AMERICAN MEDICAL ASSOCIATION
BOARD OF TRUSTEES MEETING
SUMMARY AND HIGHLIGHTS

September 7-September 10, 2017 AMA Headquarters
Chicago, IL

Members of the Board Present
Gerald E. Harmon, MD, Chair
Jack Resneck, Jr., Chair-Elect
Patrice A. Harris, MD, MA, Immediate Past Chair
David O. Barbe, MD, MHA, President
Barbara L. McAneny, MD, President-Elect
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Susan R. Bailey, MD, Speaker, House of Delegates
Bruce A. Scott, MD, Vice Speaker, House of Delegates
Willarda V. Edwards, MD, MBA
William E. Kobler, MD
Russell W.H. Kridel, MD
William A. McDade, MD, PhD
S. Bobby Mukkamala, MD
Albert J. Osbahr, III, MD
Stephen R. Permut, MD, JD
Ryan J. Ribeira, MD, MPH
Karthik V. Sarma, MS
Carl A. Sirio, MD
Georgia A. Tuttle, MD
Kevin W. Williams

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James L. Madara, MD, Executive Vice President, CEO
Bernard L. Hengesbaugh, Chief Operating Officer
Brian D. Vandenberg, JD, General Counsel
Howard Bauchner, Editor-in-Chief, JAMA Network, Senior Vice President, Scientific Publications
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Laurie A.S. McGraw, Senior Vice President, Business Solutions
Kenneth Sharigian, PhD, Senior Vice President, Chief Strategy Officer
Rodrigo A. Sierra, Senior Vice President, Chief Communications & Marketing Officer
Todd D. Unger, MBA, Chief Experience Officer and Senior Vice President, Physician Engagement
Leslie Weber, Senior Vice President, Senior Vice President and Chief Information Officer
Modena H. Wilson, MD, MPH, Senior Vice President, Chief Health and Science Officer
Jon Burkhart, Chief of Staff, Vice President, Executive Offices

The Board meeting was called to order at 10:00am (Central) on Thursday, September 7, 2017 by the Chair, Gerald E. Harmon, MD. Dr. Harmon commented on the current and ongoing hurricane devastation, making particular mention of the AMA members affected, and thanked the AMA for contributions made to relief efforts. Dr. Osbahr was given the floor to provide brief remarks on the

AMA's historical role in creating impairment guidelines and acknowledged that the AMA is still widely involved and recognized for its role in this area.

- **Board Roles and Responsibilities –** The Board **heard** brief opening remarks from the Chair including: a reminder of the Board Norms & Principles approved at the April 2016 Board meeting, a reminder that those Board members participating in IHMI video interviews occurring Saturday are to wear business attire, and a point of personal privilege with Jesse M. Ehrenfeld, MD, MPH, Secretary, who joined Dr. Harmon for a private swearing in ceremony of the new Surgeon General, Dr. Jerome Adams, who made mention of the AMA in his swearing in speech.

- **Introduction and Overview –** The Board **heard** from James L. Madara, MD, EVP, CEO of the AMA a brief recap on past and ongoing initiatives including: the AMA's multifaceted response to Hurricane Harvey; Compensation Committee reaffirmation of best practices; evolving health reform and how the body of a bill may provide a possible stop forward; the evolution since 2011 of the three focus areas into the following integrative conceptual arcs currently driving the AMA mission strategy: 1) vital practice resources; 2) improving the health of the nation; and 3) lifelong professional development; and an update on the governance, and business architecture of Health2047, noting that an in-depth update on Health2047 will be done at this meeting.

- **Strategic Plan Discussion "Walk in the Woods" –** The Board **heard** from Dr. Harmon a brief summary of upcoming presentations, handouts, and the upcoming Walk in the Woods. The Board then **heard** from Dr. Madara a brief summary of items to be discussed by the Board including: the evolution of the three big focus areas of: 1) patient outcomes; 2) improving medical education; and 3) physician satisfaction; into the arcs currently driving the AMA mission strategy: (1) vital practice resources; (2) improving the health of the nation; and (3) lifelong professional development with a note that in depth presentations on ACE, PS2, and IHO will occur at this meeting; what success in these conceptual arcs will look like; how success will be defined; what barriers to success will be; what needs to change to achieve success; what partnerships with what organizations will be needed; how the Walk in the Woods is a time for reflection and introspection; and how strategy must have continuity--not just be reinvented all the time.

  After reconvening the Board **discussed** how each group defined success in 10 years within their assigned arcs, anticipated barriers to those facets of success, and common themes between the groups. There was a general consensus that success included: AMA as a vital and central hub and/or collaborator in medical technology and curator of resources that create economically more viable practices, increase in favorable patient outcomes, and modernized practices and medical education. Common themes in perceived barriers included: diversity of physician practices; physician apathy; relative isolation of physicians and students; lack of socialization; lack of data control and interoperability; economic and resource pressures; and the current regulatory and advocacy environment. The question of whether we have defined chronic health problems wrong was discussed, making examples of toothpaste marketed for making you kissable, and the issue of commoditizing the delivery of health entirely.

  The Board **reaffirmed** the arcs and noted that "vital practice resources" was less visionary than the original focus item of providing critical tools and policies to the field. Overall, this exercise

produced robust conversations of how the Board and management have been shaping their ideas on the AMA's future role and forecasting for greater leverage in the medical and business population.

- **Integrated Health Model Initiative (IHMI) – *Soft Launch* –** The Board **heard** a presentation on IHMI's upcoming soft launch from Laurie McGraw, SVP, Health Solutions; Kristina Finney, MPH, Manager of the Integrated Health Model Initiative; Tom Frederick; and Drs. Kathy Blake and Michael Hodgkins, who lead the Clinical Review Group (CRG) and came to provide physician perspective to questions. Highlights of the presentation included: a brief recap on the evolution of the discussion on interoperability and the Integrated Health Model Initiative (IHMI) in order to provide better patient care, an accurate, evolving and dynamic coding system, and manageable data while prioritizing disease, economic, and societal burdens; a preview of the October 2nd IHMI initiative public unveiling; an overview of what the IHMI is and why it is important, noting particularly how it will be based on continuous learning and development including a rigorous clinical review process which Ms. McGraw overviewed; a summary of initial soft launch partners and events; and Ms. Finney's informative live demo of the IHMI Collaboration Platform.

- **Board Reports to HOD at I-17 –** The Board **considered** and **approved** for transmittal to the House of Delegates at the 2017 Interim Meeting the following reports (revised as noted):
  1. Redefining the AMA's Position on ACA and Healthcare Reform
  2. 2017 AMA Advocacy Efforts
  3. Removing Restrictions on Federal Funding for Firearm Violence Research (Res. 201-I-16)
  4. Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care (Res. 225-I-16)
  5. Effective Peer Review (Res. 006-I-16)
  6. Electronically Prescribed Controlled Substances without Added Processes (Res. 216-A-17)
  7. Medical Reporting for Safety-Sensitive Positions (revised)
  8. 2018 Strategic Plan
  9. Parental Leave
  10. High Cost to Authors for Open Source Peer Reviewed Publications (Res. 604-A-17)
  11. Anti-Harassment Policy (revised)
      Secretary Note: this report was submitted to HOD after further review and approval by the liaisons and was included in the Handbook Addendum.

- **Regulation of Physician Assistants** (Resolution 233-A-17) – The Board **considered** a report and recommendations from management on Amendment B-3 of Resolution 233-A-17 which was referred for decision to the Board at the 2017 Annual Meeting of the House of Delegates. Amendment B-3, which was sponsored by the Georgia Delegation, added a third resolve to Resolution 233 that asked that our AMA adopt policy that APRNs are subject to the jurisdiction of state medical licensing and regulatory boards for the regulation and discipline of APRNs in their performance of medical acts and develop model state legislation in support of states to accomplish this policy. Specifically, the HOD expressed concern that adoption of Amendment B-3 would confuse the goals of Resolution 233-A-17 to advocate on PA issues. Testimony suggested that different regulatory structures of PAs and APRNs—whereby PAs predominantly are under the regulation of medical boards while APRNs are largely under the regulation of nursing boards—necessitated a separate study of the regulation of the respective health care professionals.

The management report recommended that our AMA (1) adopt policy that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts and (2) develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs. It is also recommended that the title of the new policy be change to "Regulation of Advanced Practice Registered Nurses." Our AMA Council on Legislation is in the process of developing model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs, pursuant to the second recommendation above.

In lieu of Resolution 233-A-17, Amendment B-3, the Board **voted** to **approve** that our AMA:

1. Adopt policy that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts, and

2. Develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs. In addition, the title of the new policy be "Regulation of Advanced Practice Registered Nurses."

- **Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder** (Resolution 506-A-17) – The Board **considered** a report from management regarding a second resolve to be added to Resolution 506-A-17, which was referred for decision to the Board at the 2017 Annual Meeting of the House of Delegates. Resolution 506-A-17, sponsored by the Medical Student Section and the American Society of Addiction Medicine, asked our AMA to study solutions to overcome the barriers preventing appropriately trained physicians from prescribing buprenorphine for treatment of opioid use disorder. A second resolve was added to Resolution 506 and was referred for decision by the House. The additional resolve asked our AMA to support eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder. Originally, Resolution 506-A-17 called for our AMA to study solutions to overcome the barriers preventing appropriately trained physicians from prescribing buprenorphine. This resolve was amended to call for the AMA Opioid Task Force to publicize existing resources on overcoming such barriers and implementing solutions, and was adopted as amended. Noting that one obvious barrier is the federal requirement for special training, record keeping, and federal oversight to prescribe buprenorphine for opioid use disorder, the reference committee added a second resolve that our AMA support elimination of this requirement, which was referred for decision.

  The Board **voted** to **adopt** the new resolve added to Resolution 506-A-17 "Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder" to read as follows:

  > Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

- **Inclusion of Continuing Care Retirement Centers and Long-Term Care Facilities in Accountable Care Organizations Investment Model** (Resolution 707-A-17) – The Board **considered** a report from management regarding Resolution 707-A-17, which was referred for

decision to the Board at the 2017 Annual Meeting of the House of Delegates. Resolution 707, sponsored by AMDA-The Society for Post-Acute and Long-Term Care Medicine, asked our AMA to advocate to CMS to enable Continuing Care Retirement Centers and long-term care facilities and physicians working in those settings to initiate ACO Investment Models. The House of Delegates supported referral for decision of Resolution 707-A-17 due to mixed testimony at the reference committee hearing. Some speakers expressed a need for more information on this issue and raised concerns about potential for abuse, while a member of the Council on Medical Service offered an amendment to include not only those physicians wanting to participate in ACOs but also those looking to participate in Comprehensive Primary Care Plus (CPC+) and other medical home models. The reference committee saw potential for Resolution 707 to increase the availability of APMs but agreed with concerns that a more thoughtful analysis was required.

In lieu of Resolution 707-A-17, the Board **voted** to **adopt** policy to support participation of physicians practicing in Continuing Care Retirement Centers (CCRC) and other long-term care facilities in accountable care organizations (ACOs), medical homes, and other alternative payment models (APMs) to read as follows:

> Our AMA supports participation of physicians practicing in Continuing Care Retirement Centers and other community-based long-term care settings in ACOs, medical homes, and other APMs.

- **Removing "Three Star Minimum" Requirement for Skilled Nursing Facilities to Participate in Next Gen Accountable Care Organizations & Bundled Payments for Care Improvement Programs and Care for Patients with Waiver of Three Night Hospital Stay Requirement** (Resolution 708-A-17) – The Board **considered** a report from management regarding Resolution 708-A-17, which was referred for decision to the Board at the 2017 Annual Meeting of the House of Delegates. Resolution 708-A-17, sponsored by AMDA-The Society for Post-Acute and Long-Term Care Medicine, asked our AMA to advocate for CMS to remove the three-star quality ratings for skilled nursing facilities to participate in NextGen ACOs and BCPI programs with wavier of three-day hospital stay for patients. Currently under Medicare, beneficiaries are eligible for Medicare covered skilled nursing facility services when a beneficiary has an inpatient hospital stay of three consecutive days or more, starting with the day the hospital admits the beneficiary as an inpatient, but not including the day the beneficiary leaves the hospital. However, waivers can allow beneficiaries to be eligible for Medicare covered skilled nursing facility services when they do not meet the 3-day hospital stay requirement. Specifically, section 1115A(d)(1) of the Social Security Act authorizes the Secretary of the U.S. Department of Health and Human Services to waive certain program requirements, including the three-day qualifying inpatient hospital stay, for the purposes of testing payment and service delivery models developed by the Center for Medicare & Medicaid Innovation (CMMI). CMMI has used their waiver authority to remove the three-day hospital stay requirement for skilled nursing facilities to participate in the NextGen ACO and BPCI programs, as well as other APMs such as Medicare Shared Savings Program ACOs. However, the requirement is only waived for those skilled nursing facilities that achieve at least three stars in the Medicare skilled nursing facility five-star quality rating system. The Medicare skilled nursing facility five-star quality rating system was launched by CMS in 2008 on its Nursing Home Compare website to provide information to consumers to help them differentiate between nursing homes. Skilled nursing facilities with five stars are considered by CMS to have above average quality and nursing homes with one star are considered to have below

average quality. Quality ratings are based on health inspections, staffing and quality measures. While our AMA agrees with the intent of Resolution 708-A-17, a substitute resolution that supports removal of the three star requirement for any alternative payment models (APMs) would be more effective. AMA policy supports extending the protections offered to NextGen ACOs and BPCI programs by Resolution 708-A-17 to any existing APMs or new APMs that may be developed in the future.

In lieu of Resolution 708-A-17, the Board **voted** to **adopt** the following general policy:

> Our AMA advocate for the Center for Medicare & Medicaid Services to remove the three-star quality requirement for all skilled nursing facilities to participate in alternative payment models with waiver of the three-day hospital stay requirement. (New HOD Policy)

- **Pediatric/Adolescent Informed Consent Concussion Discussion** (Resolution 409-A-17) – The Board **considered** a report from management regarding Resolution 409-A-17, which was referred for decision to the Board at the 2017 Annual Meeting of the House of Delegates. Resolution 409, submitted by the New York Delegation, asked that our American Medical Association support federal legislation that includes informed consent prior to participation in intramural and interscholastic athletics and that this consent discuss the risk of short and long term impact of mild traumatic brain injuries. While Resolution 409 was supported in concept, concerns were raised in Reference Committee on several fronts. First, the resolution focuses solely on federal legislation despite the fact that this issue has been mostly legislated at the state level. Second, informed consent laws vary by state and children and adolescents may not be able to provide consent by law. Third, the resolution requires the consent to specifically provide information on "mild" traumatic brain injuries rather than the full spectrum of traumatic brain injuries. Since May 2009, all 50 states and the District of Columbia have enacted youth sports concussion safety laws. Most of these laws include three key elements: (1) Inform and educate coaches, athletes and their parents and guardians about concussions through training and/or a concussion information sheet. (2) Remove an athlete who is believed to have a concussion from play right away. (3) An athlete can only return to play after at least 24 hours and with permission from a health care professional. While all 50 states and DC have enacted laws to address this public health issue, 46 jurisdictions specifically require the distribution of a concussion information sheet. Thirty-seven jurisdictions require a parent or guardian to sign a concussion information sheet in order for their child to participate in athletics. Thirty-one jurisdictions also require a student's signature as a condition of initial participation in athletics. Laws in 39 jurisdictions require that a concussion information sheet be distributed at least annually to parents of athletes or student athletes. However, the substance of such education and the language to include on the information sheet are not clearly specified in most of the laws. The Centers for Disease Control and Prevention has developed training courses and customizable materials that have been explicitly mentioned in some laws as a model for creating educational materials. It is also worth noting that few laws require forms to be updated as new techniques to identify and treat concussions become available. Informed consent is defined as an agreement to do something or to allow something to happen, made with complete knowledge of all relevant facts, such as the risks involved or any available alternatives. While some jurisdictions explicitly refer to the process of having the parent review and sign the concussion information sheet as informed consent, others do not.

  In lieu of Resolution 409-A-17, the Board **voted** to **adopt** as **amended** Policy H-470.959 to read as follows:

H-470.959 Reducing the Risk of Concussion and Other Injuries in Youth Sports
…3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; (c) promote evidenced-based educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers; (d) encourage further research to determine the most effective educational tools for the prevention and management of pediatric/adolescent concussions.

4. Our AMA supports (a) requiring states to develop and revise as necessary, evidenced-based concussion information sheets that include the following information: (1) current best practices in the prevention of concussions, (2) the signs and symptoms of concussions, (3) the short-and long-term impact of mild, moderate, and severe head injuries, and (4) the procedures for allowing a student athlete to return to athletic activity; and (b) requiring parents/guardians and students to sign concussion information sheets on an annual basis as a condition of their participation in sports. (New HOD Policy

- **Developing Physician Leadership in the Implementation of Diagnostic Error Surveillance** (Resolution 718-A-17) – The Board **considered** a report from management regarding Resolution 718-A-17, which was referred for decision to the Board at the 2017 Annual Meeting of the House of Delegates. Resolution 718-A-17, sponsored by the American Association of Public Health Physicians, asked that our AMA: (1) endorse the recommendations of the Improving Diagnosis in Health Care report published by the National Academy of Medicine (NAM) in 2015; (2) support having physician satisfaction with administrative and support systems as a standard measure in assessments of diagnostic error; (3) analyze from a policy perspective how best to position physicians in what may be increasing review of a physician's diagnostic skills; and (4) report the findings of this analysis, and any recommendations based on these findings, at the 2018 Annual Meeting of the House of Delegates. The NAM report is comprehensive and thoroughly supported by a significant amount of peer-reviewed research. Since the report was issued, the National Quality Forum (NQF) has convened a committee tasked with developing a framework for measuring diagnostic accuracy, and is utilizing the NAM report as the foundation for this work. The NQF committee issued a draft framework on which our AMA offered feedback in July 2017. Also in July 2017, our AMA participated in a workshop hosted by the NAM to review progress made since the report was published, as well as continuing challenges. Notwithstanding the thoroughness of the report and the reputable nature of its publishing organization, our AMA did not have an opportunity to participate in the development of the report, nor did the AMA have an opportunity to review it prior to publication.

  A high-level review by AMA staff in the Professional Satisfaction and Practice Sustainability, Improving Health Outcomes and Science Policy units resulted in several observations including: our AMA does not historically endorse reports to which it did not contribute; the report concedes that there is a lack of substantiating data on diagnostic error, putting in question the foundation for the recommendations made within the report.

  The second resolve of Resolution 718 asked our AMA to support "physician satisfaction with administrative and support systems" as a standard measure in the assessment of diagnostic

error. Administrative and support systems are numerous and widely varied. Ratings of physician satisfaction with specific individual systems like EHRs or medication tracking systems may be more easily standardized, but creating a holistic, standard measurement for satisfaction with all systems would be challenging due to several factors: (1) the variety of systems and tools utilized in the daily practice of medicine; (2) not all physicians have access to the same systems, technology, and processes within their organizations and practices; (3) what one physician may find a burdensome and dissatisfying process may be simple and inconsequential to another; and (4) practice geography, size, specialty and other factors pose important variables that would be difficult to account for in an attempt to standardize. Our AMA supports inclusion in the peer review of diagnostic errors an assessment of physician satisfaction with administrative and support systems (AMA policy H-450.966). However, diagnostic errors often occur due to shortcomings in the system or organization, and there are unforeseen challenges in standardizing this specific measure across systems. Amending the resolution as recommended will reflect our AMA's understanding of these challenges and our commitment to supporting organizations that work to rectify them.

The third resolve of Resolution 718 requested that our AMA analyze from a policy perspective how to position physicians in anticipation of increased review of diagnostic skills, and the fourth resolve asks for a report on that analysis. Our AMA, through its ongoing advocacy, strategic goals, and existing policies, remains committed to representing physicians as the health care environment evolves. Separate analysis of "how to position physicians" on this particular issue would be redundant with existing AMA advocacy efforts.

In lieu of Resolution 718-A-17, the Board **voted** to **adopt** the following:

1. Reaffirm Policies H-335.965, "Patient Safety," H-450.988, "Guidelines for Quality Assurance," H-450.995, "Quality of Care - Essentials and Guidelines for Quality Assessment," H-450.994, "Quality Assurance in Health Care," D-405.985, "Physician Satisfaction," D-215.988, "Capturing Physician Sentiments of Hospital Quality," and H-160.912, "The Structure and Function of Interprofessional Health Care Teams;"

2. Not endorse the National Academy of Medicine (NAM) report and amend the first resolve to read as follows: "RESOLVED, That our AMA support further study of diagnostic error, its causes and consequences, and mechanisms to improve diagnostic accuracy. (New HOD Policy);"

3. Amend the second resolve to read as follows: "RESOLVED, that our AMA support the systematic collection and utilization of physician feedback on administrative and support systems by health care organizations in efforts to reduce error and improve diagnostic accuracy. (New HOD Policy);" and

4. Not adopt the third and fourth resolves.

- **Women Physicians Section: Updated Internal Operating Procedures** – The Board **received** a report from management regarding updated internal operating procedures of the Women Physicians Section. The Council on Constitution and Bylaws, per Bylaw 6.1.3.3, serves as advisory to the Board of Trustees in reviewing updated internal operating procedures (IOPs) of the AMA sections. It has recently completed a review of proposed updates to the IOPs of the Women Physicians Section (WPS), last approved by the Board of Trustees in September 2013.

The concurrent elections for the positions of WPS Delegate and Alternate Delegate have presented some operational challenges; thus, the Section proposes to have elections for these positions occur in separate years rather than simultaneously. Staggering the terms of the WPS representatives to our AMA-HOD representatives affords the WPS the following advantages:

- Continuity of WPS representation in the AMA House of Delegates;
- A newly elected Delegate and Alternate Delegate do not assume responsibilities at the same meeting; and
- The Delegate will have the opportunity to mentor the Alternate Delegate should that person aspire to a delegate position in the WPS or elsewhere in the future.

The Council on Constitution and Bylaws completed its review, and did not identify any conflicts between our AMA Bylaws and the proposed changes. Per Bylaw 7.0.7, "All rules, regulations, and procedures adopted by each Section shall be subject to the approval of the Board of Trustees."

The Board **voted** to approve the updated Internal Operating Procedures of the Women Physicians Section (see Attachment A).

- **Structure and Procedures of the CPT Editorial Panel**– The Board **received** a report from management regarding a restructure of the CPT Editorial Panel (Panel) to add "permanent and rotating seats to the [Panel] to ensure that orthopaedics as well as other major specialty societies are consistently represented on the Panel" which was requested from the American Academy of Orthopaedic Surgeons (AAOS) to the American Medical Association (AMA). The AAOS request was a result of the AMA Board of Trustees' decision to not reappoint AAOS's nominee Bernard L. Pfeifer, MD, to a second four-year term on the Panel. This request is not predicated on a defect in CPT or in the current working of the Panel. In fact, in their correspondence the AAOS recognizes the value of the Panel process. The change sought by AAOS may also require an amendment to existing policy on the Panel structure (1983 Agreement with the Center for Medicare and Medicaid Services (CMS) and HOD Policy H-70.925). The Board received copies of the AAOS request and the AMA's response. The Panel held a closed session on June 3 to discuss the AAOS request. The Panel considered the points raised by AAOS as well as other factors relevant to the issue, including the desire for regular rotation of Panel members. The Panel discussion focused on whether the "representational" model proposed by the AAOS is superior to the current model and would improve the functioning of the Panel and quality of the CPT® code set. While the Panel recognized the need for the expert input of the medical specialties when evaluating potential changes to the CPT code set, and the value that each Panel member's expertise brings to the discussion, the Panel concluded that the proposal for designated seats for AAOS or other specialties would not substantially enhance the expertise or the functioning of the Panel. As a result, the Panel does not support the change to its structure as requested by the AAOS.

  The Board **voted** to **adopt** the following:

  (1) That the AAOS request to change the structure of the Panel to one that requires a designated seat for orthopaedics or any other medical specialty **not** be **accepted**; and

  (2) That the current Panel 17-member composition and structure be retained.

- **Accelerating Change in Medical Education (ACE) Board of Trustees Update –** The Board **heard** remarks from Susan Skochelak, GVP, Medical Education, about ACE including: a brief recap on historical goals of improving medical education to current successes; a summary on ACE's external dissemination including physical text, conferences, webinars, the sold out upcoming ChangeMedEd 2017 in Chicago; a summary of the current process to transition from changing undergraduate medical education (UME) to changing graduate medical education (GME); and a deeper summary of the strategy to target GME effectively. Additionally, Dr. Skochelak mentioned ACE's desire to target physicians in different stages of their career.

- **Professional Satisfaction and Practice Sustainability (PS2) Update –** The Board **received/heard** remarks from Michael Tutty, GVP, Physician Satisfaction and Practice Sustainability, about PS2 including: brief updates on completed and ongoing work in each of the three key focus areas of: (1) practice transformation, (2) digital health, and (3) payment and quality; updates specifically on the focus areas of: research, convening, advocating, and empowering physicians within each of the key focus areas. Dr. Tutty went into depth on the various surveys, workshops, advocacy initiatives, networks, collaboration, models, policies, and various strains of research being pursued to fulfill PS2, highlighting in depth the Physician Network.

- **Improving Health Outcomes (IHO) Update–** The Board **heard** a presentation from Karen Kmetik, GVP, Health Outcomes about IHO including: reaffirmation of IHO's focus on improving the health of the nation and building a sustainable model; brief review of ongoing work and goals in pre diabetes and diabetes prevention including: metrics 2017 to (estimated) 2020 in areas of national goals, population reached, AMA direct influence, advocacy, and awareness noting the new 1-minute risk test videos; update on Outcome Health's partnership with the AMA; update on new awareness campaign assets including celebrities voices, Samsung collaboration with AMA and ADA in their health app pre-diabetes risk test; and national state collaborations. Dr. Kmetik also presented on the AHA and AMA's collaboration to propose a new model for chronic disease prevention (H2^x) with a core focus on hypertension, and summarized: a co-hired program director position; what Target:BP is, how it is structured, and how it will offer real value; market segments; credibility; accomplishments to date noting Target:BP participation since roll out in March 2017, refresh of MAP tools and guidance, and public awareness campaign to launch in 2017; potential new partners; a summary of priorities for 2017 and 2018; and the landscape we are in currently.

- **Nancy Brown, CEO, American Heart Association (AHA) –** Dr. Madara welcomed Nancy Brown, CEO of the AHA, giving a brief background of Ms. Brown's history with the AHA. The Board **heard** remarks about AHA including: a brief history of the AHA since June 1924 highlighting the changing mission statement over the years; metrics of cardiovascular disease (CVD) as a global challenge; governance model; affiliates; revenue sources; strategic priorities (research, standards of care, changing environments, empowering consumers, quality of care, saving lives, representing patients and the public, and transforming communities); current challenges of social determinants of health; AHA's growth (deeper investment, new areas of impact); the Institute for Precision Cardiovascular Medicine; One Brave Idea initiative and team; My Research Legacy initiative for individual data donation; AHA's new "blue print" for goals moving forward; brain health and aging guidelines; and evolving business structure (core, commercial, ventures). Ms. Brown also commented on new insights into CVD including new drug study outcomes, diet, gene editing, and nicotine replacement vehicles. The Board had a

robust discussion with Ms. Brown on current and future AHA initiatives, advocacy, and potential for collaboration on various fronts.

- **Physician Engagement (PE)/Membership Board of Trustees Update –** The Board **heard** an informational report from Todd Unger, Chief Experience Officer (CXO), Physician Engagement and AMA Membership including: how we are leveraging the digital platform to increase membership and market share as well as where we've been and where we are going with both acquisition and retention using initiatives that will roll out over time. Mr. Unger provided: an in-depth membership update on what current membership goals are and how progression has been since January 2016, noting how the AMA was at a deficit last year and has now recovered with great momentum; a brief overview of key membership actions made in digital marketing that have helped to increase membership (landing pages, loads of testing, join/renew app, digital media buying); a summary of membership programs that are increasing retention (GME Competency Education Program and Physician Wellness Program); a summary of sales; and an overview of the 11 new digital platform improvements. Mr. Unger also gave a summary of 2018 goals including: digital marketing transformation; the Digital Summit: Possibilities by Design; improving the AMA website; segment marketing (targeting physicians through interest and behaviors; three big content segments of advocacy, clinical, and practice transformation; and new intensity in reaching residents and young physicians); enhancing FREIDA; 2018 Membership campaign acquisition and retention strategy noting the focus on the moveable middle and the "Membership Moves Medicine"; Integrated media strategy; proof point direct mail series with email and digital ads as well; evolving group membership noting impact of GCEP at resident level and noting that a more in depth discussion of membership strategy and advancements will occur at the November meeting; member influencer program; network community; Content Commerce and Community--three C's; renewed focus on segments (students, residents, and physicians); and the playbook for 2018.

- **Advocacy Update -** The Board **heard** an update from Rich Deem, SVP, Advocacy, including: a summary of successes and ongoing projects on the Advocacy Dashboard with a note of blocking big health insurance mergers in 2017 as a huge success; ongoing health system reform with an in-depth summary of the ACA repeal, replace, refine process and conflicting policymaker stances; next step goals in health reform and an overview of the packed legislative agenda for September; brief remarks on proposed changes to MACRA and QPP in 2018 including discussion of virtual groups, APMs, MIPS, regulatory wins in QPP, CMS, Medicare, and EHR; a brief summary of regulatory relief priorities; and a note of other and ongoing issues that are advocacy priorities (opioids, Medicare fee schedule, E&M codes, telemedicine, physician-owned hospitals, women's health issues, medical liability reform, drug pricing, gender/LGBT issues, immigration, gun violence, climate change, and vaccines).

- **Awards and Nominations Committee -** The Board **considered** the brief report from the Awards/Nominations Committee and **voted** to **approve** as a consent calendar the following for information:

  CME Letter of Thanks – The AMA Council on Medical Education submitted a letter of thanks to the Board for adding the Optional Diversity questions to the nomination form.

  Awards and Nominations Committee Orientation Guide - The Board was provided with an informational guide highlighting the Awards and Nominations Committee's processes.

The Board also **considered** as a consent calendar the following for action:

Management Report 8: Structure and Procedures of the CPT Editorial Panel – The Board **voted** to **retain** the current Structure and Procedures of the CPT Editorial Panel and not accept the request from the American Academy of Orthopaedic Surgeons to add permanent and rotating seats for orthopaedics or other specialty societies.

Introduction of a New Category for the Dr. Nathan Davis Awards – The Board **voted** to **approve** a new award category recognizing individuals or organizations that have made significant contributions to improve national health and that this award be given in conjunction with the existing Nathan Davis Awards.

- The Board **heard** informational reports from the President, President-Elect, Immediate Past President, Chair, Chair-Elect, Immediate Past Chair, and the EVP on their recent representational visits and other activities. Hurricane Harvey physician initiatives and AMA donations were discussed in depth. In addition, the Board **received** checklists from the other Trustees on their recent representational visits.

- **CEO Update for AMA Board –** The Board **heard** from Dr. Madara a brief summary of updates since the July Boston retreat, including: new Health2047 assets of Mark Tanoury, Tom Furst, and Adler and Colvin as well as Jesse Ehrenfeld as a H2047 board member; H2047 Commercialization Group with Ken Sharigian; AMA Digital Summit with Todd Unger and Chunka Mui; Federation CEO meeting; joint AMA-AHA CEO update; NAM-NAE kick-off panel for rethinking clinical data and looking at the issue from an advisory engineering perspective; and invitations to do Annual Watson Lecturer and AHIP Executive Leadership Summit's plenary lecture. Afterwards the Board had a robust discussion of the Anti-Harassment issue.

- **Intra-Board Committees - Closed and Executive Sessions**
  The Board also considered reports from the Audit, Compensation, Executive, and Finance Committees in either Closed or Executive Sessions. The Board voted to **approve** the recommendations of these Committees as submitted.

The meeting adjourned on Saturday, September 9 at 4:07 pm (Central).

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Gerald E. Harmon, MD, Chair

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Jesse M. Ehrenfeld, MD, MPH, Secretary