
New Mexico	1,254	3	278	0	0	209	1	1
New York	22,864	38	3,699	3	2	10,101	2	1
North Carolina	5,395	10	673	1	1	1,608	0	0
North Dakota	1,315	2	356	0	0	98	0	0
Ohio	10,750	20	2,299	3	3	3,936	2	2
Oklahoma	3,393	7	1,036	1	1	1,036	3	3
Other	3,294	7	401	1	1	473	0	0
Oregon	786	1	22	0	0	48	0	0
Pennsylvania	14,059	26	2,072	3	1	3,670	1	0
Puerto Rico	1,460	2	597	0	0	306	0	0
Rhode Island	1,070	5	251	0	0	341	2	2
South Carolina	3,392	8	1,014	1	1	737	0	0
South Dakota	1,316	4	355	0	0	140	0	0
Tennessee	5,132	8	1,477	1	1	1,330	0	0
Texas	21,053	31	4,468	4	3	7,300	5	4
Utah	2,093	3	718	0	0	336	0	0
Vermont	522	1	119	0	0	119	0	0
Virgin Islands	28	1	0	0	0	0	0	0
Virginia	6,776	15	1,379	2	2	1,572	1	1
Washington	5,779	10	465	0	0	747	0	0
West Virginia	1,820	2	385	0	0	708	0	0
Wisconsin	4,733	10	735	2	2	1,413	1	0
Wyoming	192	2	4	0	0	11	0	0
TOTAL	290,796	539	52,881	62	52	84,951	44	34

Gini-Simpson Diversity Index (GSI) of the House of Delegates and AMA Leadership

A diversity index is a probabilistic measure that two individuals selected at random will represent different identities. The index provides a balanced and robust assessment of diversity and has been widely applied across demographic and clinical research contexts. The Council utilized the Gini-Simpson Diversity Index (GSI) which is the probability that two individuals selected at random will represent different identities; it is measured from 0 to 1, where 0 represents an absence of diversity and 1 represents the greatest possible diversity. CLRPD assessed diversity trends within the AMA HOD and AMA Leadership from 2014 to 2024, specifically focusing on member age, gender, and race/ethnicity.

From 2014 to 2024, the HOD demonstrated gradual but consistent increases in gender and racial/ethnic diversity, rising from 0.36 to 0.49 for gender, and 0.33 to 0.49 for race/ethnicity, while age diversity remained stable around 0.78. The total diversity index for HOD consequently improved from 0.49 to 0.59 over this period.

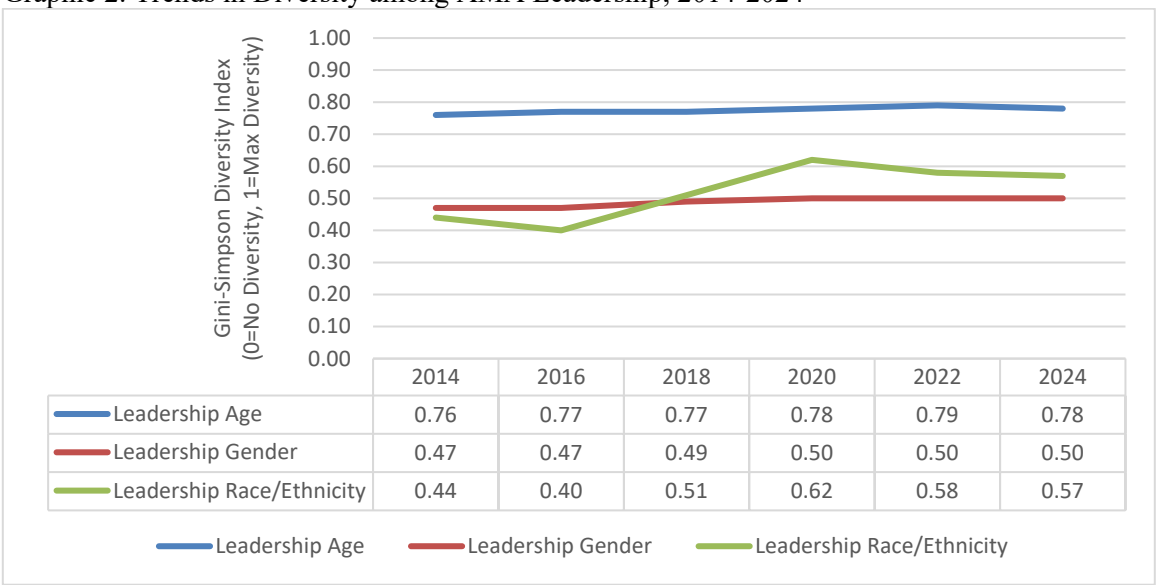
Graphic 1. Trends in Diversity in the AMA House of Delegates, 2014-2024



	2014	2016	2018	2020	2022	2024
HOD Age	0.78	0.77	0.78	0.79	0.79	0.80
HOD Gender	0.36	0.40	0.41	0.45	0.47	0.49
HOD Race/Ethnicity	0.33	0.33	0.39	0.42	0.48	0.49

Among AMA Leadership, a similar trajectory was observed. Gender diversity increased from 0.47 to approximately 0.50, and racial/ethnic diversity rose notably from 0.44 in 2014 to a peak of 0.62 in 2020 before slightly adjusting to 0.57 in 2024. Age diversity remained relatively constant around 0.77. The overall leadership diversity improved from 0.56 in 2014 to 0.62 in 2024, reflecting positive, though modest, gains.

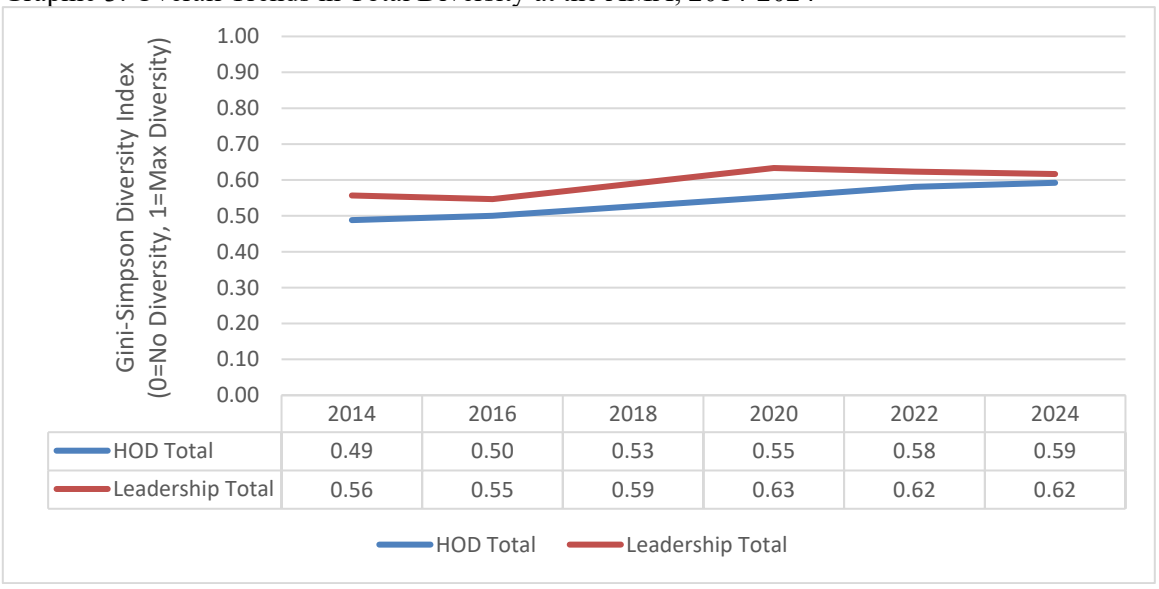
Graphic 2. Trends in Diversity among AMA Leadership, 2014-2024



	2014	2016	2018	2020	2022	2024
Leadership Age	0.76	0.77	0.77	0.78	0.79	0.78
Leadership Gender	0.47	0.47	0.49	0.50	0.50	0.50
Leadership Race/Ethnicity	0.44	0.40	0.51	0.62	0.58	0.57

The GSI illustrates that while diversity has gradually increased within AMA leadership and delegates, continuous efforts are necessary to foster further improvements, particularly in the representation of diverse gender and racial/ethnic identities.

Graphic 3. Overall Trends in Total Diversity at the AMA, 2014-2024



	2014	2016	2018	2020	2022	2024
HOD Total	0.49	0.50	0.53	0.55	0.58	0.59
Leadership Total	0.56	0.55	0.59	0.63	0.62	0.62

APPENDIX B

Specialty classification using physicians' self-designated specialties

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

American Medical Association Councils and Sections

COUNCILS

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

SECTIONS

- Academic Physicians Section
- Integrated Physician Practice Section
- International Medical Graduates Section
- LGBTQ+ Section
- Medical Student Section
- Minority Affairs Section
- Organized Medical Staff Section
- Private Practice Physicians Section

- Resident and Fellow Section
- Senior Physicians Section
- Young Physicians Section
- Women Physicians Section

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-25

Subject: Prescription Drug Affordability Boards

Presented by: Stephen Epstein, MD, MPP, Chair

Policy D-110.984 was adopted at the 2024 Annual Meeting and asks our American Medical Association (AMA) to study how upper payment limits (UPLs) established as a part of prescription drug affordability boards (PDABs) impact physician reimbursement and patient access to medications. The following informational report discusses the background of PDABs, the current state of these boards, potential impacts on patients and physicians, and existing AMA policy on the topic.

BACKGROUND

Drug prices in the United States (U.S.) make up nine to ten percent of total medical spending each year, or over $700 billion annually.[1] Research demonstrates that over the last 65 years, the prices of prescription medications have increased faster than both inflation and non-prescription medications.[2] This is due largely to high-priced branded drugs, which make up about 80 percent of U.S. drug spending.[1] American spending is also significantly higher than other comparable nations, with estimates of spending on prescription drugs over 200 percent higher per capita. This higher level of spending does not appear to result from American patients purchasing a higher quantity of medication, as the same study found that U.S. consumers purchased 12 percent fewer days of medications than patients in the other similar nations.[2] Rather, the high drug costs in the U.S. are a result of an incredibly complex, and largely opaque, system. While not all-encompassing, experts specify that the higher spending comes from a combination of higher transaction prices, selection of more expensive medications, monopoly pricing, patent extensions/gaming, and influential rebates.[1,2,3]

In an attempt to combat high drug prices and patient out-of-pocket (OOP) costs for medications, some states have begun to pass legislation to implement PDABs.[4,5] The first PDAB was established in Maryland in 2019 and in recent years more states have enacted legislation creating PDABs.[5] However, few states have actually begun to implement the work that is outlined in legislation, making the impact of these PDABs difficult to assess. Generally, PDABs are designed to both evaluate the jurisdiction's (typically a state's) spending on prescription drugs and to establish methods for lowering this spending. While there is a wide variety in the makeup, scope, and power of these boards, most focus on a specific set of prescription medications and release reports evaluating the state's spending and recommendations to increase affordability.[6] PDABs are often made up of health care providers, advocates, payer representatives, and patients/patient group representatives. Members are typically selected via an application process or by gubernatorial/congressional appointment.[6,7]

The majority of the states that have enacted PDABs utilized the National Academy for State Health Policy's (NASHP) model legislation, originally released in 2017 and updated in 2022, which includes references to federal legislation on drug pricing.[8] This model legislation is designed to

give states the authority to establish a framework that defines which medications are "unaffordable." The NASHP model bill includes PDAB authority to define upper payment limits (UPLs) for medications that are designated as "unaffordable."[8] UPLs are designed to set a maximum price for a specific drug based on its cost-effectiveness and affordability.[7] UPLs are intended to prevent price gouging and ensure that patients have access to essential medications. While state PDABs do not automatically have authority to establish UPLs, some states have chosen to include this authority.[7,8]

STATE PDABs

As of March 2025, 11 states (CO, ME, MD, MA, MN, NH, NJ, NY, OH, OR, and WA), have enacted legislation and some have begun to implement PDABs.[9] Details of each of the existing state PDABs can be found in Appendix A. Some states have limited the impact of PDABs to only public plan enrollees, others have incorporated the boards as a part of Medicaid plans only, while other states have indicated the intent for expansion to all enrollees, regardless of payer type. While many states have chosen not to include UPLs, four states, Colorado, Maryland Minnesota, and Washington, have included authority to establish UPLs.[9,10]

Each state has outlined different methods for selecting board members and medications, funding the work, and the reach of authority. Some states, like New York and Massachusetts have incorporated PDAB authorities into existing governmental organizations, NY Medicaid and MA Health and Human Services, respectively.[11,12] As a result, no additional funding or employees were allocated to those states' boards. However, other states have made significant investments in establishing a PDAB. For example, Oregon, Washington, and New Jersey have allocated at least $1.5 million each for the startup of the boards.[13,14,15] Funding origins are also diverse with some states, like Colorado, listing it as a state budget line while others have alternative funding sources.[16] Specifically, states like Oregon and Maryland plan to generate future funding via fees on drug manufactures, insurance carriers, wholesale distributors, and/or Pharmacy Benefit Managers (PBMs).[13,17]

States also vary in the makeup of boards and the impacted population(s). In addition to the employees that some states have hired (or plan to hire) to run the PDAB, states have chosen various methods to select board members. Most states utilize/plan to utilize a combination of appointments from congressional leaders and/or the governor. However, the makeup of expertise on the board varies from state to state.[6,8] Many states encourage or require that patients or patient advocates be a part of the board, while other states, like Colorado and Washington, require a certain level of drug pricing policy or clinical expertise for a certain subset of board members.[14,16] Further, states vary in the length of time board members can serve and if they must be confirmed by the state legislature. Additionally, states vary greatly in the populations that will be impacted by the outcome of PDAB decisions. Many states, like Maine, Maryland, and New Hampshire, have chosen to focus only on public plan beneficiaries.[17,18,19] However, other states, like Colorado, Minnesota, and Washington, have chosen to focus on all consumers with minor exceptions for plans preempted by the Employee Retirement Income Security Act that chose to opt out.[14,16,20]

In addition to the differences in the structure and authority of PDABs, states differ in which drugs are eligible to be covered. A few states have relatively open criteria while others have more stringent requirements. States like New Hampshire and Maine focus on any prescription medications that are purchased by public payers and may cause "affordability challenges."[18,19] However, the majority of states have more strict criteria typically centering around drugs with high wholesale acquisition cost (WAC) launch prices, have substantial percentage WAC increases, those with a certain WAC price, and/or generics that are not a specified percentage less expensive than

the reference medication. For example, in Maryland for a drug to be considered by the PDAB it must meet the following criteria:

- if the medication is brand name and has a WAC of $30,000+ or a $3,000+ price increase in 12 months; or
- if the medication is a biosimilar and has a WAC that is less than 15 percent lower than the reference medication; or
- if the medication is generic and has a WAC of more than $100 for a 30-day prescription or an increase in WAC over 200 percent.[17]

While the details vary by state, those with more specific criteria tend to be comparable to the aforementioned requirements in Maryland. However, Oregon has unique criteria in that the legislation outlines the selection of 10 drugs to be reviewed each calendar year. One of the selected drugs must be an insulin product and the other nine are selected from the state's Prescription Drug Price Transparency Program, excluding any medication designed to treat a Food and Drug Administration (FDA) designated rate disease or condition.[13] Additionally, some states, like Ohio, have chosen to not focus on specific drugs but, rather, to focus on strategies to reduce overall drug spending, increase transparency, and optimize resources and bargaining power.[21]

An important distinction in state legislation is whether PDABs are given the authority to set UPLs. Of the 11 states that have enacted PDAB legislation, only four have granted authority to set UPLs: Colorado, Maryland (pending legislative approval), Minnesota, and Washington. Within states with UPL authority, Washington is only able to set UPLs for up to 12 drugs, while Colorado and Minnesota do not have a limit for establishing UPLs on PDAB-reviewed drugs.[14,16,17,20] Each of these states have unique processes for establishing the UPL based on a combination of cost and value measures. For example, in Washington if a drug is ruled as "unaffordable" by the board, the following must be taken into account when setting an UPL: the cost of administering the medication; the cost of delivering the drug to the patient, if the drug is included in the FDA drug shortage list; and any relevant administrative costs related to the delivery and/or production of the drug. Additionally, the board must monitor the drug for future drug shortages and can suspend the UPL should a shortage occur. Finally, the board must assess the value that the drug has for those who utilize it to enhance health and/or elongate life.[14] While each state with UPL authority has different specific requirements, they all generally follow the above-mentioned requirements. Nonetheless, at the time this report was written, no state had set an UPL.

Of important note, some state PDABs have faced legislative and legal challenges that limit their implementation. For example, in 2019, Ohio successfully passed legislation outlining the creation and implementation of a state PDAB. However, in 2021, an amendment to the statute that originally authorized the PDAB was made that essentially nullifies the state's PDAB in practice.[22] In addition to legislative challenges, PDABs are facing legal challenges, often from drug manufacturers. For example, after Colorado's PDAB ruled that the drug Enbrel® was "unaffordable," paving the way for the establishment of a UPL, the drug's manufacturer, Amgen, sued the state, claiming that the PDAB law violates several state constitutional provisions and attempts to regulate federal health care programs.[23] At the time this report was written, the outcome of this case is unknown. However, it is highly likely that more lawsuits will begin to materialize as additional states make claims of unaffordability and, in some cases, establish UPLs.

State Example: Colorado

The Council highlights Colorado as an example in this report as its PDAB is perhaps the furthest along in the process and includes UPLs authority. In 2021, legislation to establish a PDAB in

Colorado became law. The board is overseen by the Division of Insurance of the Colorado Department of Regulatory Agencies (DORA). The board consists of up of five members who have advanced degree(s) or experience in health care economics or clinical medicine and are appointed by the governor and confirmed by the state senate. The board began meeting in late 2021 and in 2024, Colorado's PDAB voted to determine the affordability of the first five drugs. This process included presentations by experts, testimony from witnesses, including open public testimony, and deliberation of the board members. Two medications were ruled as "not unaffordable" and the other three were ruled "unaffordable" to Colorado consumers. For the three medications that were ruled "unaffordable," the PDAB is working to establish UPLs. Per the original design, the board has a preset process that was anticipated to take approximately six months. However, due to certain barriers, such as legal challenges from the manufacturer, this process has been drawn out and UPLs have not yet been established for the three medications ruled "unaffordable." The first UPL rulemaking hearing was scheduled to be held in early March 2025, which will begin the process of establishing the payment limit for the specific medication.[16]

POTENTIAL IMPACTS

PDABs and UPLs are novel to the drug pricing landscape and, as a result, much of the information regarding their impact is speculative. Many states have established policies to create PDABs, but the majority of boards have either not yet started meeting or started very recently. While researchers have theorized how these boards and/or limits may impact patients and physicians, data to establish firm, research-based conclusions of the actual impacts are not available at this time.

Proponents of PDABs and UPLs explain that these strategies are designed to rein in out-of-control drug prices, ensure that patients have access to their medications at a reasonable price, and lower state drug spending.[24,25] Supporters point to similar practices in the non-medical communities, such as public utility commissions. Each state has its own public utility commission which works to regulate providers to ensure that the prices that consumers pay for public utilities are fair for all involved. While these commissions have been relatively successful in controlling utility costs, the difference between the structure of utility pricing and delivery and drug pricing and delivery is quite significant.[26] Additionally, it is a reasonably common practice for states to set payment rates for health care services to ensure they are affordable and accessible to patients. For example, fee schedules are commonly set by state and federal governments that list the maximums that a physician or provider is paid for a service. Some anticipate that PDABs and UPLs could function in a similar way to control costs.[25] Supporters of PDABs believe that by focusing on the drug payment rate specifically, patent preemption (i.e., breaking the patent) is avoided while also allowing for control of drug cost. At the core, those who champion PDABs argue that medications are exceptionally expensive and these boards will lower drug prices, thus making drugs more accessible and affordable to patients.[24,25]

While most experts agree that prescription medications in the US are prohibitively expensive, some experts have expressed concern regarding the impact that PDABs and UPLs may have on patients and physicians.[7,27] Concern has been expressed that the implementation of these boards will negatively impact patient access to medications. One specific concern centers around medication formulary placement. If a medication is given an UPL, payers may choose to place it on a less desirable formulary tier. This could result in patients not being able to access the most effective medication affordably and/or increase required utilization management for that medication.[7,27] Further, this could result in limits to physician payment and disrupt physician/practice ability to purchase medications in a fiscally responsible manner. This is especially salient if the drug's UPL is less than the acquisition cost, as purchasers would not be able to affordably stock the medication.[10]

Concern also has been raised that patient assistance programs could suffer for selected medications. These concerns are particularly salient for patients who are on essential, specified, and expensive prescriptions, especially HIV, cancer, and Hepatitis C treatments/medications.[27] For example, research has suggested that patients on HIV medications saved 91 percent of their OOP costs due to copay assistance programs. Should these medications be given UPLs, it is possible that manufacturers could reassess assistance programs. This could lead to a situation where the medication cost may be below the UPL, but patients may be required to pay greater OOP costs due to lessened or removed assistance programs.[7,27] Research has suggested that even a minor increase in patient OOP spending impacts patient adherence. For example, a recent study found that a minor increase from $0 to $10 OOP cost doubled the abandonment rate for patients using oral HIV pre-exposure prophylaxis (PrEP). This study, along with others linking increases in patient OOP costs to lower treatment adherence, exemplifies the potential impact of even a small change to programs designed to relieve patient OOP costs.[28] There is ample concern that the implementation of PDABs, especially those with UPL authority, could significantly impact programs designed to relieve patient OOP costs potentially impacting treatment adherence.[27]

Additionally, advocacy groups have recently raised concerns around the disproportionate impact of PDABs on people with disabilities. While the states that have released lists of selected medications are still relatively limited, initial lists indicate that the vast majority of selected medications are disproportionately used to treat conditions that are likely or highly likely to be classified as "disabling" under the Americans with Disabilities Act (ADA).[29,30] Even while Washington state has the lowest rate of medications used to treat potentially disabling diagnoses, it still amounts to over 86 percent. Across the published lists, each state has at least one HIV antiretroviral, with medications to treat cancer, genetic disorders, autoimmune disorders, and endocrine disorders also disproportionately represented.[29] Serious concerns have been raised that the selection of these medications could cause disparate impacts on the disability community and limit patient access to essential medications. Experts explain that the potential downline supply chain disruptions and lack of guaranteed patient cost savings, paired with the aforementioned unknown impact on patient assistance programs, could lead to significant barriers in patient access.[29,30]

While it remains to be seen how PDABs and their UPLs will impact patients and physicians, it is important to acknowledge the enforcement potential of these boards. Experts agree that while PDABs are likely very well intentioned, there is not much enforcement to back up the recommendations that are made. This is especially relevant for states that have not granted UPL authority to their PDAB. However, even among the states that have given authority to grant UPLs, there are significant questions as to whether these limits will impact actual drug prices. For example, there is current discussion as to whether these UPLs will apply to insurers that are not regulated by the state. In other words, federal or interstate plans may be outside the scope of authority for state PDABs.[23,31] Without effective enforcement, which no PDAB seems to have at the present time, it is unlikely that manufacturers, payers, and PBMs will adhere to the suggested prices.

AMA POLICY AND ADVOCACY

The AMA has a robust body of policy to ensure that prescription medications are affordable and accessible to patients. Specifically, Policy H-110.997 outlines support for programs that are designed to mitigate the cost of prescription medications, physician autonomy to prescribe the most appropriate and effective medication to their patient, and for payers to cover prescribed medications. Policy H-110.987 builds on the aforementioned policy to ensure that pharmaceutical companies and their proxies are not participating in anticompetitive behaviors or mergers/acquisitions that unduly raise the cost of prescription medications. This policy also

addresses the need to ensure that prescription prices are reasonable and do not exceed the pace of inflation. Policy H-330.864 focuses specifically on reforming Medicare drug reimbursement and ensuring that it is done in a manner that allows for patient access and also reimburses physicians fairly. Finally, Policy H-100.964 outlines AMA support to ensure that prescription medications are covered by payers in a manner that keeps them affordable and accessible to patients.

Additionally, the AMA has a robust history of drug pricing advocacy. Over the last few years, numerous letters and testimonies have been sent to regulators (CMS 2023, CMS 2024), legislators (House 2023, House 2023(a), Senate 2024), and payers (NAIC 2023) working to mitigate the high price of prescription drugs and ensure that patients are able to afford their medications. In addition to this advocacy work, the AMA has a longstanding grassroots campaign, TruthinRx, that is designed to increase transparency of drug pricing and decrease costs.

In addition to policy and advocacy surrounding drug pricing, AMA policy addresses concerns raised by sceptics of PDABs and UPLs. The AMA has a long history of working to lessen utilization management, especially prior authorization via campaigns (e.g., Fix Prior Auth) and policy. Specifically, Policies H-320.939 and D-320.982 outline the AMA's stance against prior authorization and efforts to ensure that physicians are not overburdened by these requirements. Additionally, Policy H-125.991 outlines the AMA's efforts to ensure that payer formularies are fair and inclusive of physician-prescribed medications.

DISCUSSION

Proponents of PDABs believe that they will do what they intend—lower drug prices in the U.S. and create a more affordable system for patients. However, critics voice concerns around the actual impacts. Concern has been expressed that PDABs, especially those with the authority to establish UPLs, may increase physician administrative burden, increase costs for patients and physicians, and disproportionately impact patients with ADA disabling conditions. Additionally, concerns have been raised that if UPLs are set below the acquisition cost for a physician administered drug, there may be an adverse impact on medication availability and could result in market distortions. Others question the actual enforcement authority these boards have, or will have, on regulating drug prices. Since PDABs and UPLs are relatively new, it will take time to see if these strategies result in their intended goal—to lower drug prices and make prescription medications more affordable for patients.

CONCLUSION

The Council believes that the AMA has robust advocacy efforts and clear policy supporting the need for prescription drugs to be affordable and accessible to patients. However, due to the relative recency of PDABs, there is no research yet available on actual impacts or outcomes of the boards. Therefore, the Council will continue to monitor this issue and report back when a reasonable body of research has been established in which to form conclusions and guide additional, well-informed policy on the impact of PDABs and UPLs on patients and physicians.

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Appendix A
State Prescription Drug Affordability Boards

State	Initiative	Budget/Funding	UPL Authority?	Membership	Populations	Drug Inclusion Criteria
Colorado	CO SB 175-2021	State budget line. *Approximately $750,000/year.*	Yes.	2 FTE and 2 PTE employee allocation. Additional contractors approved with board review. Additional $250,000 allocated. The Board consists of 5 members appointed by the governor and confirmed by the senate. All must have either an advanced degree and experience or expertise in health care economics or clinical medicine.	All consumers. *Exemption for state funded plans that choose to opt out.*	Drugs that meet 3+ of the following: - Brand-name drugs and biologics that have a wholesale acquisition cost (WAC) of $30,000+ - Brand-name drugs and biologics that have a WAC increase of 10%+ in the last 12 months - Biosimilars that launch at a WAC that is not at least 15% less than the reference - Generics that have a WAC of over $100/30 days
Maine	ME LD 120 (2021)	Absorbed by existing budgets.	No.	0 FTE. Board supported by the Office of Affordable Health Care. The Board consists of 13 members, 6 appointed by the Senate President, 5 by the Speaker of the House, 2 state commissioners (non-voting).	Public plan beneficiaries.	Drugs that are purchases by public payers and may cause "affordability challenges."
Maryland	MD HB 768-2019	Start up costs provided by the State budget. Annual funding from fees on drug manufacturers, PBMs, carriers, and wholesale distributors. *2024*	Yes. *If legislative approval is gained.*	5 FTE and 1 PTE. Additional contractors approved with board review. Additional $250,000 allocated. The Board consists of 5 members appointed by the governor, President of the Senate, Speaker of the House, Attorney General, and jointly	Public plan beneficiaries. *Have indicated potential to attempt expansion to all payers.*	Drugs that meet the following criteria: - Brand-name that launch with a WAC of over $30,000/yr - Brand-name with a price increase of $3,000+/year - Biosimilars that launch at a WAC that is not at least 15% less than the reference

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		budget: 1.4 million+		by the House Speaker and Senate President.		- Generics that have a WAC of over $100/30 days OR increased by 200%+ in the last year
Massachusetts	HB 4000 – Section 46 of FY 2020 Budget	No additional funding appropriated.	No.	Implemented through MA Medicaid agency and Health Policy Commission.	Medicaid beneficiaries.	Drugs covered by Medicaid that cost more than $25,000/yr per person or $10 million to the program. Excludes medications in which a supplemental rebate agreement is reached.
Minnesota	MN SF 2744-Section 62J.85	Base appropriation of at least $500,000/year from the State budget.	Yes.	1 FTE with the potential for more. Board to be supported by the Commissioner of Health and Attorney General. The Board consists of 9 members. 7 voting members appointed by the governor, 1 nonvoting member appointed by the senate majority leader, and 1 nonvoting member appointed by the speaker of the house.	All consumers. *Plans preempted by ERISA can choose to opt out.*	Drugs that meet the following criteria: - Brand name/biologics that have a WAC increase of over 15% or more than $3,000 annually or during the course of treatment after adjusting for Consumer Price Index - Brand name/biologics with a WAC of over $60,000 per year or course of treatment - Biosimilars that launch at a WAC that is not at least 20% less than the reference - Generics that have a WAC of over $100/30 days, a course of treatment, or one unit - Generics that have a price increase by 200%+ in the last year The Board may identify additional drugs that impose significant affordability challenges.
New Hampshire	NH HB 1280-2020	Appropriation of approximately $350,000/annually.	No.	N/A The Board consists of two members appointed by the president of the senate, two members appointed by the speaker of the house, and one appointed by the governor.	Public plan beneficiaries.	Drugs that are purchases by public payers and may cause “affordability challenges.”

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New Jersey	P.L. 2023, c. 106	Appropriation of $1.5 million to implement the initial bill.	No.	The Board consists of 5 public members; 3 appointed by the governor; 1 on recommendation of the senate president, and 1 on recommendation of the house speaker. Will work in tandem with the Drug Affordability Council/Drug Affordability Unit.	N/A	Drug practice reports are reviewed and the board is able to make recommendations to increase affordability.
New York	PHL Sec 280-2017	No additional funding appropriated.	No.	Implemented through NY Medicaid Agency's Medicaid Drug Benefit Cap.	Medicaid beneficiaries.	- Drugs that will exceed the state's Medicaid drug cap (set annually) - Newly launched drugs that are "high cost" or meet the following o Brand-name that launch with a WAC of over $30,000/yr o Brand-name with a price increase of $3,000+/year o Biosimilars that launch at a WAC that is not at least 15% less than the reference o Generics that have a WAC of over $100/30 days o Gene therapies
Ohio	OH HB 166-133 2019	N/A. 2021 amendment to the authorizing statute mitigated authority. Board is still technically intact.	No.	The board is comprised of 17 individuals. 6 state employees (director of administrative services; director of health; Medicaid director; director of mental health and addiction services; administrator of workers' compensation) and 12 members who work in drug affordability and availability and are appointed by the governor, senate	N/A.	Not focused on specific drugs, instead the Board is tasked in creating reports including the following information: - How the state can best achieve drug price transparency - Avenues/payment models to increase/create affordability - Levering the state's purchasing power - Creating efficiencies to reduce costs

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				president, and house speaker (3 appointments each).		- Outcomes to be measured to improve state's purchasing of drugs - How existing resources cab be optimized
Oregon	OR SB 844-2021	$1.7+ million appropriated to the Department of Consumer and Business Services with the intent for reimbursement from manufacturer fees. The ongoing budget will come from fees.	No.	5 FTE. The Board consists of 5 members all appointed by the governor.	N/A.	Nine drugs and one insulin product each year based on drugs reported in OR's Prescription Drug Price Transparency Program. Excludes any drug designated by the FDA to treat a rare disease/condition.
Washington	WA SB 5532/Chapter 153-2022	Initial appropriation of $1.5 million over the first 3 years.	Yes. *For up to 12 drugs.*	4 FTE. The Board consists of 5 members appointed by the governor with expertise in health care economics or clinical medicine.	All consumers. *Exemption for state funded plans that choose to opt out.*	Drugs that have been on the market for 7+ years, are not designated by the FDA to treat a rare disease/condition, and meet the following criteria: - Brand name/biologics with a WAC of over $60,000 per year or course of treatment - Brand name/biologics that have a WAC increase of over 15% over 1 year or 50% over 3 years - Biosimilars that launch at a WAC that is not at least 15% less than the reference - Generics that have a WAC of over $100/30 days, a course of treatment, or have a price increase by 200%+ in the last year
Adapted from the NASHP Comparison of State Prescription Drug Affordability Review Initiatives and source legislation.						