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* Report of the House of Delegates Committee on Compensation of the Officers

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REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-16

Subject: Minority Affairs Section and Integrated Physician Practice Section, Five-Year Reviews

Presented by: Mary T. Herald, MD, Chair

Referred to: Reference Committee F
(Gary R. Katz, MD, MBA, Chair)

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, only with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

The Council analyzed information from letters of application submitted by the Minority Affairs Section (MAS) and the Integrated Physician Practice Section (IPPS) for renewal of delineated section status.

APPLICATION OF CRITERIA TO THE MINORITY AFFAIRS SECTION

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

Initially established in 1992 as a Board of Trustees advisory committee, the House of Delegates (HOD) adopted the MAS as a delineated section in 2011. The MAS facilitates the development of information and policies for underrepresented minority (URM) physicians and medical students, and provides a national platform to advocate for minority health issues. URMs represent only nine percent of the U.S. physician workforce. In the medical profession certain racial and ethnic groups, such as African Americans, Hispanics/Latinos, and American Indians/Alaska Natives lag significantly behind their numbers in the general population. Studies have documented that physicians from diverse backgrounds increase patient satisfaction, provide culturally competent care, and decrease racial and ethnic health care disparities.

CLRPD assessment: The MAS provides the only formal structure for minority physicians to participate directly in the deliberations of the HOD and activities of the AMA.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The primary objectives of the MAS are to influence and contribute to AMA policy and program development on issues of importance to minority physicians and the AMA. The section works to

eliminate racial and ethnic disparities in health care and improve the health status of minority patients; promote diversity in the profession and increase the number of URMs in medicine; assist physicians in delivering culturally effective health care; and increase membership, participation, and leadership of minority physicians in the AMA.

The MAS collaborates with other sections on policy development and reports, and planning educational sessions and outreach programs. The section developed the Doctors Back to School™ program as a diversity pipeline initiative to inspire the next generation of URM physicians. The MAS collaborates with the Medical Student Section as well as external partners by connecting members with minority youth in classrooms and school assemblies around the nation. Since its launch in 2002, tens of thousands of children have been engaged through this educational program. The MAS collaborated with the Accelerating Change in Medical Education (ACE) strategic focus area by participating with ACE grant recipients in efforts to identify best practices and common barriers to increasing diversity at their institutions.

CLRPD Assessment: The MAS serves its constituents by bringing professional issues unique to them to the forefront of organized medicine and by providing targeted educational and policy resources.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

The MAS convenes a nine-member governing council (GC) to direct the section's agenda and strategies. Only current MAS members with an active AMA membership are eligible to be nominated to the designated positions on the GC. Prior leadership experience and an interest or expertise in minority health issues are recommended for anyone wishing to run for the GC. Three minority physician organizations (National Medical Association, Association of American Indian Physicians, and National Hispanic Medical Association) nominate representatives to be elected to designated positions on the GC. Each of the three AMA fixed sections (Medical Student Section, Resident Fellow Section, and Young Physicians Section) also nominates their respective representatives, whom the MAS membership elects via electronic ballot. The GC elects its chair and vice-chair in a closed session at each Annual Meeting of the HOD. To facilitate section business and policy development, the section's GC meets in-person three times each year. Additional GC meetings are held monthly via teleconference.

CLRPD Assessment: The MAS convenes a GC from its members. The section has established business meetings that are open to its members and provides venues for sharing concerns and identifying opportunities for URM physicians and medical students, which is consistent with the objectives of this section.

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

Over 4,400 medical students and physicians have joined the MAS via an online registration form. Approximately 300 members are active participants in MAS programs, events, and meetings. The AMA has approximately 24,000 URM members and all of these physicians are eligible members of the MAS. The section undertakes regular communications and recruitment efforts to attract new

members. When the AMA attends ethnic medical association meetings, the primary goal is to recruit new AMA and MAS members.

CLRPD Assessment: The MAS is comprised of members from an identifiable segment of AMA membership and the general physician population. This group is able to represent a minimum of 1,000 AMA members.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

Approximately, 100 members attend each of the two MAS meetings held in conjunction with HOD meetings. A typical agenda for a MAS meeting includes a networking reception, a report from the chair on current MAS activities, the MAS delegate's report on resolutions, a keynote presentation on a critical minority health issue, and a discussion of new business. Physicians have benefited from participation in the MAS in the following ways: members vote and comment on MAS resolutions before they are submitted to the HOD, propose strategies to increase diversity in the recruitment and selection of nominees (e.g., proposed revisions to the AMA Nominations Form), identify gaps in policy, and propose research projects that may improve minority health. Examples of issues brought forth by the MAS to the HOD include the need for expanded immunization promotion in minority communities; broader awareness of sexual violence against Native American/Alaska Native women; and inclusion of cultural competency, medical translators, patient navigators, and diversity in the physician work force to address racial and ethnic disparities in patient outcomes.

CLRPD Assessment: The MAS has a long history with the AMA, which benefits from having a distinct voice of the MAS in the HOD. Since its inception, the MAS has taken numerous steps to align its structure with the policymaking activities of the AMA.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the AMA HOD.

The MAS represents the interests of its members in the HOD through the actions of its elected delegate. Individual members with an active AMA membership may submit resolutions for consideration, which the GC either approves for adoption as written or works with the author(s) on refining language and/or researching citations. To develop a consensus on MAS resolutions, section members meet virtually and offer votes supporting or opposing a resolution. Members also may submit comments or testimony, which suggest revisions to the original resolution. The GC considers all comments, votes, and testimony before editing the resolution for a final ratification vote. A majority vote of those present (via electronic vote) directs the action of the GC and delegate to submit (or not submit) a resolution to the HOD. Additionally, the MAS holds business meetings in conjunction with HOD meetings to solicit additional ideas and identify gaps in current policies to submit at future HOD meetings. The section contributes to the advocacy agenda by participating in the Grassroots Advocacy Network on issues such as repealing the sustainable growth rate (SGR) and the Save GME initiative.

CLRPD Assessment: The MAS provides numerous opportunities for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the HOD policymaking process.

CONCLUSION

The CLRPD has determined that the MAS meets all criteria; therefore, it is appropriate to renew the delineated section status of the section.

APPLICATION OF CRITERIA TO THE INTEGRATED PHYSICIAN PRACTICE SECTION

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The HOD adopted the Integrated Physician Practice Section (IPPS) as a delineated section in 2011 and the section held its inaugural meeting at the 2013 Annual Meeting. The precursor to the IPPS was the Advisory Committee on Group Practice Physicians, a Board-appointed committee founded in the early 1990s. The characteristic that distinguishes IPPS from other AMA component groups is that the section focuses on the continuum of care through an integrated delivery system. The IPPS works to advance the interests of multi-specialty, physician-led, integrated health care delivery systems, and medical groups actively working toward systems of coordinated care. Since the founding of the IPPS, key factors have moved health care delivery in the direction of integrated, accountable care, including implementation of the Affordable Care Act and its requirement that Medicare create an Accountable Care Organization (ACO) program, and the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

CLRPD assessment: The IPPS provides the only formal structure for physicians in or actively working toward multi-specialty, physician-led, integrated health care delivery groups or systems to participate in the deliberations of the HOD and impact policy.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The IPPS collaborates with other sections, most frequently with the Organized Medical Staff Section, on topics of common interest. Both sections participate in biannual meetings with the AMA-appointed Commissioners to the Joint Commission. AMA councils have sought IPPS's input on a variety of reports. The Council on Ethical and Judicial Affairs (CEJA) met with the IPPS seeking early input on its report on free pharmaceutical samples, and the Council on Medical Service (CMS) sought IPPS input on reports related to physician-led team-based care. Further, the IPPS contributes to efforts of the Physician Satisfaction and Practice Sustainability focus area by providing input on alternative payment models, contributing to surveys of physician leaders, and participating in a multi-stakeholder work group to develop the AMA/AHA integrated physician leadership model, which resulted in the Integrated Leadership for Hospitals and Health Systems: Guiding Principles.

CLRPD Assessment: The IPPS works with a variety of groups to help support the vital work of the AMA related to health system reform and physician-led integrated care. Additionally, participation in the IPPS serves as a key member benefit for physician groups considering AMA group membership.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

Candidates for the IPPS governing council (GC), including the delegate and alternate delegate, must be from physician-led, integrated groups or health systems and meet the criteria for Associate membership in the IPPS. Voting members of the IPPS select GC members. Following the completion of its first cycle of meetings, the GC proposed and the Board adopted changes to the IPPS Internal Operating Procedures to refine its governance structure and election procedure. To ensure balanced representation from groups of varying size, the IPPS added slotted seats for representation from a small-medium sized group (50 physicians or less) and a large group (more than 51). The "officer track" was eliminated, and a chair and vice chair are now elected separately. Intra-council elections were eliminated and replaced with direct elections for all positions.

CLRPD Assessment: The IPPS convenes a GC from its members. The section has established business meetings that are open to its members and provides venues for sharing concerns and identifying opportunities for physicians from various-sized group practices, which is consistent with the objectives of this section.

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

Regarding potential IPPS membership, no existing data clearly identify eligible members. Additionally, potential members of IPPS span a broad spectrum. Members could be from physician-led, integrated, multi-specialty groups of all sizes and types, or from small independent practices of any specialty aligned through one of a variety of models such as IPAs, PHOs, ACOs, etc. Since there is no way to know if a physician is from an organization that fits these descriptors, the IPPS casts a wide net in seeking to attract members and welcomes any physician who either meets the IPPS member criteria or is simply interested in learning more about physician-led integrated care.

Currently, 46 organizations have completed the IPPS certification form. The number of physicians practicing within those organizations is approximately 41,000. Assuming an AMA market share of 14 percent of practicing physicians, there are approximately 5,800 physician members in those groups. Meeting registration varies from 80-120 attendees, and the number of IPPS-certified physicians at any given meeting is 25-35.

CLRPD Assessment: A substantial number of AMA members would be represented by IPPS. This group is able to represent a minimum of 1,000 AMA members.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

The IPPS has been fully functioning as a section for 2.5 years and has sponsored five meetings; thus, the amount of data indicating stability is limited compared to other sections. Before each meeting, the IPPS uses the AMA database to identify group practice physicians in surrounding states and sends an email inviting them to the IPPS meeting. Further, the IPPS has developed a database that includes mailing addresses for over 600 physician leaders from mostly large multi-

specialty groups and Medicare ACOs. While the IPPS is still developing its policymaking process and capacity, the section's voice has benefited the AMA's policy development process on a number of occasions resulting in the adoption of new AMA policy, such as the importance of physician leadership in all modes of practice, and quality reporting for physician-led, team-based care. These policy positions bring the section's unique perspective to bear on AMA policy.

CLRPD Assessment: As a relatively new section, the IPPS has not yet had the opportunity to demonstrate the same level of stability as other sections. However, since its inception, the IPPS has taken numerous steps to align its structure with the policymaking activities of the AMA and grow its membership. The AMA and physicians from physician-led integrated practices benefit from having a distinct voice of the IPPS in the HOD.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

At each meeting, the IPPS GC presents a report identifying select items from the HOD Handbook that may be of particular interest to members of the IPPS, as well as all IPPS resolutions. The IPPS Policy Development Committee is open to all members, who are invited to comment on the items, as well as raise items of interest from the HOD that have not been included. During the discussion, if it is unclear where the attendees stand on an issue, the Chair calls for a vote. It is through this discussion and voting process that the IPPS develops consensus on HOD business. The IPPS has actively sought to include physicians from smaller and independent practices, a minority within the section, with the creation of a slotted seat on the GC for a physician from a smaller integrated practice. Frequently, breakout sessions during the meetings are organized by group size, thereby affording smaller groups greater opportunity to be involved. At the I-15 meeting, IPPS reached out to members of the HOD by offering an education program, "How to integrate and remain independent."

CLRPD Assessment: The IPPS provides numerous opportunities for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the HOD policymaking process.

CONCLUSION

The CLRPD has determined that the IPPS meets all criteria; therefore, it is appropriate to renew the delineated section status of this section.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Minority Affairs Section and the Integrated Physician Practice Section through 2021 with the next review no later than the 2021 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Report I-16

Subject: Report of the House of Delegates Committee on Compensation of the Officers

Presented by: Anthony M. Padula, MD, Chair

Referred to: Reference Committee F
(Jane C. Fitch, MD, Chair)

This report by the Committee at the 2016 Interim Meeting presents five recommendations. It also documents the compensation paid to Officers for the period July 1, 2015 thru June 30, 2016 and includes the 2015 calendar year IRS reported taxable value of benefits, perquisites, services, and in-kind payments for all Officers.

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the "Committee"). The Officers are defined in the American Medical Association's (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to "Officer," which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and Vice Speaker of the HOD, collectively referred to in this report as Officers). The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.645 provides:

> The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of total compensation which was added to the Glossary of the AMA Constitution and Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual for work performance including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

At A-08, the HOD approved changes that simplified compensation practices with increased transparency and consistency. At A-10, Reference Committee F requested that this Committee recommend that the HOD affirm a codification of the current compensation principle, which occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base its recommendations for Officer compensation on the principle of the value of the work performed, consistent with IRS guidance and best practices as recommended by the Committee's external independent consultant, who is expert in Board compensation.

At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation with that of all other Officers (excluding Presidents and Chair) because these positions perform comparable work.

Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves Group, to update his 2007 research by providing the Committee with comprehensive advice and counsel on Officer compensation. The Committee asked for this update because it had been four years since the last comprehensive review and because the Committee wanted to continue refining its compensation practices to improve simplification and transparency. The updated compensation structure was presented and approved by the HOD at I-11 with an effective date of July 1, 2012.

At I-11, Reference Committee F requested that the Committee list the specific benefits, perquisites and in-kind payments provided to the Officers and to document annually the taxable value of these benefits. The Committee first reported this information, as reported to the IRS, in its A-12 report.

The Committee's I-12 report referenced discussion and research concerning Presidents' travel on regional airlines. The A-13 report expanded the travel discussion to include travel on airlines without preferred status. The HOD approved the Committee's recommendation to provide a travel allowance for each President to be used for upgrades, primarily on non-preferred status airlines, because of the significant volume of travel by the Presidents in representing our AMA.

CASH COMPENSATION SUMMARY

The cash compensation of the Officers shown in the following table will not be the same as compensation reported annually on the AMA's IRS Form 990 because Form 990s are based on a calendar year. The total cash compensation in the summary is compensation for the days these Officers spend away from home on AMA business approved by the Board Chair. The total cash compensation in the summary includes work as defined by the Governance Honorarium and Per Diem for Representation including conference calls with groups outside of the AMA, totaling 2 hours or more per calendar day as approved by the Board Chair. Detailed definitions are located in the Appendix.

The summary covers July 1, 2015 to June 30, 2016:

AMA Officers	Position	Total Compensation	Total Days
Maya A Babu, MD, MBA	Resident Officer	$ 72,900	62
Susan R Bailey, MD	Speaker, House of Delegates	$ 74,700	52
David O Barbe, MD, MHA	Officer	$ 92,700	78
Willarda V Edwards, MD, MBA	Officer	-	2.5
Jesse M Ehrenfeld, MD, MPH	Young Physician Officer	$ 87,900	64
Julie K Goonewardene	Public Board Member Officer	$ 61,500	37
Andrew W Gurman, MD	President-Elect	$ 274,000	128
Gerald E Harmon, MD	Secretary	$ 65,700	57
Patrice A Harris, MD, MA	Chair-Elect	$ 205,500	94
William E Kobler, MD	Officer	$ 92,700	71
Russell WH Kridel, MD	Officer	$ 73,500	54.5
Omar Z Maniya, MBA	Medical Student Officer	-	1.5
Barbara L McAneny, MD	Immediate Past Chair	$ 87,300	75.5
Mary Anne McCaffree, MD	Officer	$ 89,700	69.5
William A McDade, MD, PhD	Officer	-	1
Albert J Osbahr, III, MD	Officer	$ 87,300	59
Stephen R Permut, MD, JD	Chair	$ 269,500	106
Dina Marie Pitta, MPP	Medical Student Officer	$ 61,500	31.5
Jack Resneck, Jr, MD	Officer	$ 77,100	59
Bruce A Scott, MD	Vice Speaker, House of Delegates	$ 61,500	44
Carl A Sirio, MD	Officer	$ 106,500	80
Steven J Stack, MD	President	$ 279,000	169
Georgia A Tuttle, MD	Officer	$ 77,700	56
Robert M Wah, MD	Immediate Past President	$ 274,000	129
Kevin W Williams	Public Board Member Officer	-	2

President, President-Elect, Immediate Past President and Chair
In 2015-2016, each of these positions received an annual Governance Honorarium which was paid in monthly increments. These four positions spent a total of 532 days on approved Assignment and Travel, or 133 days each on average.

Chair-Elect
This position received a Governance Honorarium of approximately 75% of the Governance Honorarium provided to the Chair.

All other Officers
All other Officers received cash compensation, which included a Governance Honorarium of $61,500 paid in monthly installments. The remaining cash compensation is for Assignment and Travel Days that are approved by the Board Chair to externally represent the AMA. These days are compensated at a per diem rate of $1,200.

Assignment and Travel Days
The total Assignment and Travel Days for all Officers (excluding the President, President-Elect, Immediate Past President and Chair) were 1051; this includes reimbursement for telephonic representation meetings for external organizations that are 30 minutes or longer during a calendar day and total 2 or more hours. These are reimbursed at ½ of the current per diem rate. During this reporting period, there were 30 reimbursed calls, representing 15 per diem days.

EXPENSES

Total expenses paid for the period, July 1, 2015 – June 30, 2016, were $881,137 compared to $832,337 for the previous period, representing a 5.9% increase. This includes $1,040 in upgrades for Presidents' travel per the approved Presidential Upgrade Allowance of $2,500 per position per term.

BENEFITS, PERQUISITES, SERVICES AND IN-KIND PAYMENTS

Officers are able to request benefits, perquisites, services and in-kind payments, as defined in the "AMA Board of Trustees Standing Rules on Travel and Expenses." These non-taxable business expense items are provided to assist the Officers in performing their duties:

- AMA Standard laptop computer or iPad
- iPhone
- American Express card (for AMA business use)
- Combination fax/printer/scanner
- An annual membership to the airline club of choice offered each year during the Board member's tenure
- Personalized AMA stationery, business cards and biographical data for official use.

Additionally, all Officers are eligible for $300,000 term life insurance and are covered under the AMA's $500,000 travel accident policy and $10,000 individual policy for medical costs arising out of any accident while traveling on official business for the AMA. Life insurance premiums paid by the AMA are reported as taxable income.

Secretarial support, other than that provided by AMA's Board office, is available up to defined annual limits as follows: President, during the Presidential year, $15,000; $5,000 each for the President-Elect, Chair, Chair-Elect and Immediate Past president per year. Secretarial expenses incurred by other Officers in connection with their official duties are paid up to $750 per year per Officer. This is reported as taxable income.

Travel expenses incurred by family members are <u>not</u> reimbursable, with the exception of the family of the incoming President at the Annual Meeting of the HOD.

Calendar year taxable life insurance and taxable secretarial fees reported to the IRS totaled $25,755 and $20,375 respectively for 2015. An additional $16,500 was paid to third parties for secretarial services during 2015.

METHODOLOGY

As noted in its A-16 report, the Committee commissioned a comprehensive compensation review with an outside consultant expert in Board compensation to refresh the Committee's knowledge of market conditions related to Board compensation because it has been five years since the last compensation review. The purpose of the review is to ensure the Officers are compensated appropriately for the work performed on behalf of the AMA. The Committee also continues to be interested in reviewing and refining its compensation practices for increased simplification and transparency. The Committee also asked the consultant to review the structure of Officer compensation to ensure continued alignment with current trends in for-profit Board compensation which had been to move away from paying for each individual Board or Board committee meeting to one annual fee.

The Committee's review and subsequent recommendations for Officer compensation are based on the principle of the value of the work performed, as affirmed by the HOD. In addition, the following additional guidelines were followed:

- Compensation should be based on the value expected by the AMA from its Officers.
- Compensation should take into account that the AMA is a complex organization when comparing compensation provided to Board members by for-profit organizations and by complex not-for-profit organizations of similar size and activities.
- Compensation should be aligned with the long-term interests of AMA members and the fulfillment of the fiduciary responsibilities of the Officers.
- Officers should be adequately compensated for their value, time, and effort.
- Compensation should reinforce choices and behaviors that enhance effectiveness.
- Compensation should be approached on a comprehensive basis, rather than as an array of separate elements.

It is important to note that the process the Committee followed along with the aforementioned principles are consistent with the guidelines recommended by the IRS for determining reasonable and competitive levels of Officer compensation.

To complete the compensation review, the Committee retained a new consultant, Becky Glantz Huddleston, of Willis Towers Watson. Ms. Huddleston is an expert in Board compensation and works with both for-profit and not-for profit organizations. The firm she works for, Willis Towers Watson, is one of the largest, most prestigious and well-respected compensation consulting firms.

To develop her recommendations with the Committee, Ms. Huddleston:

- Met with internal AMA staff assigned to support this Committee to review and understand the current compensation structure.
- Interviewed certain Board members to gain an understanding of their thoughts and insights related to the current Officer compensation program.
- Discussed her interview results with the Committee.
- Reviewed and analyzed Officer compensation data for the past three terms.
- Analyzed and researched pay practices for Board of directors at for-profit and not-for-profit organizations similar to the AMA who pay their Board members.
- Prepared a final report to the Committee following a collaborative, deliberative and objective process to arrive at the recommendations as documented in this report to the House of Delegates.

FINDINGS

The Committee notes that Officers continue to make significant time commitments in supporting our AMA in governance and representation functions. Given the amount of time required of Board members, it is important that individuals seeking a position on the Board be aware of the scope of the commitment and the related compensation.

The Committee further notes that external data indicates for-profit organizations are continuing the trend of eliminating meeting fees while increasing the annual retainer in an effort to simplify the program and to recognize that Board work has become more fluid in nature and is increasingly completed outside of formal meetings; this is also a trend at the AMA based on Officer feedback.

In 2011, the HOD approved this Committee's recommendation to refine the AMA's compensation structure for non-leadership Officers by expanding the Governance definition to include Chair-assigned internal representation and increasing the amount of the annual Governance Honorarium. Chair-assigned External Representation continued to be paid by a Per Diem. The $61,500 annual Governance Honorarium has been in effect since July 1, 2012 and the $1200 Per Diem has been the same amount since 2008.

The Committee and its consultant reviewed and considered feedback from the interviews with Officers. The overall consensus from the Officers interviewed was that the Board compensation program is generally working and while there were not any major issues, modest adjustments to the compensation levels may be appropriate. However, Officer interviews included concerns that the current structure resulted in an unequal internal time commitment among Officers because some internal representation assignments result in greater time commitments which, by definition, are included as part of the Governance Honorarium unlike external assignments compensated by per diem.

Review of AMA data for the past three terms showed that the time commitment for Board-related work was generally consistent among the Officers. Internal representation had more variability than Board-related work and External Representation was the most variable. The Governance Honorarium does not address the variability of internal representation. The wide variance in External Representation reflects the unique skillset and expertise of each Officer and the responsibility of the Board Chair to make assignments that optimize the Officers' expertise. The current use of the Per Diem for External Representation addresses the wide variance in time commitment of the Officers.

Compensation data from both for-profit and not-for-profit organizations was reviewed. For-profit Board compensation data was sourced from the National Association of Corporate Directors (NACD) 2015-2016 survey of organizations with revenue between $50M - $500M. This data indicated for-profit Board compensation consisted of both a pay and stock component. The Committee's external consultant noted that not-for-profit organizations do not have the ability to grant stock awards and therefore do not necessarily intend to be competitive with the for-profit sector from the perspective of total compensation. While AMA's Governance Honorarium was close to the median cash compensation, it was well below the total Board compensation due to absence of stock awards.

The consultant collected and analyzed data from not-for-profit organizations determined to be of similar size and complexity as the AMA; AMA's not-for-profit peer group. This information was collected from Form 990 filings, generally for 2014. This data showed that AMA non-leadership Officers spend significantly more time on internal Board and representation when compared to the peer group. Further analysis, to adjust for the variance in time commitments, showed that AMA's Governance Honorarium was significantly lower than the peer group.

In determining the Governance Honorarium recommendation for non-leadership Officers, the Committee balanced simplicity, transparency and comparability versus pay for internal representation days as a compensation structure, Board feedback and the total cost of governance to the AMA. There is no good external comparison for Per Diem pay for External Representation for non-leadership Officers given the unique nature of this function at the AMA. However, the Per Diem amount has not changed since 2008 and the Committee used the data from the not-for-profit peer group Governance Honorarium comparison to directionally inform them.

Officers in leadership, the Board Chair, Chair-elect, President, President-elect and Immediate Past President have a significant level of responsibility, representing a time commitment well above that required by other non-profit Board leadership. This led to further analysis by the consultant to adjust for the variance in time commitment. This analysis showed that compensation for AMA Officers in leadership roles for the past three terms ranged near the median, resulting in the recommendation that leadership compensation continues to be appropriate and no change is necessary.

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendations be adopted and the remainder of this report be filed:

1. That there be no change to the current Definitions effective July 1, 2012 as they appear in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for External Representation and Telephonic Per Diem for External Representation except for the Governance Honorarium and Per Diem amounts as recommended in 2, 3 and 4 below.

    - Definition of Governance Honorarium effective July 1, 2012:

    The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted above.

    - Definition of Per Diem for Representation effective July 1, 2012:

    The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel for Officers, excluding Board Chairs and Presidents. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather related travel delays.

    - Definition of Telephonic Per Diem for External Representation effective July 1, 2011:

    Officers, excluding the Board Chairs and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments, receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board.

2. That the Governance Honorarium for all Board members excluding leadership, Board Chair, Board Chair-elect, President, President-elect, and Immediate Past President Board Chairs be increased effective July 1, 2017 to $65,000. (Directive to Take Action)

3. That the Per Diem for Chair-assigned representation external to the AMA or for participation in a group or organization with which he AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc., and related travel be increased effective July 1, 2017 to $1,300 per day. (Directive to Take Action)

4. That the Per Diem for Chair-assigned Telephonic Per Diem for External Representation be increased effective July 1, 2017 to $650 as defined. (Directive to Take Action)

5. Except as noted above, there be no other changes to the Officers compensation for the period beginning July 1, 2017. (Directive to Take Action)

Fiscal Note: Estimated annual cost of Recommendations 2, 3 and 4 is $80,350 based on data reported for July 1, 2015 through June 30, 2016. This cost represents the impact of the Governance Honorarium increase ($3,500 for each of the 16 non-leadership Officers), the Per Diem increase ($100 per External Representation day as defined), and the Telephonic Per Diem increase ($50 per teleconference meeting as defined).

APPENDIX

Current Leadership Compensation Summary
Officer compensation and definitions initially approved at I-11 and effective July 1, 2012.

POSITION	GOVERNANCE HONORARIUM
President	$279,000
Immediate Past President & President-Elect	$274,000
Chair	$269,500
Chair-Elect	$199,500
Other Officers	$61,500

Definition of Governance Honorarium Effective July 1, 2012:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted above.

Definition of Per Diem for Representation effective July 1, 2012:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather related travel delays. Per Diem for Chair-assigned representation and related travel is $1,200 per day.

Definition of Telephonic Per Diem for External Representation effective July 1, 2011:

Officers, excluding the Board Chair and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments, receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or $600.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(I-16)

Introduced by: Young Physicians Section

Subject: Equality

Referred to: Reference Committee F
(Gary R. Katz, MD, Chair)

Whereas, In its Code of Medical Ethics, the American Medical Association (AMA) states, "Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care. Nor may physicians decline a patient based solely on the individual's infectious disease status"; and

Whereas, Physicians have a professional obligation, and a specific ethical duty and policies that prohibit discrimination, and physicians are expected to adhere to it; and

Whereas, When discrimination based on race, color, religion. national origin, language, creed, sexual orientation and gender identity and gender expression continues, it leads to lower productivity of individuals, worse health outcomes and increased suicide rates in the affected populations; therefore be it

RESOLVED, That all future meetings and conferences organized and/or sponsored by our American Medical Association, not yet contracted, only be held in towns, cities, counties, and states that do not have discriminatory policies based on race, color, religion, ethnic origin, national origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age. (New HOD Policy)

Fiscal Note: No fiscal impact.

Received: 09/26/16

RELEVANT AMA POLICY

E-1.1.2 Prospective Patients

As professionals dedicated to protecting the well-being of patients, physicians have an ethical obligation to provide care in cases of medical emergency. Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care. Nor may physicians decline a patient based solely on the individual's infectious disease status. Physicians should not decline patients for whom they have accepted a contractual obligation to provide care.

However, physicians are not ethically required to accept all prospective patients. Physicians should be thoughtful in exercising their right to choose whom to serve.

A physician may decline to establish a patient-physician relationship with a prospective patient, or provide specific care to an existing patient, in certain limited circumstances:

(a) The patient requests care that is beyond the physician's competence or scope of practice; is known to be scientifically invalid, has no medical indication, or cannot reasonably be expected to achieve the intended clinical benefit; or is incompatible with the physician's deeply held personal, religious, or moral beliefs in keeping with ethical guidelines on exercise of conscience.

(b) The physician lacks the resources needed to provide safe, competent, respectful care for the individual. Physicians may not decline to accept a patient for reasons that would constitute discrimination against a class or category of patients

(c) Meeting the medical needs of the prospective patient could seriously compromise the physician's ability to provide the care needed by his or her other patients. The greater the prospective patient's medical need, however, the stronger is the physician's obligation to provide care, in keeping with the professional obligation to promote access to care.

(d) The individual is abusive or threatens the physician, staff, or other patients, unless the physician is legally required to provide emergency medical care. Physicians should be aware of the possibility that an underlying medical condition may contribute to this behavior.

AMA Principles of Medical Ethics: I,VI,VIII,X

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(I-16)

Introduced by: Medical Student Section

Subject: Support a Study on the Minimum Competencies and Scope of Medical Scribe Utilization

Referred to: Reference Committee F
(Gary R. Katz, MD, Chair)

Whereas, There will be an estimated 100,000 medical scribes in 2020 with no national standardization of training in place;[1] and

Whereas, Because medical scribes have no patient care responsibilities, they are not currently required to undergo specific training or meet any background requirements prior to starting their positions;[2] and

Whereas, Federal law inhibits medical scribes from entering certain patient information including but not limited to prescription medication and lab and imaging orders, but there is no enforcement mechanism to ensure adherence;[3] and

Whereas, Nearly 1 in 5 physicians currently employ medical scribes who are unlicensed workers hired to enter patient history and physical exam findings into the electronic health record (EHR) at the direction of a physician or practitioner;[4] and

Whereas, Several studies suggest that medical scribes improve clinician satisfaction, productivity, time-related efficiencies, revenue, and patient-clinician interactions since EHR-use can be cumbersome and time-consuming;[5] and

Whereas, ScribeAmerica, the largest professional medical scribe training and management company in the United States, provides only two weeks of training for new medical scribes;[1] and

Whereas, Health information technology experts, health informaticists, and the American College of Medical Scribe Specialists would be useful partners in establishing standardized training for medical scribes; therefore be it

RESOLVED, That our American Medical Association partner with The Joint Commission and other stakeholders to study the minimum skills and competencies required of a medical scribe regarding documentation performance and clinical boundaries of medical scribe utilization. (Directive to Take Action)

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[1] Conn J. Medical scribes lack consensus on training, certification. Modern Healthcare 2013. Available at: http://www.modernhealthcare.com/article/20130905/news/309059952. Accessed April 20, 2016.
[2] ACEP. Scribe FAQ // 2015. Available at: https://www.acep.org/physician-resources/practice-resources/administration/financial-issues-/-reimbursement/scribe-faq/. Accessed April 19, 2016.
[3] Use of Unlicensed Persons Acting as Scribes. The Joint Commission- Standards FAQ Details. Available at: http://www.jointcommission.org/mobile/standards_information/jcfaqdetails.aspx. Accessed February 8, 2016.
[4] Gillespie L. The Unregulated Rise of the Medical Scribe. The Atlantic 2015. Available at: http://www.theatlantic.com/health/archive/2015/12/why-so-many-doctors-are-hiring-scribes/419838/?utm_source=sffb. Accessed February 8, 2016.
[5] Shultz CG, Holmstrom HL. The Use of Medical Scribes in Health Care Settings: A Systematic Review and Future Directions. The Journal of the American Board of Family Medicine 2015;28(3):371–381. doi:10.3122/jabfm.2015.03.140224.

Fiscal Note: Moderate - between $5,000 - $10,000.

Received: 09/29/16

Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians D-478.976 - 1. Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs-open source and proprietary-to create more transparency and support more informed decision making in the selection of EHRs. 2. Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs. 3. Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes. 4. Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.
BOT Rep. 23, A-13; BOT Rep. 24, A-13; Reaffirmed: BOT Rep. 17, A-15

Status and Utilization of New or Expanding Health Professionals in Hospitals H-35.996 - (1) The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff. Thus this statement covers regulation of such categories as the new physician-support occupations generically termed physician assistants, nurse practitioners, and those allied health professionals functioning in an expanded medical support role. (2) The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws: (a) Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as applications for medical staff membership and privileges. (b) The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant. (c) In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions.

BOT Rep. G, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10; Reaffirmation A-12

Health Workforce H-200.994 - The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency.
BOT Rep. C, I-81 Reaffirmed: Sunset Report, I-98 Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13

Protecting Physician Led Health Care H-35.966 - Our American Medical Association will continue to work with state and specialty medical associations and other organizations to collect, analyze and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that permit independent practice of allied health professionals as compared to those that do not. This analysis should include consideration of practitioner settings and patient risk-adjustment.
Res. 238, A-15

Council on Medical Education. B-6.2
6.2.1 Functions.
6.2.1.1 To study and evaluate all aspects of medical education continuum, including the development of programs approved by the House of Delegates, to ensure an adequate continuing supply of well-qualified physicians to meet the needs of the public;
6.2.1.2 To review and recommend policies for medical and allied health education, whereby the AMA may provide the highest education service to both the public and the profession;
6.2.1.3 To consider and recommend means by which the AMA may, on behalf of the public and the medical profession at-large, continue to provide information, leadership, and direction to the existing inter-organizational bodies dealing with medical and allied health education; and
6.2.1.4 To consider and recommend the means and methods whereby physicians may be assisted in maintaining their professional competence and the development of means and criteria for recognition of such achievement.
6.2.2 Membership.
6.2.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student.

AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982 - 1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners. 2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety. 3. Our AMA will actively oppose health care teams that are not physician-led.
Res. 240, A-13; Reaffirmation A-15

Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital H-35.978 - The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of

patients served by that hospital, and for outpatient educational programs provided by that hospital.
BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13

Patient Protection and Clinical Privileges H-230.989 - Concerning the granting of staff and clinical privileges in hospitals and other health care facilities, the AMA believes: (1) the best interests of patients should be the predominant consideration; (2) the accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training, experience, and demonstrated current competence. In implementing these criteria, each facility should formulate and apply reasonable, nondiscriminatory standards for the evaluation of an applicant's credentials, free of anti-competitive intent or purpose; (3) differences among health care practitioners in their clinical privileges are acceptable to the extent that each has a scientific basis. However, the same standards of performance should be applied to limited practitioners who offer the kinds of services that can be performed by limited licensed health care practitioners or physicians; and (4) health care facilities that grant privileges to limited licensed practitioners should provide that patients admitted by limited licensed practitioners undergo a prompt medical evaluation by a qualified physician; that patients admitted for inpatient care have a history taken and a comprehensive physical examination performed by a physician who has such privileges; and that each patient's general medical condition is the responsibility of a qualified physician member of the medical staff.
Sub. Res. 36, A-84; Reaffirmed: CME Rep.8, I-93; Reaffirmed: Res. 802, I-99; Reaffirmed: CME Rep. 2, A-09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-16)

Introduced by: American Thoracic Society

Subject: Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere

Referred to: Reference Committee F
(Gary R. Katz, MD, Chair)

Whereas, Our AMA encourages our members to reduce firearm morbidity and mortality by asking their patients about household firearms and educating their patients about the dangers such firearms may pose. The AMA opposes laws that restrict physicians from discussing firearms safety with their patients; and

Whereas, The state of Florida enacted the Firearms Owner's Privacy Law (FOPL), which prohibits health care providers from;
(i) intentionally recording information concerning firearm ownership in a patient's medical record if the information is not relevant to the patient's medical care or safety or the safety of others;
(ii) asking a patient whether he or she owns a firearm unless the information is relevant to the patient's medical care or safety or the safety of others:
(iii) discriminating against a patient based solely on firearms ownership; and
(iv) unnecessarily harassing a patient about firearm ownership. Violation of the law constitutes grounds for discipline under the Florida licensure statutes; and

Whereas, Our sister organizations, American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians have challenged the Florida Firearms Owners Privacy law in court; and

Whereas, Our AMA has filed an amicus brief in support of our sister organizations seeking to overturn the Firearms Owner Privacy Law; and

Whereas, Our AMA is holding our 2016 Interim House of Delegates meeting in Orlando, Florida; and

Whereas, Orlando, Florida joins a long list of U.S. cities who have suffered directly from mass shootings; therefore be it

RESOLVED, That our American Medical Association adopt policy that bars our AMA from holding House of Delegates meetings in states that enact physician gun gag rule laws (New HOD Policy); and be it further

RESOLVED, That our AMA contact governors and convention bureaus of states that have enacted physician gun gag rules and inform them that our AMA will no longer hold House of Delegates meetings in their state, until the restrictive physician gun gag rule is repealed or struck down by the courts. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.
Received: 10/11/16