AMA-IMG Section 21st Congress Business Meeting

Saturday, June 9, 2018

Hyatt Regency Chicago

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AMA INTERNATIONAL MEDICAL GRADUATES SECTION
21st CONGRESS BUSINESS MEETING
AGENDA
Saturday, June 9, 2018
Hyatt Regency - Chicago
5:30 pm – 7:30 pm, Columbus G

TAB

I. **Networking Reception until 5:45 pm**

II. **Welcome and Introductions,** Ved Gossain, MD, Chair

III. **AMA-IMG Section Rules of Order**
American Institute of Parliamentarians Rules of Order, Parliamentary Procedures — **A**

IV. **Featured Speakers' Biographies**
"AMA ECFMG Update" – William Pinsky, MD, CEO/President — **B**
"Ross University School of Medicine" – William F. Owen, MD, Dean/Chancellor

V. **Full meeting schedule** (informational) — **C**

VI. **Reports & Resolutions**
A. **IMGS Resolutions** — **D**
a. IMG Section Chair's Report
b. Resolution 228 – Medicare Quality Incentives
c. Resolution 229 – Green Card Backlog for Immigrant Doctors on H-1B Visa
d. Resolution 308 – Foreign Trained IMGs Obtaining a U.S. License Without U.S. Residency
e. Resolution 309 – Foreign Trained IMGs Competency-Based Specialty Exam Without U.S. Residency
f. Resolution 310 – U.S. Institutions with Restricted Medical Licensure

VII. House of Delegates Reports/Resolutions — **E**
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(*Obesity Medicine Association/Minority Affairs Section)*

AMA AMERICAN MEDICAL ASSOCIATION

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b. Resolution 230 - Opposition to Funding Cuts for Programs that Impact the Health of Populations *(Minority Affairs Section)*
c. Resolution 304 – Persons with Intellectual and Developmental Disabilities Designated as a Medically Underserved Population *(American Academy of Physical Medicine & Rehabilitation)*
d. CME Report 1 - Sunset Review of 2008 House Policies
e. CME Report 2 – Update on Maintenance of Certification and Osteopathic Continuous Certification
f. CME Report 3 – Expanding UME Without Concurrent GME Expansion
g. CME Report 4 – Evaluation of Clinical Documentation Training
h. CME Report 5 – Study of Declining Native American Medical Student Enrollment
i. CME Report 6 – Mental Health Disclosures on Physician Licensing Applications

VIII. **Organizational Reports**
A. AMA Foundation
B. AMA Alliance

IX. **Open Discussion/New Business**
A. Ideas for I-18 resolutions
B. IMG Physicians Online Community **F**

X. **Announcements/Informational Items**
A. I-18 Virtual Congress Schedule **G**
B. **Monday, June 11- IMGS & Minority Affairs Section Delegates Caucus, 8:30 am – 9:30 am, Roosevelt 3A, East Tower, Concourse level (review Reference Committee reports)**
C. **Monday, June 11 - Busharat Ahmad, MD Leadership Development Program, 10:45 am – 11:45 am, Columbus E/F, East Tower**
D. Leadership Opportunities Grid **H**
E. 16th Annual Joint Research Symposium, Friday, Nov. 9, 2018
a. Need volunteer judges*
b. Research Symposium IMG Section categories: Clinical Vignette, Clinical Medicine, Improving Health Outcomes (cardiovascular disease, diabetes)
c. Abstract deadline: August 8, 2018
F. Summary of Actions (2017 Interim Meeting) **I**
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K. Sections and Special Groups Fliers **N**

XI. **Future IMG Section Meetings**

A. November 9-12, 2018, IMG Section 21st Interim Meeting, National Harbor, Maryland
B. July 4-8, 2018 – AAPI – Columbus Convention Center, Columbus, OH
C. July 4-8, 2018 – APPNA 41ST Annual Convention, Hilton Anatole, Dallas, TX
D. September 1-3, 2018 – 40th NAAMA Convention, Detroit, MI
E. November 8-12, 2018 – IMG Section 21st Interim Meeting, National Harbor, Maryland
F. February 11-13, 2019, AMA National Advocacy Conference, Washington, DC
G. June 7-10,2019 – IMG Section 22nd Annual Meeting
H. November 15-18, 2019 – IMG Section 22nd Interim Meeting, San Diego, CA

American Institute of Parliamentarians Standard Code of Parliamentary Procedure
Basic Rules Governing Motions

Order of Rank/Precedence[1]	Interrupt	Second	Debate	Amend	Vote	Applies to what other motions?	Can have other motions applied?[5]	Renewable
Privileged Motions								
1. Adjourn	No	Yes	Yes[2]	Yes[2]	Majority	None	Amend, Close Debate, Limit Debate	Yes
2. Recess	No	Yes	Yes[2]	Yes[2]	Majority	None	Amend, Close Debate, Limit Debate	Yes[6]
3. Question of Privilege	Yes	No	No	No	None	None	None	Yes
Subsidiary Motions								
4. Table	No	Yes	No	No	2/3	Main Motion	None	No
5. Close Debate	No	Yes	No	No	2/3	Debatable Motions	None	Yes
6. Limit Debate	No	Yes	Yes[2]	Yes[2]	2/3	Debatable Motions	Amend, Close Debate	Yes[6]
7. Postpone to a Certain Time	No	Yes	Yes[2]	Yes[2]	Majority	Main Motion	Amend, Close Debate, Limit Debate	Yes[6]
8. Refer to Committee (or Board)	No	Yes	Yes[2]	Yes[2]	Majority	Main Motion	Amend, Close Debate, Limit Debate	Yes[6]
9. Amend	No	Yes	Yes[3]	Yes	Majority	Rewordable Motions	Close Debate, Limit Debate	No[6]
Main Motions								
10a. The Main Motion	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
10b. Specific Main Motions								
Adopt in-lieu-of	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
Amend a Previous Action	No	Yes	Yes	Yes	Same Vote	Adopted MM	Subsidiary	No
Ratify	No	Yes	Yes	Yes	Same Vote	Adopted MM	Subsidiary	No
Recall from Committee	No	Yes	Yes[2]	No	Majority	Referred MM	Close/Limit Debate	No
Reconsider	Yes[4]	Yes	Yes[2]	No	Majority	Vote on MM	Close/Limit Debate	No
Rescind	No	Yes	Yes	No	Same Vote	Adopted MM	Subsidiary; *not* amend	No

American Institute of Parliamentarians Standard Code of Parliamentary Procedure Motions Table

Incidental Motions (non-ranking within the classification)								
Motions								
No order of Rank/Precedence	**Interrupt**	**Second**	**Debate**	**Amend**	**Vote**	**Applies to what other motions?**	**Can have other motions applied?**	**Renewable**
Appeal	Yes	Yes	Yes	No	Majority[7]	Ruling of Chair	Close/limit debate	No
Suspend the Rules	No	Yes	No	No	2/3	Procedural Rules	None	Yes
Consider Informally	No	Yes	No	No	Majority	Main Motion or Subject	None	Yes
Requests								
Point of Order	Yes	No	No	No	None	Procedural error	None	No
Inquiries	Yes	No	No	No	None	All motions	None	No
Withdraw a Motion	Yes	No	No	No	None[8]	All motions	None	No
Division of a Question	No	No	No	No	None[8]	Main Motion	None	No
Division of Assembly	Yes	No	No	No	None[8]	Indecisive Vote	None	No

MM = Main Motion

[1]Motions are in order only if no motion higher on the list is pending.
[2]Restricted
[3]Not debatable when applied to undebatable motion
[4]Member may interrupt proceedings, but not a speaker
[5]Withdraw may be applied to all motions
[6]Renewable at discretion of presiding officer (chair)
[7]Tie or majority vote sustains the ruling of the presiding officer; majority vote in negative reverses the ruling
[8]If decided by assembly (by motion), requires a majority vote to adopt

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American Institute of Parliamentarians Standard Code of Parliamentary Procedure Motions Table

William W. Pinsky, M.D., FAAP, FACC
President and Chief Executive Officer, ECFMG
Chair, Board of Directors, FAIMER

William W. Pinsky is President and Chief Executive Officer of the Educational Commission for Foreign Medical Graduates (ECFMG) and Board Chair of the Foundation for Advancement of International Medical Education and Research (FAIMER), ECFMG's nonprofit foundation. Prior to joining ECFMG in mid-2016, Dr. Pinsky was Executive Vice President and Chief Academic Officer of Ochsner Health System (OHS). He also served as Executive Vice President for Ochsner International and Professor and Head at the Ochsner Clinical School, a U.S. partner of The University of Queensland School of Medicine in Australia. Dr. Pinsky retains an Honorary Professor title from the University of Queensland. Dr. Pinsky graduated from Saint Louis University School of Medicine, and trained at Baylor College of Medicine and at Texas Children's Hospital. Before joining OHS, Dr. Pinsky held a number of senior academic and executive roles at Wayne State University School of Medicine (Associate Dean) in Detroit, and at the Detroit Medical Center.

Dr. Pinsky has served on the Boards of the Accreditation Council for Graduate Medical Education, the Accreditation Council for Continuing Medical Education, and the Alliance of Independent Academic Medical Centers where he also served as President. He is the founder of Racing For Kids®, a 501(c)(3) foundation that uses professional motorsports to promote the health care needs of children and children's hospitals. Dr. Pinsky is a Fellow of the American Academy of Pediatrics, the American College of Cardiology, and the American College of Chest Physicians. His most recent honors include the Leadership Award for the Faculty of Medicine and Biological Sciences, presented by The University of Queensland in 2015, and The Founders Award, presented by the American Academy of Pediatrics in 2013.

William F. Owen, Jr., MD, FACP

William F. Owen, Jr., MD, FACP is the newly appointed Dean and Chancellor for Ross University School of Medicine, Adtalem Global Education Group, Inc.

Dr. Owen is an experienced academic executive with a unique breadth of strategic and operational experiences in undergraduate, graduate, and postgraduate education, especially in the health sciences. Throughout his career, he has worked at the intersection of health career education, medical service, and life sciences research, providing leadership to align global educational interests and priorities with the pressing healthcare and workforce challenges of society. For example from 2005 to 2007, he served as Chancellor & Senior Vice President of Health Affairs at the University of Tennessee (TN), responsible for all aspects of the $370 million/yr flagship College of Medicine and TN's five other health professional colleges. He then served for five years as President of the University of Medicine and Dentistry of New Jersey, the statewide health education and medical services component of Rutgers University. In this role, he oversaw all aspects of New Jersey's sixth largest employer ($1.7 billion/yr), which was also America's largest public funded academic health system – made up of two nationally ranked, allopathic medical schools, an osteopathic medical school, five other health professional schools (nursing, public health, allied health, dentistry, and graduate medical sciences), as well as several large magnet teaching hospitals and research institutes.

Dr. Owen has a long-standing commitment to global education and health and has been an astute observer of the trends and forces impacting the evolution of the global health workforce. For example from 2012 to 2014, he was the inaugural Chief Executive Officer of Sidra Medical & Research Center in Qatar, the major international training site for Weill Cornell Medical College. He was health policy advisor to the President of the International Association of University Presidents, an NGO that advises the United Nations on matters of higher education, and was a Visiting Professor at Imperial College London in its Institute of Global Health Innovation. Immediately prior to his current role at Ross, Dr. Owen was the Dean of Medical Sciences at DeVry's American University of the Caribbean School of Medicine.

A graduate of Phillips Academy, Brown University, and Tufts University (MD with honors), Dr. Owen trained in internal medicine and nephrology at Harvard Medical School's Brigham and Women's Hospital, where he was a Robert Wood Johnson Foundation Fellow (Minority Medical Faculty Development Program) and a full time faculty member at Harvard. As a tenured Professor at Duke University, University of Tennessee, and AUC, he is an accomplished academician with over 180 peer-reviewed articles, chapters, and books to his credit, and is the recipient of ~$10 million in research grants.

IMG SECTION MEETING SCHEDULE

2018 21st Annual Meeting
Hyatt Regency Chicago

IMGS Meetings: June 7-10
HOD Meetings: June 8-13

ATTIRE: BUSINESS CASUAL

Friday, June 8

7:00 a.m-4 p.m.	Registration for all meeting attendees	Across from Grand Ballroom
3:00–5:10 p.m.	IMGS & Minority Affairs Section Board Officer Candidates Interviews	Columbus G, East Tower

Saturday, June 9

6:00 a.m.	Ron Davis Memorial 5K run/walk and other healthful activities	Motor entrance, East Tower
8:00 a.m.	IMGS Emergency Resolutions due	Send to img@ama-assn.org

8:00 a.m.	Joint Sections and Special Groups educational sessions *- All approved for Category 1 PRA CME Credit*	***Varied locations, please see schedule***
2:00–6:00 p.m.	House of Delegates Opening Session (Rules of Order, Speeches, Nominations, Other presentations)	Grand Ballroom
5:30–8:00 p.m.	IMGS Congress and Reception ***Speakers: William Pinsky, CEO, ECFMG*** ***Dr. William Owen, Dean,*** ***Ross University School of Medicine***	Columbus G, East Tower
9:30–11:00 p.m.	IMGS 12th Desserts from Around the World Reception – *experience ethnic desserts with an international flair and entertainment*	Crystal Ballroom

Sunday, June 10

8–8:30 a.m.	House of Delegates Second Opening Session (Business – Introduction of Reports and Resolutions, Extraction of Informational Reports, Supplementary Report of Committee on Rules and Credentials)	Grand Ballroom
8:30 a.m.-noon	Reference Committee on Constitution and Bylaws	Crystal Ballroom
	Reference Committee B – Legislation	Regency B
	Reference Committee C – Medical Education	Regency C
	Reference Committee D – Science/Technology	Regency D
	Reference Committee G – Medical Practice	Regency A
1:30–5:00 p.m.	Reference Committee A – Medical Service	Regency A
	Reference Committee E – Public Health	Regency D

	Reference Committee F – Finance/Governance	Grand Ballroom

Monday, June 11

8–11 a.m.	HOD Ancillary & Education Sessions	Various
8:30–9:30 a.m.	IMGS Delegates Caucus (to discuss Reference Committee reports)	Roosevelt 3A, East Tower, Concourse Level
10:45-11:45 a.m.	Busharat Ahmad, MD Leadership Development Program ***"Climbing the Ladder of Leadership"*** ***Speaker: Ardis Hoven, MD,*** ***AMA Past President***	Columbus E/F, East Tower
11:00 a.m.–1:45 p.m.	State/Specialty Caucuses	***(various) See Meeting Schedule***
2:00–6:00 p.m.	House of Delegates Business Session	Grand Ballroom

Tuesday, June 12

7:30–8:45 a.m.	Elections	
9:00 a.m.–3 p.m.	House of Delegates Business Session	Grand Ballroom
5 p.m.	Inauguration of Barbara McAneny, MD, 173rd AMA President	Crystal Ballroom
6:30-11:00 p.m.	Inaugural Reception and Dinner Dance	Grand Ballroom

Wednesday, June 13

8:00 a.m.–noon	House of Delegates Business Session	Grand Ballroom

To: AMA-IMG Section Members

From: Ved Gossain, MD, Chair
IMGS Governing Council

Date: June 1, 2018

Subject: AMA-IMG Section Governing Council Chair's Report

The following report is submitted on behalf of the AMA-IMGS Governing Council (GC), covering highlights for the 2017-2018 year and provides an overview of current issues affecting IMGs. This report is provided to keep the members of the American Medical Association International Medical Graduates Section (AMA-IMGS) informed on the activities, accomplishments and issues related to international medical graduates and the IMG Section.

Member and GC Involvement

- IMG Governing Council leadership (Chair – Dr Gossain) was appointed to the Health Equity Task Force whose mission is to adopt a health equity definition which proposed actions could be tested; learn from the contributions of the Commission to End Healthcare Disparities and help AMA to contribute positively regarding its commitment to health equity. The task force asked for a Center to End Health Equities, submitted its report to the AMA Board of Trustees which has been accepted.

- The IMGS Governing Council's has focused on the immigration issues as a result of the Presidential Proclamation currently in place which is less restrictive than the former travel ban. J-1 and H-1B visas will remain available for most countries.

- A resolution asking for a separate categories for physicians waiting to get a "green card " has been submitted

- The Section collaborated with the AMA Advocacy Department to send out another letter requesting the medical societies to get involved with advocating for licensure parity within their states.

- The IMG Governing Council has reached out to offshore medical school students and alumni to establish awareness of the AMA and its IMG Section.

- Your GC continued to update its strategic plan to better align with AMA's focus areas and address the unique needs of our Section members.

- The IMGS participated in its 6th year of the Annual AMA Research Symposiums. Many IMG Section members participated as judges and the research presented by our ECFMG-certified members, awaiting residency continue to be stellar. The next 16th Annual Research Symposium is scheduled for Friday, November 9, 2018 in National Harbor, Maryland.

- In an effort to connect with our grassroots members, state IMG committees and ethnic medical societies, the AMA IMG Section piloted its State of the Section teleconference in 2017 via the IMG Digital Community.

- The IMG Section participated in the ECFMG Stakeholders Discussion Group to maintain ongoing communications regarding international medical graduates, NRMP and ECFMG and other collaboration efforts.

- This is the eighth year of the IMGS Committee structure in operations. Committees have been combined to refocus the efforts of the IMG Section. These Committees include: Busharat Ahmad, MD Leadership Development Program, Nominating Committee Reports and Resolutions, and Social events. These committees meet quarterly via teleconferences and provide grassroots members with a tangible way to engage with our Section and fulfill the IMGS work plan. Furthermore, the committees provide leadership opportunities (without having to travel) for grassroots members. Section members are invited to participate on any committee.

- The IMG Section staff presented at the Kaplan Medical meeting which involved over 40 participants. IMG staff presented on updates of the IMG Section and answered several student inquiries regarding the AMA and its IMG Section. There were two students interested in international membership.

- Your GC leadership (Drs. Gossain and Chandra) participated in the AMA Board of Trustees and Section Leadership teleconferences which were very informative.

- The 11th *Annual Desserts from Around the World Reception* was a huge success, with over 400 attendees and entertainment from the Latin Street dancers from Chicago. Over a dozen ethnic, state and specialty medical associations contributed to this tasty affair. All physicians and organizations may be sponsors for this event.

- The IMG Section is looking for mentors to assist mentoring IMG students/residents to navigate the process of practicing medicine in the U.S. Send your request to img@ama-assn.org

Communications & Resources

- Over 23,000 subscribers receive the AMA-IMGS portion of the weekly AMA Wire and Morning Rounds electronic newsletter.

- The AMA-IMGS Web site has been revamped for early promotion of meetings information and resources. This development has provided more information and created more physician member engagement.

- Your Governing Council meets regularly via teleconference in order to stay connected and apprised about issues of concern that impact the IMG community.

- The IMG Section successfully launched its Online Digital Community to provide a forum for AMA-IMG Section members to discuss issues in a closed group environment as well as facilitate sharing of best practices among peers (e.g. licensing issues, residency interviews, where to practice; and successfully navigating the match). This new product surpassed its goal of obtaining 400 members within the first three months. A total of nine

digital panel discussions have yielded over 25,000 views and engaged over 1,300 members.

New AMA Policies

- The AMA-IMG Section continues to promote its online Member Forum (Virtual Congress) to review resolutions and provide comments for its Annual and Interim Section meetings. Five resolutions were made available to Section members to review for 2017. This online member forum is designed to obtain feedback and ratify IMG Section resolutions for submission to the AMA House of Delegates.

Membership

- Our Section membership has increased from 38,000 to over 40,000 members which represent over 16% of AMA membership. We will continue to collaborate with the AMA Membership Team to work on effective ways to recruit members and retain existing members. We are asking all IMG Section members to become ambassadors and encourage your friends to join the AMA and become a part of the new "Members Move Medicine" campaign. Your AMA Membership Moves Medicine!

- The AMA-IMG Section began discussions on a process to have offshore medical students join the AMA. More discussion is planned to accomplish development of this membership category.

- The ECFMG-certified and awaiting residency membership program created in 2010 has attracted over 1,200 new members to date. Overall IMGS membership increased by 2% as of 2017 year-end.

Top IMG Issues

The IMG Study

The IMG Section staff partnered with the AMA Market Research team to conduct a study of 304 IMG physicians to determine their interests and needs. The study revealed that IMGs wanted job shadowing opportunities, funding of GME positions, acculturation and orientation programs, mentors, and mock residency interviews. Your IMG Section is on target with providing these resources.

Licensure Parity

There are 34 states that have separate and unequal GME requirements for US medical graduates and IMGs. Our Section offers a model resolution for states to adopt in order to achieve licensure equality between US medical graduates and IMGs. Several states have adopted this equality policy have been successful in changing their state's licensing laws. The IMG Section is piloting a few states to change the disparities in graduate medical education for licensure. ***Legislation passed in Virginia this year, is expected to pass in Nebraska. Pennsylvania has just secured a sponsor for a bill to run next year. The sponsorship letter regarding anticipated Pennsylvania legislation may be found at the link below:***
http://www.legis.state.pa.us/cfdocs/Legis/CSM/showMemoPublic.cfm?chamber=H&SPick=20170&cosponId=24698 For information, email img@ama-assn.org

GME Expansion: Due to adoption of the Affordable Care Act, an ever-increasing number of patients with chronic illnesses and the increased number of physicians retiring, the physician workforce shortage continues to grow. Thousands of qualified IMGs (many who are US

citizens or permanent residents) could enter the physician workforce right now, but the number of GME (graduate medical education) positions was capped by Congress in 1994, limiting the ability of qualified IMGs to enter the physician workforce. The Section's legislative priority continues to be to call for an increase in the number of GME positions in order to alleviate the physician workforce shortage and increase access to care for patients. Additionally, we contributed to the AMA's testimony before the Institute of Medicine (IOM) GME Financing Committee. Furthermore, our Section authored two resolutions that called for alternate funding mechanisms to expand GME positions. In the 2018 Match, 56.1% (3,962 out of 7,067) IMG participants matched. A total of 57.1% (2,900) U. S. citizen IMGs matched out of 5,075 participants.

Immigration: The reauthorizations of the 1994 Conrad 30 bill have resulted in bringing more than 15,000 physicians to underserved areas. This has been accomplished by providing essential waivers to physicians who come to the U.S. on the J-1 work-study visas for residency training. Those physicians would have been forced to return home for two years before applying for a new visa or green card. In exchange, the physicians have given a three-year commitment to practice in an underserved community. The current bill has bipartisan sponsorship in the Senate and House versions (S. 898 and H.R. 2141) and, if passed, would remain in effect until 2021. The introduction of the bills will mark a positive moment for physicians who have been affected by the Executive travel orders. Our AMA will continue to advocate on immigration and other issues that affect IMGs.

Racial and Ethnic Health Care Disparities: The diverse cultural, ethnic and linguistic backgrounds of IMGs serve to improve the health care outcomes of racial and ethnic minority patients as well as raise awareness of the need for all physicians to eliminate racial and ethnic disparities. Because of the diversity of the IMGS, our Section is well-positioned to contribute to the overall strategies related to eliminating racial and ethnic health care disparities and improving health outcomes.

Leadership Development: IMG physicians make up a little over 16% of the membership of the AMA, yet IMGs are underrepresented in leadership positions in the practice setting and in organized medicine. The Leadership Development Committee provides our Section members with the tools and resources to be more effective, dynamic leaders. To address the issues related to being an effective leader, the Section created the Busharat Ahmad, MD Leadership Program in 2006. This program is held in conjunction with the AMA Annual and Interim Meetings and the attendance and scope of the topics and audience has grown each year. The November 2017 Busharat Ahmad MD Leadership Development session, "Answering the call to be a physician leader" featured Dr. George Mejicano current Chair of the AMA Academic Physicians Section, as well as the Chair of the Continuing Professional Development Section of the AAMC's Group on Educational Affairs. This year's Annual Meeting program is titled *"Climbing the Ladder to Leadership."*

Conclusion

The AMA-IMGS continues to address many issues of importance to IMGs in order to pave the way for continued and effective advocacy and membership involvement with the support of its membership. Our AMA Board of Trustees liaisons: AMA President-Elect, Barbara McAneny, MD and Russell Kridel, MD, have been a tremendous help and resource for the IMG Section. I want to thank my fellow Governing Council members and our staff (J. Mori and Carolyn) for all of their efforts and support. The AMA-IMGS continues to encourage all of its Section members to participate in their community, hospital, group practice, county society, state and specialty organizations as well as the AMA.

Thank you for being a part of organized medicine. We appreciate your involvement and support.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-18)

Introduced by: International Medical Graduates Section

Subject: Foreign Trained IMGs Obtaining a U.S. License Without U.S. Residency

Referred to: Reference Committee C
(Sherri Baker, MD, Chair)

Whereas, There is a predicted shortage of 40,800-104,900 physicians in the U.S. by 2025;[1] and

Whereas, There are many qualified International Medical Graduates (IMGs) waiting for a residency position[2]; and

Whereas, U.S. medical schools and the Accreditation Council of Graduate Medical Education (ACGME) are moving towards competency-based criteria and not necessarily time-based criteria for graduation[3]; and

Whereas, Many overseas residency programs are equally as rigorous as residency programs in the U.S.; and

Whereas, Many well trained and experienced IMGs could meet the competency-based criteria required for graduation from the residency programs; and

Whereas, There is precedent where several physicians who were trained abroad entered medical practice in the U.S., or even served on U.S. medical school faculties, without being required to undergo any additional residency training; therefore be it

RESOLVED, That our American Medical Association accept it as a policy that International Medical Graduates who have completed residency programs in their own countries, have passed the USMLE I, II, and III should be eligible for a license to practice medicine without additional residency training in the U.S. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/18

[1]Association of American Medical Colleges, "The Complexities of Physician Supply and Demand: Projections form 2015 to 2030, February 28, 2017.
[2]National Residency Matching Program, http://www.nrmp.org
[3]ACGME Common Program Requirements for Graduate Medical Education, http://www.acgme.org

RELEVANT AMA POLICY

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317

1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.
Citation: CME Rep. 3, A-14; Appended: CME Rep. 04, A-16;

Mechanisms to Measure Physician Competency H-275.936

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency.
Citation: Res. 320, I-98; Amended: Res. 817, A-99; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 313, A-12; Modified: Res. 309, I-16

See also:
AMA Principles on International Medical Graduates H-255.988
Recommendations for Future Directions for Medical Education H-295.995

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-18)

Introduced by: International Medical Graduates Section

Subject: Foreign Trained IMGs Competency-Based Specialty Exam Without U.S. Residency

Referred to: Reference Committee C
(Sherri Baker, MD, Chair)

Whereas, There is a predicted shortage of 40,800-104,900 physicians in the U.S. by 2025;[1] and

Whereas, There are many qualified International Medical Graduates (IMGs) waiting for a residency position;[2] and

Whereas, U.S. medical schools and the Accreditation Council of Graduate Medical Education (ACGME) are moving towards competency-based criteria and not necessarily time-based criteria for graduation;[3] and

Whereas, Many overseas residency programs are equally as rigorous as residency programs in the U.S.; and

Whereas, Many well trained and experienced IMGs could meet the competency-based criteria required for graduation from the residency programs; and

Whereas, There is precedent where several physicians who were trained abroad entered medical practice in the U.S., or even served on U.S. medical school faculties, without being required to undergo any additional residency training; therefore be it

RESOLVED, That our American Medical Association work with other stakeholders including the Accreditation Council of Graduate Medical Education, Association of American Medical Colleges and the American Board of Medical Specialties, to advocate that International Medical Graduates who have completed residency programs in their own countries should be eligible to take the specialties exam without being required to complete additional residency training in the U.S. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/18

[1]American Association of Medical Colleges, "The Complexities of Physician Supply and Demand: Projections from 2015-2030, February 28, 2017.
[2]National Residency Matching Program, http://www.nrmp.org
[3]ACGME Program Requirements for Graduate Medical Education, http://www.acgme.org

RELEVANT AMA POLICY

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317
1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.
Citation: CME Rep. 3, A-14; Appended: CME Rep. 04, A-16;

Mechanisms to Measure Physician Competency H-275.936
Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency.
Citation: Res. 320, I-98; Amended: Res. 817, A-99; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 313, A-12; Modified: Res. 309, I-16;

See also:
AMA Principles on International Medical Graduates H-255.988
Recommendations for Future Directions for Medical Education H-295.995

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-18)

Introduced by: International Medical Graduates Section

Subject: U.S. Institutions with Restricted Medical Licensure

Referred to: Reference Committee C
(Sherri Baker, MD, Chair)

Whereas, IMGs in the past were permitted to work in academic institutions in some states, either for their specific skills or for a need due to scarce interest of American physicians in certain specialties or geographical areas; and

Whereas, These physicians were allowed to work with an institutional or faculty temporary license granted by their local State Medical Board without having completed the USMLE examination, having ECFMG certification and without being American Board certified or eligible in their specialty; and

Whereas, These physicians completed medical school and specialty training abroad were often excellent candidates with strong curricula and their titles were recognized equivalent to the ones received in the U.S. by the receiving academic institution to allow them to work; and

Whereas, In recent years, these physicians faced the problem that many academic and non-academic institutions created rules to have only American Board Certified physicians among their faculty/staff and were unwilling to grant institutional licenses any longer; and

Whereas, This issue creates a dramatic situation for these physicians who have practiced in the U.S. for many years, bringing unique skills and much needed service for the American people and medical system; and

Whereas, In these academic institutions, these physicians have actively trained many medical students and specialists and have started new programs to allow young American physicians to become eligible to work without restrictions while their IMG professors are not; and

Whereas, These IMGs were admitted to work in the U.S. to fill a void and a need which may affect them due to more restrictive changes which are not considering such unique situations. These physicians are faced with losing their jobs without the ability to practice anywhere in the U.S.; therefore be it

RESOLVED, That our American Medical Association work with the Organized Medical Staff Section and other stakeholders to prevent hospitals from restricting the practice of medicine only to American board certified physicians (Directive to Take Action); and be it further

RESOLVED, That the AMA work with the Federation of State Medical Boards and other stakeholders to develop a process to grant unrestricted licensure for those who have practiced at least 10 years in U.S. academic institutions under institutional or faculty temporary licensure. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/18

RELEVANT AMA POLICY

Medical Specialty Board Certification Standards H-275.926
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
Citation: Res. 318, A-07; Reaffirmation A-11; Modified: CME Rep. 2, I-15

See also: Maintenance of Certification H-275.924

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-18)

Introduced by: International Medical Graduates Section

Subject: Medicare Quality Incentives

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, There are significant numbers of physicians over the age of 55, and physicians in small group practices; and

Whereas, Small group practice physicians and more senior physicians are inherently encouraged to leave practice sooner given penalties imposed due to Medicare quality initiatives and;

Whereas, Participation in Medicare quality initiatives represent significant costs small group practices and to senior physicians particularly, and at a time when a physician shortage is increasingly evident; and

Whereas, The patient population has been expanded both by growth in the senior population, population growth in general, and greater accessibility, negative incentives will serve to drive physicians out of practice earlier at a time when they are most needed, and indeed represent a pool of experience and knowledge that is hard to duplicate; and

Whereas, Quality incentives in the payment system may, or may not be justifiable, in this instance they work against the system by narrowing the workforce both in terms of numbers and experience; and

Whereas, By eliminating penalties, by offering financial rewards for remaining in practice, some of that narrowing of the workforce may be mitigated; therefore be it

RESOLVED, That the American Medical Association work with the Department of Health and Human Services in incentivizing small groups, and more senior physicians, regardless of their volume of patients total billing in dollars, with "small group", and "senior" deferments against penalties and bonuses for continued practice. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/18

References:
Centers for Medicaid and Medicare Services, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs.html

RELEVANT AMA POLICY

Measurement of Drug Costs to Assess Resource Use Under MACRA H-385.911
1. Our AMA will work with Congress and the Centers for Medicare and Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System (MIPS) or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician's performance and assumption of financial risk, unless a Physician Focused Alternative Payment Model (incorporating such costs) is proposed by a stakeholder organization and participation in the model is not mandatory.
2.Our AMA will continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the MIPSpayment adjustment as part of the Quality Payment Program (QPP).
Citation: Res. 218, A-16; Appended: Res. 225, I-17;

MACRA and the Independent Practice of Medicine H-390.837
1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.
2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.
3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.
Citation: Alt. Res. 206, A-17;

Protecting Patients Rights H-450.944
Our AMA opposes Medicare pay-for-performance initiatives (such as value-based purchasing programs) that do not meet our AMA's "Principles and Guidelines for Pay-for-Performance," which include the following five Principles: (1) ensure quality of care; (2) foster the patient/physician relationship; (3) offer voluntary physician participation; (4) use accurate data and fair reporting; and (5) provide fair and equitable program incentives.
Citation: Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-18)

Introduced by: International Medical Graduates Section

Subject: Green Card Backlog for Immigrant Doctors on H-1B Visa

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, We are facing a shortage of physicians in this country and international medical graduates provide health care to millions of people in rural and underserved communities; and

Whereas, One in four physicians in the U.S. is an immigrant physician; and

Whereas, Immigrant physicians do not replace American workers, instead, we fill the missing gaps in U.S. healthcare, create more jobs, serve mostly the rural and underserved areas; and

Whereas, At the time of writing of the 2017 VA report by Office of Inspector General there continues to be a physician shortage in the VA hospital system that is most critical for Medical Officers; and

Whereas, The physician shortage has already affected multiple hospitals in the Veterans Affairs causing postponement of surgeries and challenges in providing timely care to Veterans; and

Whereas, There are physicians currently available in the United States to meet this shortage, such as the nearly 15,000 international medical graduates from India who are actively practicing in the U.S. stuck in the green card backlog waiting to get a green card, which may take up to 20 years at the current rate; and

Whereas, Physicians apply for green cards under the employment-based category 2 (EB2), which have more 20+ years for green card, causing multiple challenges, including unable to work at additional location, limited job opportunities and career advancements and unable to invest or start new businesses; therefore be it

RESOLVED, That our American Medical Association work with the Office of the Inspector General, the Veterans Affairs Administration, United States Citizenship and Immigration Services and the Executive Branch of the United States Government to create a separate path to obtain green cards and citizenship for physicians which would allow these physicians to work unrestricted and allow them to work within the Veterans Affairs Hospital network to address the current and expected future physician shortage in these institutions. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/18

References:
U. S. Citizen & Immigration Services, Green Card Processes & Procedures.
https://www uscis.gov/greencard/green-card-processes-procedures. March 2018
The Economic Times, "Why children of H-1B workers may now have to leave America", October 2017
//economictimes.indiatimes.com/articleshow/61166125.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst
Today's Hospitalist, "The Case for Immigration Reform", May 2017, https://www.todayshospitalist.com/the-case-forimmigration-reform/
Department of Veterans Affairs Office of Inspector General, OIG Determination of VHA Occupational Staffing Shortages FY 2017Offi
https://www.va.gov/oig/pubs/VAOIG-17-00936-385.pdf
VA Hospitals Still Struggling With Adding Staff Despite Billions from Choice Act.
https://www.npr.org/2017/01/31/512052311/va-hospitals-still-struggling-with-adding-staff-despite-billions-from-choice-act
Doctor shortage forces Colorado VA hospital to postpone surgeries.
https://www.fiercehealthcare.com/healthcare/doctor-shortage-forces-colorado-va-hospital-to-postpone-surgeries

RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.
Citation: Alt. Res. 308, A-17;

Access to Health Care for Veterans H-510.985
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.
Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17;

See also:
Expansion of US Veterans' Health Care Choices H-510.983
Ensuring Access to Care for our Veterans H-510.986

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H.R.392 - Fairness for High-Skilled Immigrants Act of 2017

115th Congress (2017-2018) | Get alerts

Sponsor: Rep. Chaffetz, Jason [R-UT-3] (Introduced 01/10/2017)

Committees: House - Judiciary

Latest Action: House - 07/11/2017 ASSUMING FIRST SPONSORSHIP - Mr. Yoder asked unanimous consent that he may hereafter be considered as the first sponsor of H.R. 392, a bill originally introduced by Representative Chaffetz, for the purpose of adding cosponsors and requesting reprintings pursuant to clause 7 of rule XII Agreed to without objection. (All Actions)

Tracker: **Introduced** Passed House Passed Senate To President Became Law

Summary: H.R.392 — 115th Congress (2017-2018)

All Information (Except Text)

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There is one summary for H.R.392. Bill summaries are authored by CRS.

Shown Here:
Introduced in House (01/10/2017)

Fairness for High-Skilled Immigrants Act of 2017

This bill amends the Immigration and Nationality Act to: (1) eliminate the per-country numerical limitation for employment-based immigrants, and (2) increase the per-country numerical limitation for family-based immigrants from 7% to 15% of the total number of family-sponsored visas.

The Chinese Student Protection Act of 1992 is amended to eliminate the provision requiring the reduction of annual Chinese immigrant visas to offset status adjustments under such Act.

The bill establishes a transition period during which a percentage of employment-based second and third preference (EB-2 and EB-3) immigrant visas are reserved as follows:

- for FY2017, 15% of such visas are allotted to natives of countries other than the two countries with the largest aggregate numbers of natives obtaining such visas in FY2011;
- for FY2018, 10% of such visas are allotted in each category to natives of countries other than the two with the largest aggregate numbers of natives obtaining such visas in FY2012; and
- for FY2019, 10% of such visas are allotted in each category to natives of countries other than the two with the largest aggregate numbers of natives obtaining such visas in FY2015.

During the transition period, not more than 25% of the total number of the reserved EB-2 and EB-3 visas shall be allotted to natives of a single country.

Public Documents

Resolution 229 – Green Card Backlog for Immigrant Doctors on H-1B Visas

H.R. 392, the Fairness for High-Skilled Immigrants Act of 2017 has been introduced in Congress. The bill is currently sponsored by Rep. Kevin Yoder (R-KS), although the bill was originally introduced by Rep. Jason Chaffetz (R-UT). There is a list of 321 bipartisan cosponsors on the bill.

S. 281, the Fairness for High-Skilled Immigrants Act of 2017 has been introduced in Congress. Sen. Mike Lee (R-UT) is spearheading the bill, along with four cosponsors.

Department of Veterans Affairs Office of Inspector General, OIG Determination of VHA Occupational Staffing Shortages FY 2017 (Report).

I

115TH CONGRESS
1ST SESSION

H. R. 392

To amend the Immigration and Nationality Act to eliminate the per-country numerical limitation for employment-based immigrants, to increase the per-country numerical limitation for family-sponsored immigrants, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 10, 2017

Mr. CHAFFETZ (for himself, Mr. BISHOP of Michigan, Mr. COHEN, Mrs. COMSTOCK, Mr. CONNOLLY, Mr. COURTNEY, Mr. CUMMINGS, Mr. DEUTCH, Mr. FARENTHOLD, Ms. KELLY of Illinois, Mr. LANGEVIN, Mrs. LOVE, Ms. MENG, Mr. O'ROURKE, Mr. PAULSEN, Mr. PEARCE, Mr. QUIGLEY, Mr. RYAN of Ohio, Ms. SLAUGHTER, Ms. STEFANIK, Mr. STEWART, Mr. SWALWELL of California, Mr. TAKANO, Mrs. WAGNER, Mr. WALZ, and Mr. YARMUTH) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To amend the Immigration and Nationality Act to eliminate the per-country numerical limitation for employment-based immigrants, to increase the per-country numerical limitation for family-sponsored immigrants, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Fairness for High-Skilled Immigrants Act of 2017".

SEC. 2. NUMERICAL LIMITATION TO ANY SINGLE FOREIGN STATE.

(a) IN GENERAL.—Section 202(a)(2) of the Immigration and Nationality Act (8 U.S.C. 1152(a)(2)) is amended—

(1) in the paragraph heading, by striking "AND EMPLOYMENT-BASED";

(2) by striking "(3), (4), and (5)," and inserting "(3) and (4),";

(3) by striking "subsections (a) and (b) of section 203" and inserting "section 203(a)";

(4) by striking "7" and inserting "15"; and

(5) by striking "such subsections" and inserting "such section".

(b) CONFORMING AMENDMENTS.—Section 202 of the Immigration and Nationality Act (8 U.S.C. 1152) is amended—

(1) in subsection (a)(3), by striking "both subsections (a) and (b) of section 203" and inserting "section 203(a)";

(2) by striking subsection (a)(5); and

(3) by amending subsection (e) to read as follows:

"(e) SPECIAL RULES FOR COUNTRIES AT CEILING.—If it is determined that the total number of immigrant visas made available under section 203(a) to natives of any single foreign state or dependent area will exceed the numerical limitation specified in subsection (a)(2) in any fiscal year, in determining the allotment of immigrant visa numbers to natives under section 203(a), visa numbers with respect to natives of that state or area shall be allocated (to the extent practicable and otherwise consistent with this section and section 203) in a manner so that, except as provided in subsection (a)(4), the proportion of the visa numbers made available under each of paragraphs (1) through (4) of section 203(a) is equal to the ratio of the total number of visas made available under the respective paragraph to the total number of visas made available under section 203(a).".

(c) COUNTRY-SPECIFIC OFFSET.—Section 2 of the Chinese Student Protection Act of 1992 (8 U.S.C. 1255 note) is amended—

(1) in subsection (a), by striking "subsection (e))" and inserting "subsection (d))"; and

(2) by striking subsection (d) and redesignating subsection (e) as subsection (d).

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect as if enacted on September

30, 2016, and shall apply to fiscal years beginning with fiscal year 2017.

(e) TRANSITION RULES FOR EMPLOYMENT-BASED IMMIGRANTS.—

(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection and notwithstanding title II of the Immigration and Nationality Act (8 U.S.C. 1151 et seq.), the following rules shall apply:

(A) For fiscal year 2017, 15 percent of the immigrant visas made available under each of paragraphs (2) and (3) of section 203(b) of such Act (8 U.S.C. 1153(b)) shall be allotted to immigrants who are natives of a foreign state or dependent area that was not one of the two states with the largest aggregate numbers of natives obtaining immigrant visas during fiscal year 2011 under such paragraphs.

(B) For fiscal year 2018, 10 percent of the immigrant visas made available under each of such paragraphs shall be allotted to immigrants who are natives of a foreign state or dependent area that was not one of the two states with the largest aggregate numbers of natives obtaining immigrant visas during fiscal year 2012 under such paragraphs.

(C) For fiscal year 2019, 10 percent of the immigrant visas made available under each of such paragraphs shall be allotted to immigrants who are natives of a foreign state or dependent area that was not one of the two states with the largest aggregate numbers of natives obtaining immigrant visas during fiscal year 2015 under such paragraphs.

(2) PER-COUNTRY LEVELS.—

(A) RESERVED VISAS.—With respect to the visas reserved under each of subparagraphs (A) through (C) of paragraph (1), the number of such visas made available to natives of any single foreign state or dependent area in the appropriate fiscal year may not exceed 25 percent (in the case of a single foreign state) or 2 percent (in the case of a dependent area) of the total number of such visas.

(B) UNRESERVED VISAS.—With respect to the immigrant visas made available under each of paragraphs (2) and (3) of section 203(b) of such Act (8 U.S.C. 1153(b)) and not reserved under paragraph (1), for each of fiscal years 2015, 2016, and 2017, not more than 85 per-

cent shall be allotted to immigrants who are natives of any single foreign state.

(3) SPECIAL RULE TO PREVENT UNUSED VISAS.—If, with respect to fiscal year 2015, 2016, or 2017, the operation of paragraphs (1) and (2) of this subsection would prevent the total number of immigrant visas made available under paragraph (2) or (3) of section 203(b) of such Act (8 U.S.C. 1153(b)) from being issued, such visas may be issued during the remainder of such fiscal year without regard to paragraphs (1) and (2) of this subsection.

(4) RULES FOR CHARGEABILITY.—Section 202(b) of such Act (8 U.S.C. 1152(b)) shall apply in determining the foreign state to which an alien is chargeable for purposes of this subsection.

○

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S.281 - Fairness for High-Skilled Immigrants Act of 2017

115th Congress (2017-2018) | Get alerts

Sponsor: Sen. Lee, Mike [R-UT] (Introduced 02/02/2017)

Committees: Senate - Judiciary

Latest Action: Senate - 02/02/2017 Read twice and referred to the Committee on the Judiciary. (All Actions)

Tracker: **Introduced** Passed Senate Passed House To President Became Law

Summary: S.281 — 115th Congress (2017-2018)

All Information (Except Text)

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There is one summary for S.281. Bill summaries are authored by CRS.

Shown Here:
Introduced in Senate (02/02/2017)

Fairness for High-Skilled Immigrants Act of 2017

This bill amends the Immigration and Nationality Act to: (1) eliminate the per country numerical limitation for employment-based immigrants, and (2) increase the per country numerical limitation for family based immigrants from 7% to 15% of the total number of family-sponsored visas.

The Chinese Student Protection Act of 1992 is amended to eliminate the provision requiring the reduction of annual Chinese immigrant visas to offset status adjustments under such Act.

The bill establishes the following transition period for employment-based second and third preference (EB-2 and EB-3) immigrant visas:

- for FY2017, 15% of such visas allotted to natives of countries other than the two countries with the largest aggregate numbers of natives obtaining such visas in FY2011;
- for FY2018, 10% of such visas allotted in each category to natives of countries other than the two with the largest aggregate numbers of natives obtaining such visas in FY2012; and
- for FY2019, 10% of such visas allotted in each category to natives of countries other than the two with the largest aggregate numbers of natives obtaining such visas in FY2015.

The bill sets forth the following per country distribution rules: (1) for transition period visas, not more than 25% of the total number of EB-2 and EB-3 visas for natives of a single country; and (2) for non-transition period visas, not more than 85% of EB-2 and EB-3 visas for natives of a single country.

Amendments made by this bill shall take place as if enacted on September 30, 2016, and shall apply beginning in FY2017.

II

115TH CONGRESS
1ST SESSION

S. 281

To amend the Immigration and Nationality Act to eliminate the per-country numerical limitation for employment-based immigrants, to increase the per-country numerical limitation for family-sponsored immigrants, and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 2, 2017

Mr. LEE introduced the following bill; which was read twice and referred to the Committee on the Judiciary

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A BILL

To amend the Immigration and Nationality Act to eliminate the per-country numerical limitation for employment-based immigrants, to increase the per-country numerical limitation for family-sponsored immigrants, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Fairness for High-Skilled Immigrants Act of 2017".

SEC. 2. NUMERICAL LIMITATION TO ANY SINGLE FOREIGN STATE.

(a) IN GENERAL.—Section 202(a)(2) of the Immigration and Nationality Act (8 U.S.C. 1152(a)(2)) is amended to read as follows:

"(2) PER COUNTRY LEVELS FOR FAMILY-SPONSORED IMMIGRANTS.—Subject to paragraphs (3) and (4), the total number of immigrant visas made available to natives of any single foreign state or dependent area under section 203(a) in any fiscal year may not exceed 15 percent (in the case of a single foreign state) or 2 percent (in the case of a dependent area) of the total number of such visas made available under such section in that fiscal year.".

(b) CONFORMING AMENDMENTS.—Section 202 of such Act (8 U.S.C. 1152) is amended—

(1) in subsection (a)—

(A) in paragraph (3), by striking "both subsections (a) and (b) of section 203" and inserting "section 203(a)"; and

(B) by striking paragraph (5); and

(2) by amending subsection (e) to read as follows:

"(e) SPECIAL RULES FOR COUNTRIES AT CEILING.—If the total number of immigrant visas made available under section 203(a) to natives of any single foreign state

or dependent area will exceed the numerical limitation specified in subsection (a)(2) in any fiscal year, immigrant visas shall be allotted to such natives under section 203(a) (to the extent practicable and otherwise consistent with this section and section 203) in a manner so that, except as provided in subsection (a)(4), the proportion of the visas made available under each of paragraphs (1) through (4) of section 203(a) is equal to the ratio of the total visas made available under the respective paragraph to the total visas made available under section 203(a).''.

(c) COUNTRY-SPECIFIC OFFSET.—Section 2 of the Chinese Student Protection Act of 1992 (8 U.S.C. 1255 note) is amended—

(1) in subsection (a), by striking ''(as defined in subsection (e))'';

(2) by striking subsection (d); and

(3) by redesignating subsection (e) as subsection (d).

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect as if enacted on September 30, 2016, and shall apply to fiscal year 2017 and each subsequent fiscal year.

(e) TRANSITION RULES FOR EMPLOYMENT-BASED IMMIGRANTS.—

(1) IN GENERAL.—Subject to paragraphs (2) through (4), and notwithstanding title II of the Immigration and Nationality Act (8 U.S.C. 1151 et seq.), the following rules shall apply:

(A) For fiscal year 2017, 15 percent of the immigrant visas made available under each of paragraphs (2) and (3) of section 203(b) of such Act (8 U.S.C. 1153(b)) shall be allotted to immigrants who are natives of a foreign state or dependent area that was not one of the two states with the largest aggregate numbers of natives obtaining immigrant visas during fiscal year 2011 under such paragraphs.

(B) For fiscal year 2018, 10 percent of the immigrant visas made available under each of such paragraphs shall be allotted to immigrants who are natives of a foreign state or dependent area that was not one of the two states with the largest aggregate numbers of natives obtaining immigrant visas during fiscal year 2012 under such paragraphs.

(C) For fiscal year 2019, 10 percent of the immigrant visas made available under each of such paragraphs shall be allotted to immigrants who are natives of a foreign state or dependent

area that was not one of the two states with the largest aggregate numbers of natives obtaining immigrant visas during fiscal year 2015 under such paragraphs.

(2) PER-COUNTRY LEVELS.—

(A) RESERVED VISAS.—The number of visas reserved under each of subparagraphs (A) through (C) of paragraph (1) made available to natives of any single foreign state or dependent area in the appropriate fiscal year may not exceed 25 percent (in the case of a single foreign state) or 2 percent (in the case of a dependent area) of the total number of such visas.

(B) UNRESERVED VISAS.—Not more than 85 percent of the immigrant visas made available under each of paragraphs (2) and (3) of section 203(b) of the Immigration and Nationality Act (8 U.S.C. 1153(b)) and not reserved under paragraph (1), for each of the fiscal years 2015, 2016, and 2017, may be allotted to immigrants who are natives of any single foreign state.

(3) SPECIAL RULE TO PREVENT UNUSED VISAS.—If, with respect to fiscal year 2015, 2016, or 2017, the application of paragraphs (1) and (2)

would prevent the total number of immigrant visas made available under paragraph (2) or (3) of section 203(b) of the Immigration and Nationality Act (8 U.S.C. 1153(b)) from being issued, such visas may be issued during the remainder of such fiscal year without regard to paragraphs (1) and (2).

(4) RULES FOR CHARGEABILITY.—Section 202(b) of such Act (8 U.S.C. 1152(b)) shall apply in determining the foreign state to which an alien is chargeable for purposes of this subsection.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-18)

Introduced by: Obesity Medicine Association, Colorado, Minority Affairs Section

Subject: Removing Barriers to Obesity Treatment

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, Obesity has been recognized by our AMA as a disease (AMA Policy H-440.842); and

Whereas, There are many evidence-based, effective and safe treatment options for obesity including intensive lifestyle intervention[1,2,3], pharmacotherapy[4], and surgery[5]; and

Whereas, Our AMA "will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions) (D-440.954);" and

Whereas, Weight-bias is a significant problem in our society, at the state and federal level, and even in our health-care system with most patients affected by obesity often being victims of weight-bias including from their health care provider (H-440.821); and

Whereas, Our AMA has recognized that medical education regarding evidence-based treatment is inconsistent and inadequate[6]; and

Whereas, Pharmacotherapy for obesity has been proven to safely and effectively double to triple the odds of losing 5-10% body weight, an amount that has been proven to prevent diabetes, improve blood pressure and decrease health care costs[7]; and

Whereas, Current state and federal regulations make it even more difficult for healthcare providers to provide treatment:

- Medicare does not allow payment for any anti-obesity medication (AOM) due to an out-of-date policy, which prohibits Medicare from covering any "drugs for weight loss or weight gain."
  Medicare further restricts payment for intensive lifestyle intervention to primary care providers in the primary care setting. For this reason, this benefit is scarcely being used.
- Our AMA has already supported the Treat and Reduce Obesity Act (TROA)[8] in the 114th Congress, and will continue to support the bill in the 115th congress, H.R. 1953/S. 830 – legislation that would eliminate the Medicare Part D prohibition on weight loss medications and allow other qualified health care providers such as registered dietitians and social workers to provide behavioral treatment.
- Most states allow physicians to utilize FDA medications for off-label uses to treat chronic conditions should these practices be viewed as within the standard of care for that

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[1] https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-adults-screening-and-management, accessed 1/15/2018
[2] Centers for Medicare and Medicaid Services (CMS), November 29th, 2011
[3] Jensen MD et al. *J Am Coll Cardiol.* 2014;63(25 pt B):2985-3023 NIH / NHLBI, October 2000
[4] https://doi.org/10.1210/jc.2015-1782, accessed 1/15/2018
[5] http://www.nejm.org/doi/full/10.1056/NEJMoa056254#t=article, accessed 1/15/2018
[6] Counsel on Medical Education Report CME-3, Obesity Education at a17
[7] Milken Institute Report. http://www.milkeninstitute.org/publications/view/833. Accessed 1/15/2018
[8] https://www.congress.gov/bill/115th-congress/house-bill/1953

condition. However, this is not the case in some areas of the country regarding off-label prescribing for AOMs[9,10]. For example, some older drug labels state that the medications are for "short-term" use only, which is now inconsistent with what we know about the chronic nature of obesity. It has been proven that treatment is only effective so long as it is continued as is the case with all chronic disease such as diabetes and heart disease. Current publications including one from our Endocrine colleagues[11] call for chronic prescribing of all AOMs, and include guidelines to be used for safe prescribing of these older medications; and

Whereas, The use of AOMs long-term for obesity has been approved by the FDA for our 4 newest drugs, and recent studies of our older drugs shows that "abuse or psychological dependence (addiction) does not occur..."[12]; and

Whereas, Due to these issues and many others, patients affected by obesity are unlikely to receive proper evidence-based treatments including behavioral intervention and medication. Current research shows that only 2% of patients affected by obesity with an on-label indication for pharmacotherapy are receiving medication. In contrast, 86% of patients affected by type 2 diabetes receive pharmacotherapy[13]; therefore be it

RESOLVED, That our American Medical Association work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment (Directive to Take Action); and be it further

RESOLVED, That our AMA actively lobby with state medical societies and other interested stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 03/21/18

RELEVANT AMA POLICY

Recognition of Obesity as a Disease H-440.842 - Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. Res. 420, A-13

Addressing Obesity D-440.954 - 1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. 2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions). BOT Rep. 11, I-06 Reaffirmation A-13 Appended: Sub. Res. 111, A-14 Modified: Sub. Res. 811, I-14

Person-First Language for Obesity H-440.821 - Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully. Res. 402, A-17 Modified: Speakers Rep., I-17

[9] http://www.med.ohio.gov/Portals/0/DNN/PDF-FOLDERS/PRESCRIBER-RESOURCES-PAGE/Weight-Loss-Drugs/PrescribingQsymiaBelviqforChronicWeightManagement.pdf
[10] Miss. Code Ann. §73-43-11 (1972, as amended).
[11] https://doi.org/10.1210/jc.2015-1782, accessed 1/15/2018
[12] https://www.ncbi.nlm.nih.gov/pubmed/23736363/, accesses 1/24/2018
[13] Thomas CE, Mauer EA, Shukla AP, Rathi S, Aronne LJ. Low adoption of weight loss medications: a comparison of prescribing patterns of antiobesity pharmacotherapies and SGLT2s. Obesity (Silver Spring). 2016; 24(9):1955–61

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-18)

Introduced by: Minority Affairs Section

Subject: Opposition to Funding Cuts for Programs that Impact the Health of Populations

Referred to: Reference Committee B
(R. Dale Blasier, MD, Chair)

Whereas, The World Health Organization[1] defines the social determinants of health (SDOH) as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life; and

Whereas, These forces and systems include economic policies, development agendas, social norms, social policies and political systems; and

Whereas, Healthy People 2020 "highlights the importance of addressing the social determinants of health by including "create social and physical environments that promote good health for all"[2]; and

Whereas, Our American Medical Association (AMA) policies support efforts to ensure that individuals have access to safe, high-quality and patient-centered health care; and

Whereas, Our AMA adopted policy H-295.874,"Educating Medical Students in the Social Determinants of Health and Cultural Competence'; and

Whereas, Our AMA opposes polices and rules that would lead to barriers to access resources that are examples of SDOH such as housing applicants who consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance or Temporary Assistance for Needy (TANF) and work requirements for Supplemental Nutrition Assistance Program (SNAP); and

Whereas, The federal government is proposing budget cuts to the U.S. Department of Agriculture's discretionary budget by $3.5 billion, or 15 percent by eliminating $17 billion in funds available to SNAP (food stamps); and

Whereas, The federal government seeks to cut more than $3 billion from the U.S. Department of Education; and

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[1] World Health Organization, http://www.who.int/social_determinants/sdh_definition/en/, accessed March 22, 2018
[2] U.S. Dept. of Health and Human Services, Office of Disease Prevention and Health Promotion, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health, accessed March 22, 2018

Whereas, The federal government seeks to substantially reduce Section 8 federal housing subsidies, eliminate the $1.9 billion fund for public housing capital repairs, zero out community development block grants, discontinue grants to states and local governments to increase homeownership for the lowest-income Americans, and institute work requirements for individuals receiving housing subsidies; and

Whereas, The federal government seeks to decrease funding for National Dislocated Worker Grants -- support for those who lose their jobs in natural disasters or factory closures -- from $219.5 million in 2017 to $51 million in 2019; and

Whereas, The federal government seeks to decrease funding for Adult Employment and Training Activities, which serve veterans, Native Americans and young people who have dropped out of high school, by nearly half, from $810 million in 2017 to $490.3 million in 2019; and

Whereas, Our AMA seeks to maximize opportunities for collaboration among federal-, state-, and local-level partners related to social determinants of health; therefore be it

RESOLVED, That our American Medical Association actively advocate that Congress, the White House, and senior cabinet officials ensure that programs designed to meet daily needs, support changes in individual behavior, and improve the health of populations remain funded at current levels and remain available without additional restrictions or rules. (Directive to Take Action)

References:

The Washington Post, "What Trump Cut in His Agency Budgets," https://www.washingtonpost.com/graphics/politics/trump-presidential-budget-2018-proposal/?utm_term=.26c3ab4a453c, accessed March 22, 2018

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/02/18

RELEVANT AMA POLICY

Healthy Lifestyles H-425.972
1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.
2.Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.
Citation: Res. 423, A-12; Appended: Res. 959, I-17;

See also:
Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Improvements to Supplemental Nutrition Programs H-150.937
Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-18)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Persons with Intellectual and Developmental Disabilities Designated as a Medically Underserved Population

Referred to: Reference Committee C
(Sherri Baker, MD, Chair)

Whereas, Few physicians have had formal training regarding the specific needs of patients with intellectual and developmental disabilities (IDD) or may not possess the comfort level required to treat people with IDD and only 25% of medical schools include content regarding people with such disabilities in their curricula[1]; and

Whereas, All medical school graduates should, by demonstration of necessary knowledge, skills, and attitudes, be comfortable and competent in assessing and participating in the comprehensive continuing management of patients with disability due to disorders of the nervous, musculoskeletal, or closely related systems[2]; and

Whereas, AMA Policy H-90.968, "Medical Care of Persons with Developmental Disabilities," articulates the importance of educating medical students, medical residents, and physicians about the medical care of and health disparities experienced by patients with developmental disabilities[3]; and

Whereas, Persons with intellectual and developmental disabilities are less likely to receive adequate medical care than the general population despite their increased burden of chronic health problems and shortened life expectancy[4]; and

Whereas, The federal government defines "medically underserved populations" (MUP) according to a formula that weighs a population's lack of primary care providers, its experience with poverty and infant mortality, and its percentage of people over age 65 and then applies that result to a population within a defined geographic area[5]; and

Whereas, Persons with IDD are not limited to particular geographic areas; and

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[1] Woodward L et al. An innovative clerkship module focused on patients with disabilities. Academic Medicine, Vol. 87, No. 4. April 2012.
[2] Educational Goals and Objectives in Physical Medicine and Rehabilitation for the Medical School Graduate: a position statement approved by the American Academy of Physical Medicine and Rehabilitation Board of Governors August 2012.
[3] Medical Care of Persons with Developmental Disabilities (H-90.968): a resolution introduced by the American Academy of Pediatrics, last modified 2017. (https://policysearch.ama-assn.org/policyfinder/detail/intellectual%20disability?uri=%2FAMADoc%2FHOD.xml-0-5283.xml)
[4] U.S. Surveillance of Health of People with Intellectual Disabilities: A White Paper; Centers for Disease Control and Prevention/National Center on Birth Defects and Developmental Disabilities Health Surveillance Work Group. September 2009.
[5] Health Resources & Services Administration, Medically Underserved Areas and Populations (MUA/Ps) shortage designation, (https://bhw.hrsa.gov/shortage-7esignation/muap)

Whereas, Our AMA[6], and American College of Physicians[7] have previously articulated the need for persons with intellectual and developmental disabilities to have MUP designation; therefore be it

RESOLVED, That our American Medical Association advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools and graduate medical education programs to include IDD-related competencies and objectives in their curricula. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/17/18

RELEVANT AMA POLICY

Medical Care of Persons with Developmental Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities. 2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals. 3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them. 4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities. 5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community. 6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities. 7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities. 8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities. 9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities. *CCB/CLRPD Rep. 3, A-14 Appended: Res. 306, A-14 Appended: Res. 315, A-17*

Early Intervention for Individuals with Developmental Delay H-90.969
(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population. CCB/CLRPD Rep. 3, A-14 Reaffirmed: Res. 315, A-17

[6] American Medical Association CMS Report 3-I-11: Designation of the Intellectually Disabled as a Medically Underserved Population (resolution 805-I-10)
[7] Advocating for Health Research and Services Administration Designation of Individuals with Intellectual and Developmental Disabilities as a Medically Underserved Population (6-S15): a resolution of the American College of Physicians, Spring 2015.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-18

Subject: Council on Medical Education Sunset Review of 2008 House Policies

Presented by: Lynne Kirk, MD, Chair

Referred to: Reference Committee C
(Sherri S. Baker, MD, Chair)

AMA Policy G-600.110, "Sunset Mechanism for AMA Policy," is intended to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations. The current policy reads as follows:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

The Council on Medical Education's recommendations on the disposition of the 2008 House policies that were assigned to it are included in the Appendix to this report. Due to their complexity, and the need for a more thorough consolidation of policy than is available through the sunset report mechanism, the following policies will be addressed in a Council on Medical Education report(s) at the 2018 Interim Meeting:

H-200.956, "Appropriations for Increasing Number of Primary Care Physicians"
H-200.966, "Federal Financial Incentives and Medical Student Career Choice"
H-200.973, "Increasing the Availability of Primary Care Physicians"
H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians"
H-200.978, "Loan Repayment Programs for Primary Care Careers"
H-200.997, "Primary Care"
H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers"
H-310.979, "Resident Physician Working Hours and Supervision"
H-310.999, "Guidelines for Housestaff Contracts or Agreements"
D-305.970, "Proposed Revisions to AMA Policy on Medical Student Debt"
D-305.978, "Mechanisms to Reduce Medical Student Debt"
D-305.980, "Immediate Legislative Solutions to Medical Student Debt"

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX
RECOMMENDED ACTIONS ON 2008 AND OTHER OR RELATED HOUSE OF DELEGATES POLICIES

HOUSE OF DELEGATES POLICIES	
Policy Number, Title, Policy	*Recommended Action*
H-200.975, "Availability, Distribution and Need for Family Physicians"	
The AMA will continue to recommend specific strategies to increase the availability of primary care physicians, which may include curricular modification, financing mechanisms for medical education and research, financial aid options, and modifications of the practice environment. (Sub. Res. 306, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, I-03; Reaffirmation I-08)	Sunset; superseded by H-200.973, "Increasing the Availability of Primary Care Physicians"; relevant segments include: (4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. (5) All four years of the curriculum in every medical school should provide experiences in primary care for all students.... (8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians. (9) There should be increased financial incentives for physicians practicing primary care. (10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate "hassle" and unnecessary paper work should be undertaken. (11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas. (12) States should be encouraged to provide positive incentives--such as scholarship or loan repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities--to support medical students' choice of a primary care specialty. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
H-250.991, "Support of the AMA Mission in International Medicine"	
The AMA will include the International Medical Graduates Section as a resource for international medical initiatives. (Res. 608, A-98; Reaffirmed: CLRPD Rep. 1, A-08)	Retain; still relevant.

H-255.980, "USMLE Scores not Sole Criteria for Residency Selection"

Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates' attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicants merit and qualifications. Citation: Res. 143, A-90; Appended Res. 303, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Modified: Speakers Rep. 01, A-17	Retain; still relevant.

H-275.937, "Patient/Physician Relationship and Medical Licensing Boards"

(1) Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are: (a) Open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in his or her care.(b)- Commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician's personal interests. (c) Provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more nor less.(d)- Avoidance of any conflict of interest or inappropriate relationships outside of the therapeutic relationship. (2) The relationship between a physician and a patient is fundamental and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship. (3) Any act or failure by a physician that violates the trust upon which the relationship is based may place the physician at risk of being	Retain; still relevant, with the editorial change shown below: ~~(1)~~ Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: (1) . . . .

found in violation of the Medical Practice Act. (4) The following statement reflects the policy of the (name of state) Board of Medical Examiners regarding the physicians it licenses. (5) A (name of state) physician has both medical-legal and ethical obligations to his or her patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients. (BOT Rep. 30, I-98; Reaffirmed: CME Rep. 2, A-08)	

H-275.938, "USMLE Part III and Licensure"

Our AMA will lobby the Federation of State Medical Boards to discourage states from linking mandatory application for licensure with application to take the USMLE Part III. (Res. 325, A-98; Reaffirmed: CME Rep. 2, A-08)	Retain, still relevant, with the following editorial changes: Our AMA will ~~lobby~~ advocate to the Federation of State Medical Boards to discourage states from linking mandatory application for licensure with application to take ~~the~~ USMLE ~~Part III~~Step 3.

H-275.957, "Changing the Grading Policy for Medical Licensure Examinations"

Our AMA is concerned about the potential for inappropriate use of numerical scores of licensing examinations, particularly as a significant criterion in appointment to residency training programs. Past studies show some residency programs inappropriately use USMLE examination scores in screening their applicants. Our AMA supports the development of mechanisms to ensure confidentiality of the results of licensure exams, and that these results are used only in an appropriate fashion. (BOT Rep. GGG, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CME Rep. 2, A-10)	Sunset; superseded by H-255.980, "USMLE Scores not Sole Criteria for Residency Selection," as follows: Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates' attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicants merit and qualifications."

H-275.968, "Recredentialing of Physicians"

The AMA vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration. (Res. 201, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)	Retain through incorporation into H-275.978, "Medical Licensure," as follows: (23) vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration.

H-275.972, "Annual Report of Disciplinary Actions from the Federation of State Medical Boards"

The AMA supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards. (Sub. Res. 126, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)	Retain through incorporation into H-275.978, "Medical Licensure," to read as follows: (24) supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards.

H-275.978, "Medical Licensure"

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions	Revise to incorporate the following relevant policies that are being appended to this policy: H-275.968, "Recredentialing of Physicians" H-275.972, "Annual Report of Disciplinary Actions from the Federation of State Medical Boards." The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of

which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing	educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement

boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. (CME Rep. A, A-87 Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10; Reaffirmed: CME Rep. 6, A-12 Appended: Res. 305, A-13 Reaffirmed: BOT Rep. 3, I-14)	of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement~~; and~~ (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license~~.~~;
	(23) vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration; and
	(24) supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that

	comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards.

H-275.981, "Education in the Professional Discipline Process"

The AMA (1) urges all state medical associations to recommend that each medical school in its state invite members of the state agency in charge of professional medical conduct to lecture on the topic of professional discipline; and (2) urges each state medical association to recommend that each hospital in its state with a training program invite a member of the state agency in charge of professional medical conduct to disseminate to its housestaff information on the workings of the professional discipline agency. (Res. 8, I-86; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)	Retain; still relevant.

H-295.869, "Student Loan Empowerment"

	Retain through incorporation into D-305.993, "Medical School Financing, Tuition, and Student Debt," to read as follows: 1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of ~~a~~ developing web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection ~~and~~, loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes. 2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical

	research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts. 3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition. 4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.
Our AMA supports a requirement that medical schools inform students of all government loan opportunities along with private loans, and requires disclosure of reasons that preferred lenders were chosen. (Res. 307, A-08)	5. Our AMA supports a requirement that medical schools inform students of all government loan opportunities and requires disclosure of reasons that preferred lenders were chosen.
	~~5~~6. Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians. ~~6~~7. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians. ~~7~~8. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans. ~~8~~9. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs. ~~9~~10. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the

	United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note. ~~10~~11. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer. ~~11~~12. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility. ~~12~~13. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed. ~~13~~14. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas. ~~14~~15. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

H-295.892, "Potential Implications of Attending Non-LCME/AOA Accredited Medical Education Programs"

Our AMA encourages efforts to educate all prospective medical students about the potential implications of attending any non-Liaison Committee on Medical Education/American Osteopathic Association accredited medical education program. (Res. 322, I-98; Reaffirmed: CME Rep. 2, A-08)	Sunset; superseded by D-295.309, "Promoting and Reaffirming Domestic Medical School Clerkship Education," which reads in part: "4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA."

H-295.893, "Voting Rights for AMA-MSS NBME Representatives"

Our AMA will: (1) petition the National Board of Medical Examiners (NBME) to add AMA student representation to the National Board, the governing and voting body of the NBME; and (2) work with the NBME to ensure that the AMA-MSS, through its Governing Council, is given appropriate advance notice of any major upcoming votes. (Res. 323, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 10, A-08)	Sunset; no longer relevant, as this has been accomplished.

H-295.894, "Medical Education on Sleep and Sleep Disorders"

Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education. (Res. 310 , I-98; Reaffirmed: CME Rep. 2, A-08)	Retain; still relevant.

H-295.896, "Conscience Clause: Final Report"

Principles to guide exemption of medical students from activities based on conscience include the following: (1) Medical schools should address the various types of conflicts that could arise between a physician's individual conscience and patient wishes or health care institution policies as part of regular curricular discussions of ethical and professional issues. (2) Medical schools should have mechanisms in place that permit students to be excused from activities that violate the students' religious or ethical beliefs. Schools should define and regularly review what general types of activities a student may exempt as a matter of conscience, and what curricular alternatives are required for students who exempt each type of activity. (3) Prospective students should be informed prior to matriculation of the school's policies related to exemption from activities based on conscience. (4) There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies. (5) Policies related to exemption based on conscience should be applied consistently. (6) Students should be required to learn the basic content or principles underlying procedures or activities that they exempt. Any	Retain; still relevant.

exceptions to this principle should be explicitly described by the school. (7) Patient care should not be compromised in permitting students to be excused from participating in a given activity. (CME Rep .9, I-98; Reaffirmed: CEJA Rep. 11, A-08)	

H-295.902, "Alternative Medicine"

(1) AMA policy states that courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and practice as well as the potential therapeutic utility, safety, and efficacy of these modalities. (2) Our AMA will work with members of the Federation to convey physicians' and patients' concerns and questions about alternative care to the NIH Office of Alternative Medicine and work with them and other appropriate bodies to address those concerns and questions. (CSA Rep. 12, A-97; Appended by Res. 525, A-98; Reaffirmed: CSAPH Rep. 2, A-08)	Retain; still relevant.

H-295.972, "Education Regarding Prescribing Controlled Substances"

The AMA (1) encourages physicians, hospital medical staff organizations, resident physicians, and medical students to participate in education programs to ensure proper prescribing and dispensing of controlled substances; and (2) encourages regulatory agencies, state medical societies, and state medical boards to recognize the value of participation in such educational programs as an alternative to imposing disciplinary sanctions on well-intentioned physicians. (Sub. Res. 76, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)	Retain; still relevant.

H-295.993, "Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs"

Our AMA: (1) recognizes the need for (a) appropriate mechanisms to include medical students and resident physicians in existing medical society impaired physician programs; and (b) these programs to include activities to prevent impairment; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available medical school impairment treatment programs and that schools	Sunset; superseded by H-295.863, "Impairment Prevention and Treatment in the Training Years," which reads: "Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with

ensure that these services are provided confidentially. (Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08)	confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians." (CCB/CLRPD Rep. 3, A-14)

H-295.999, "Medical Student Support Groups"

	Retain through incorporation into H-295.858, "Access to Confidential Health Services for Medical Students and Physicians," as follows: 1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to: A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means; B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees; C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider

	designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle. 2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. 3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: A. be available to all medical students on an opt-out basis; B. ensure anonymity, confidentiality, and protection from administrative action; C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. 4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the

	presence of a psychiatric disease, irrespective of treatment or behavior. 5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. (2) Our AMA supports making these alternatives available to students at the earliest possible point in their medical education. (Res. 164, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08)	6) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

H-305.938, "Use of Social Security Numbers in Student Loan Accounts"

Our AMA will work with student loan servicers and other associated agencies to end the use of Social Security Numbers as account numbers. (Res. 302, I-98; Reaffirmed: CME Rep. 2, A-08)	Retain; still relevant.

H-310.935, "The Educational and Work Environment of Resident Physicians"

AMA policy is that there should be resident organizations in place at institutions that sponsor graduate medical education programs to facilitate the ability of residents to negotiate about issues related to their working environment. (CME Rep. 11, A-98; Reaffirmed: CME Rep. 2, A-08)	Retain; although the Accreditation Council for Graduate Medical Education has related policy in its Institutional Requirements, the AMA needs to have policy that addresses the need for residents to be able to negotiate on issues related to their working conditions.

H-310.967, "Resident Training in Varied Settings"

Our AMA reaffirms the inclusion of ambulatory care settings and the participation of community hospitals in graduate medical education. (CME Rep. A, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation I-08)	Sunset; superseded by H-310.929, "Principles for Graduate Medical Education," which reads in part: "(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty." Also reflected in H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," which reads in part: "H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs." Also reflected in H-295.949, "Encouraging Community Based Medical Education," which reads: "Our AMA recognizes and acknowledges the vital role of practicing physicians in community hospitals in medical student and resident teaching." Also reflected in The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967 (26), which reads: "Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME."

H-310.973, "Primary Care Residencies in Community Hospitals"

Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs. (Sub. Res. 27, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-08)	Retain; still relevant.

H-315.982, "CMS Documentation Guidelines for Teaching Physicians"

The AMA will work with the CMS to: (1) reduce the redundant and burdensome documentation for teaching physicians; (2) accept documentation by the physician team under the supervision of a teaching physician if it collectively meets all CMS documentation requirements: and (3) accept a statement of the teaching physician's level of participation in patient care as sufficient or adequate documentation. (Res. 861, A-98; Reaffirmed: CME Rep. 2, A-08)	Retain; still relevant.

H-350.979, "Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession"

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels. (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions. (4) Increasing the supply of minority health professionals.	Retain; still relevant.

(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores. (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students. (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)	

H-360.981, "State Legislative Response to NBME Practice of Using USMLE Step 3 Physician Licensing Exam Questions for Doctors of Nursing Practice Certification"

	Retain through incorporation into H-35.972, "Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation," as follows: 1. It is the policy of our AMA that institutions offering advanced education in the healing arts and professions shall fully and accurately inform applicants and students of the educational programs and degrees offered by an institution and the limitations, if any, on the scope of practice under applicable state law for which the program prepares the student. 2. Our AMA disapproves of questions developed for the United States Medical Licensing Examination (USMLE) being used for purposes other than the assessment of physicians-in-training and physicians. 3. Our AMA, with the Council of Medical Specialty Societies, and members of the Federation, will continue to work with the National Board of Medical Examiners (NBME) to assure that accurate information continues to be presented in communications about the use of USMLE questions in the Doctor of Nursing Practice (DNP) examination. 4. Our AMA, through its representatives to the NBME, will continue to provide feedback as plans for the restructuring of the USMLE are developed and implemented. 5. Our AMA will request the NBME to emphasize in future publications that the DNP

	certification examination is not for the purposes of licensure of nurses. 6. Our AMA will continue to monitor the use of questions developed for the USMLE and COMLEX by any group for purposes other than the assessment of physicians-in-training and physicians;
AMA policy is that the integrity of the physician (MD/DO) licensure process, through appropriate examination, be maintained so that no person is misled that the training of allied health professionals through their programs or certification is equivalent to the education, skills and training of physicians (MDs/DOs). (Res. 212, I-08)	7. Our AMA policy is that the integrity of the physician (MD/DO) licensure process, through appropriate examination, be maintained so that no person is misled that the training of allied health professionals through their programs or certification is equivalent to the education, skills and training of physicians (MDs/DOs). (Res. 211, A-06 Appended: CME Rep. 10, A-10 Modified: CCB/CLRPD Rep. 2, A-14)

H-360.982, "Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage at the Bedside"

Our AMA supports: 1. increased physician awareness of their role in solving the RN shortage at the bedside and the importance of physicians' participation in efforts to relieve the shortage; 2. increased awareness of opportunities for physician leadership and participation in efforts to solve the RN shortage at the bedside; 3. physician efforts to identify those models and strategies that are most applicable to their communities and hospitals and, additionally, will produce the best results; and 4. national efforts to increase funding for bedside nursing education. (BOT Rep. 27, A-08)	Sunset; still relevant, but superseded by D-360.998, "The Growing Nursing Shortage in the United States," which reads: "Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields; (2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients; (3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process; (4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions; (5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care."

H-360.984, "Nursing Shortage"

Our AMA supports proposals to increase basic nursing education opportunities, workforce incentives and similar efforts to increase the supply of registered nurses. (Res. 313, A-02 Reaffirmed: CME Rep. 2, A-12)	Sunset; superseded by D-360.998, "The Growing Nursing Shortage in the United States." In particular, "Our AMA (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields…."

H-360.999, "Nursing Education"

The AMA urges that a constructive attitude be assumed by the medical profession at all levels in an attempt to aid those closely concerned with nursing education, to increase the facilities for those training programs, and to aid in recruiting personnel into the training programs. (BOT Rep. D, A-59; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: CLRPD Rep. 1, I-98; Reaffirmed: CME Rep. 2, A-08)	Sunset; superseded by D-360.998, "The Growing Nursing Shortage in the United States." In particular, "Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields; (2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients…. (4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions; (5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care."

H-450.987, "Education of Physicians in Utilization and Quality Review Matters"

The AMA (1) commends medical schools that provide instruction in quality assurance and utilization review; (2) advocates making available model curriculum information to medical schools wishing to undertake such instruction; (3) reaffirms its support for the provision in the ACGME Program	Sunset; superseded by H-450.994 (5), "Quality Assurance in Health Care," which reads: "Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in clinical graduate training and

Requirements which requires that residents participate in patient care review activities; and (4) supports and encourages accredited sponsors which currently provide continuing medical education on the subject of quality assurance and utilization review or those which may be interested in developing educational activities for this purpose. (CME Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08)	in continuing education programs."

HOD DIRECTIVES	
Number, Title, Policy	*Recommended Action*

D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups. 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas. 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.	Retain in part; rescind Item 5, as having been fulfilled by Council on Medical Education Report 5-A-18, "Study of Declining Native American Medical Student Enrollment."

5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.	~~5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.~~
6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population. 7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity. 8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers. 9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs. 10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education. 11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP). 12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities. (CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17)	~~6~~5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population. ~~7~~6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity. ~~8~~7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers. ~~9~~8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs. ~~10~~9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education. ~~11~~10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP). ~~12~~11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

D-255.980, "Impact of Immigration Barriers on the Nation's Health"

1. Our American Medical Association (AMA) recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine. 2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion. 3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion. 4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care. 5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice. 6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.	Retain in part; rescind Item 7, as having been fulfilled by Council on Medical Education Report 3-I-17, "Impact of Immigration Barriers on the Nation's Health."
7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce. (Alt. Res. 308, A-17)	~~7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.~~

D-255.983, "Observerships for International Medical Graduates"

Our AMA will, through its relevant Sections, work with internal and external groups to develop guidelines for observership programs for International Medical Graduates (IMGs) who have received certification by the Educational Commission for Foreign Medical Graduates, including the following: (a) development of a set of educational objectives and a model curriculum outline; and (b) identification of educational/informational materials to address the objectives; and (c) creation of informational materials related to legal, organizational, and operational issues related to program implementation. (CME Rep. 12, A-08)	Sunset; this has been accomplished; see https://www.ama-assn.org/life-career/establish-observership-international-medical-graduates.

D-275.999, "Board Certification and Discrimination"

Our AMA will collect information from members discriminated against solely because of lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification (Res. 314, I-98; Reaffirmed: CME Report 2, A-08)	Sunset; the action called for in this policy was addressed in Council on Medical Education Report 2-A-17, "Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 315-A-16)," which was adopted in lieu of Resolution 315-A-16, "Maintenance of Certification (MOC) and Licensure (MOL) vs. Board Certification, CME and Life-Long Commitment to Learning." Resolve 2 of Resolution 315-A-16 asked that our AMA "develop an action plan to protect physicians when the Maintenance of Certification is punitively used as a requirement for licensure, credentialing, reimbursement, network participation or employment with a report back at Interim 2016." In response, the report noted: "Currently, MOC is meant to demonstrate proficiency within a chosen discipline, but is not required for state medical licensure. In addition, many hospitals have independently made the decision to require recertification for the granting of privileges, and various quality organizations and insurers use MOC to help identify commitment to professionalism and continuous performance improvement. These requirements are within their legal rights. However, some states are considering or have enacted legislation that prohibits the use of MOC as a criterion for privileging, employment, and reimbursement. Additional data will be needed to determine if an action plan should be developed to protect physicians when MOC is used as a requirement for licensure, credentialing, reimbursement, network participation or employment (Resolution 315-A-16, resolve 2). To date, the Council has not accumulated data on instances where this has occurred. However, when data become available, the Council will determine if these cases fit into a pattern and will advise the HOD on how to proceed." The principles behind this policy are also reflected in H-275.924 (15), "Maintenance of Certification": "15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation."

D-295.933, "Transparency In Medical Schools' Utilization of Funds From Tuition and Fee Increases"

Our AMA encourages the development of policies by Liaison Committee on Medical Education- and American Osteopathic Association-accredited medical schools that ensure information on the use of funds from tuition and fee increases is disclosed in a standardized format and in a timely manner to prospective and current medical students. (Sub. Res. 310, A-08)	Sunset. Schools are required to report to the LCME their actual tuition revenues, actual dollars accrued, and the percentage of total institutional revenues resulting from tuition. The complexity of medical school structure and expenditures as well as the diversity of medical school funding sources renders tracking of actual tuition dollars impossible. The LCME does monitor the percentage of total revenues from tuition dollars and expects that tuition revenues are less than 50 percent of total revenues. The LCME also monitors trends in tuition revenues, both actual dollars and the percentage of total revenues. The AOA Commission on Osteopathic College Accreditation monitors similar data among its accredited schools.

D-295.936, "Educational Implications of the Medical Home Model"

Our AMA: (1) encourages the integration of medical education into Patient-Centered Medical Home (PC-MH) demonstration projects; (2) will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to review their accreditation standards so as not to impede education in and about the PC-MH model; and (3) will advocate for funding from all sources for medical schools and residency training programs to provide medical education in the context of PC-MH models. (CME Rep. 4, A-08; Modified: Speakers Rep., I-15)	Sunset; superseded by D-200.979, "Barriers to Primary Care as a Medical School Choice," which reads in part: "6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model. 7. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 8. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 9. Our

	AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919." In addition, related to D-295.936(2), LCME standards already allow for clinical educational scenarios that include assignment of medical students to patients' homes and longitudinal experiences that emphasize continuity of patient care.

D-295.938, "Increasing Medical School Class Sizes"

Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. (Res. 309, A-08)	Retain; still relevant.

D-295.939, "Independent Regulation of Physician Licensing Exams"

Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system in support of Policy H-295.893, "Voting Rights for AMA-MSS NBME Representatives;" (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). (CME Rep. 10, A-08)	Retain in part, with the deletion shown below, as H-295.893, "Voting Rights for AMA-MSS NBME Representatives," has been accomplished and is being sunset through this report. Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system ~~in support of Policy H-295.893, "Voting Rights for AMA-MSS NBME Representatives;"~~ (2) continue to collaborate with the organizations that create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). (CME Rep. 10, A-08)

D-295.999, "Extending Impaired Physician Programs to Medical Students"

Our AMA will inform students of the variety of options available for treatment of impairment, including medical school and state medical society programs. (CME Rep. 4, I-98; Reaffirmed: CME Report 2, A-08)	Sunset; superseded by H-295.863, "Impairment Prevention and Treatment in the Training Years," which reads: "Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians." (CCB/CLRPD Rep. 3, A-14)

D-300.983, "Financial Conflicts in CME"

Our AMA will continue to monitor the implementation of the Accreditation Council for Continuing Medical Education 2004 Standards for Commercial Support and report to the House of Delegates any major evidence that these requirements are or are not effective in ensuring the independence of or adversely impact the availability of continuing medical education. (CME Rep. 13, A-08)	Sunset, no longer relevant. The ACCME Standards for Commercial Support have been in place since 2004, and have been adopted by many organizations and societies in the United States and elsewhere in the world. Monitoring is no longer necessary.

D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion"

Our AMA will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs. (Res. 301, A-08)	Retain; still relevant.

D-305.998, "Impact of the Balanced Budget Act of 1997 on Graduate Medical Education Funding in Non-Hospital Settings"

Our AMA will continue to advocate for additional funds from the federal government and other third party payers for GME programs that take place in non-hospital settings. (BOT Rep. 5, I-98; Reaffirmed: CME Report 2, A-08)	Sunset; superseded by D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," which reads in part: "7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care. 8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME." Also reflected in H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," which reads in part: "H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs." Also reflected in H-310.929, "Principles for Graduate Medical Education," which reads in part: "(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty."

D-310.962, "Evaluation of Increasing Resident Review Committee Requirements"

Our AMA will work with and monitor the Accreditation Council for Graduate Medical Education and American Osteopathic Association in studying residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement. (Res. 315, A-08)	Retain; still relevant.

D-360.994, "State Legislative Response to NBME Practice of Using USMLE Step 3 Physician Licensing Exam Questions for Doctors of Nursing Practice Certification"

Our AMA, through its Council on Legislation, will work expeditiously to develop and circulate to all state medical and national medical specialty societies, model state legislation that would prohibit the National Board of Medical Examiners from using the past, present or future content of its United States Medical Licensing Examination Step 3 exam, and National Board of Osteopathic Medical Examiners from using the past, present or future content of its COMLEX Step 3 Exam in the certification processes for non-physician providers. (Res. 212, I-08)	Sunset.

REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (A-18)
Update on Maintenance of Certification and Osteopathic Continuous Certification
(Resolutions 316-A-17 and 318-A-17)
(Reference Committee C)

EXECUTIVE SUMMARY

The Council on Medical Education has monitored Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) during the last year. This annual report, mandated by American Medical Association (AMA) Policy D-275.954, "Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC)," provides an update on some of the changes that have occurred as a result of AMA efforts with the American Board of Medical Specialties (ABMS) to improve the MOC process.

In 2017, the ABMS Board adopted a new name, "Continuing Board Certification," for its MOC Program (some ABMS member boards are still referring to the program as MOC). The ABMS and its 24 member boards also launched a major initiative to modernize continuing board certification. A planning committee established the "Continuing Board Certification: Vision for the Future" Commission to engage physicians, the public, and key stakeholders in a collaborative process.

This report highlights initiatives that are underway to improve MOC:

- Many ABMS member boards have taken steps to replace the MOC Part III examination with a more relevant, less onerous, and cost-efficient process for physicians. Some boards are looking at ways to innovate assessment of medical knowledge and are testing new models or have implemented alternatives to the traditional secure, high-stakes examination. The table at the end of this report summarizes the new models being implemented and/or piloted and board activities underway to improve the examination component (MOC Part III).
- The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) component (MOC Part IV). New activities are being implemented by the boards related to registries, systems-based practice, and practice audits.
- New studies published during the last year describe how new assessment models and IMP activities have resulted in improved quality and patient care and physician satisfaction.

Updates on the following MOC activities are also included in this report:

- AMA participation in meetings and conferences to improve the MOC process (pages 2-5)
- The ABMS Continuing Certification Directory (pages 5-6)
- Alternatives to the MOC Part III secure, high-stakes examination (pages 6-8)
- Improvement in medical practice (MOC Part IV) (pages 8-9)
- The ABMS Multi-Specialty Portfolio Program (pages 9-10)
- Emerging data and literature regarding the value of MOC (pages 10-13)
- Osteopathic Continuous Certification (pages 13-14)
- State legislation related to the use of MOC (pages 14-15)

The Council on Medical Education is committed to ensuring that continuing board certification supports physicians' ongoing learning and practice improvement and can assure the public that physicians are providing high-quality patient care. The Council continues to work with the ABMS, ABMS member boards, American Osteopathic Association, state and specialty medical societies, and key stakeholders to identify and suggest improvements to continuing certification programs. During the next year, the Council will also be actively engaged in following the work of the ABMS Commission and the development of the Commission's recommendations for the future continuing board certification process.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-18

Subject: Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolutions 316-A-17 and 318-A-17)

Presented by: Lynne M. Kirk, MD, Chair

Referred to: Reference Committee C (Sherri S. Baker, MD, Chair)

Resolution 316-A-17, "Action Steps Regarding Maintenance of Certification," Resolves 4 and 5, introduced by Florida, Pennsylvania, Georgia, California, New York, Arizona, Texas, American College of Radiation Oncology, and American Society of Interventional Pain Physicians and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to:

> 4) join with state medical associations and specialty societies in directly lobbying state medical licensing boards, hospital associations, and health care insurers to adopt policy supporting the use of satisfactory demonstration of lifelong learning with high quality CME as specified by a physician's specialty society for credentialing and bar these entities from using the ABMS sponsored MOC process using lifelong interval high stakes testing for credentialing; and
>
> 5) partner with state medical associations and specialty societies to undertake a study with the goal of establishing a program that will certify physicians as satisfying the requirements for continuation of their specialty certification by successful demonstration of lifelong learning utilizing high quality CME appropriate for that physician's medical practice as determined by their specialty society with a target start date of 2020 or before, with report back biannually to the HOD and AMA members.

Resolution 318-A-17, "Oppose Direct to Consumer Advertising of the ABMS MOC Product," introduced by Michigan and also referred by the HOD, asks the AMA to:

> 1) oppose direct-to-consumer marketing of the American Board of Medical Specialties Maintenance of Certification (MOC) product in the form of print media, social media, apps, and websites that specifically target patients and their families including but not limited to the promotion of false or misleading claims linking MOC participation with improved patient health outcomes and experiences where limited evidence exists; and
>
> 2) amend existing AMA Policy D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification" by addition as follows:
> 36. Direct the ABMS to ensure that any publicly accessible information pertaining to maintenance of certification (MOC) available on ABMS and ABMS Member Boards' websites or via promotional materials includes only statistically validated, evidence based, data linking MOC to patient health outcomes.

Policy D-275.954 (1), "Maintenance of Certification and Osteopathic Continuous Certification," asks that the AMA continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the HOD regarding the MOC and OCC processes.

BACKGROUND

Reference Committee C heard mixed testimony on Resolution 316-A-17. There was overwhelming support for the first and second resolves, which are consistent with existing HOD policy that 1) affirms that lifelong learning is a fundamental obligation of the profession, and 2) recognizes that lifelong learning for a physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) appropriate to that physician's medical practice as determined by the relevant specialty society.

However, in accordance with existing policy, the AMA has already developed model state legislation intended to prohibit hospitals, health care insurers, and state boards of medicine and osteopathic medicine from requiring participation in MOC processes as a condition of credentialing, privileging, insurance panel participation, licensure, or licensure renewal. This model bill is on file with the AMA Advocacy Resource Center, which will assist any interested state medical associations in pursuing legislation that is consistent with AMA policy. The AMA has also focused on educating state medical associations about activity around the country, as well as on the risks and benefits of legislating the use of MOC. During the testimony, it was noted that enacted and defeated state legislation related to the use of MOC is complex and its potential impact on professional self-regulation is unknown. It was therefore recommended that the fourth and fifth resolves be referred for study with a report back to the HOD on the current status of such legislation.

The reference committee also heard mixed testimony related to Resolution 318-A-17. Although the AMA opposes direct-to-consumer marketing of drugs and devices, it was noted that this resolution focuses on a different kind of communication. It was also noted that the American Board of Medical Specialties (ABMS) is making a statement to inform the public about the certification status of physicians. There is no precedent in AMA policy that supports this issue, and the AMA has no purview over how the ABMS communicates information about its certification process. It was therefore recommended that this resolution be referred for further study.

MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

The AMA Council on Medical Education and the AMA HOD have carried out extensive and sustained work in developing policy on MOC and OCC (Appendix A), including working with the ABMS and the American Osteopathic Association (AOA) to provide physician feedback to improve the MOC processes, informing our members about progress on MOC and OCC through annual reports to the House, and developing strategies to address the concerns about the MOC and OCC processes raised by physicians. The Council has prepared reports covering MOC and OCC for the past nine years.[1-9] During the last year, Council members, AMA Trustees, and AMA staff have participated in the following meetings with the ABMS and its member boards:

- ABMS Board of Directors Meeting (2/27/2018 - 3/1/2018)
- American Board of Anesthesiology/ABMS Maintenance of Certification Research Summit (9/24-25/2017)

- ABMS 2017 Conference and Forum on Organizational Quality Improvement (9/26-29/2017)
- ABMS Committee on Continuing Certification (11/15-16/2017)
- ABMS Meeting with Medical Societies to address physician concerns about MOC (12/4/2017)
- Council of Medical Specialty Societies (CMSS) National Specialties and ABMS Medical Boards Annual Dyad Meeting (12/5/2017)
- Planning Committee for the Continuing Board Certification: Vision for the Future Initiative (12/6/2017)
- Commission for the Continuing Board Certification: Vision for the Future Initiative (3/19-20/2018)
- AMA Council on Medical Education and the ABMS Jointly Sponsored Conference on Continuing Board Certification (3/26/2018)

Council on Medical Education members, AMA trustees, and AMA staff are planning additional dialogue on this topic with stakeholders throughout 2018.

"Maintenance of Certification" to be modernized and renamed "Continuing Board Certification"

In 2017, the ABMS Board adopted a new name, "Continuing Board Certification," for its MOC Program, but some member boards still refer to the program as MOC. The ABMS and its 24 member boards also launched a major initiative to modernize continuing board certification (visioninitiative.org/). A planning committee was formed to establish the "Continuing Board Certification: Vision for the Future" Commission, which includes representatives from the ABMS, Accreditation Council for Continuing Medical Education (ACCME), Accreditation Council for Graduate Medical Education (ACGME), Coalition for Physician Accountability, CMSS, and AMA Council on Medical Education, as well as public members. The Commission has been designed to engage physicians, the public, users of the credential, and other stakeholders in a collaborative process.

The planning committee identified the construct and membership of a 27-member Commission, and a member of the Council on Medical Education was selected to serve on the Commission. The planning committee also identified key questions for consideration by the Commission and will oversee a national opinion survey.

The Commission is in turn gathering information, holding hearings, addressing key questions, and making recommendations for the future continuing board certification process. During the course of its work, the Commission will generate several briefing documents for community consideration and feedback. The purposes of these documents are to present information about current and proposed practices, test concepts and ideas, and continue to engage the broader community in this process. The Commission will communicate with the broader community about the concepts and ideas and will engage in a series of discussions with stakeholders about different aspects of continuing board certification. This process is intended to facilitate the Commission's building an achievable, sustainable model. In addition, portions of the Commission meetings will be open to guests; guests will be able to hear testimony, presentations, and discussions. The Commission will also meet in closed sessions.

On March 26, 2018, the AMA Council on Medical Education, ABMS, and ABMS member boards jointly convened a conference that included additional stakeholders (i.e., specialty societies, state medical societies, ACCME, American Hospital Association, Association for Hospital Medical Education, Association of American Medical Colleges, CMSS, and the Federation of State Medical Boards) to determine how continuing certification can meet the needs of diverse stakeholders and to develop recommendations that will be sent to the Commission for their consideration on behalf

of the attendees. During the conference, several ABMS member boards shared the results of surveys to obtain feedback from physicians regarding MOC and discussed some of their recently implemented changes. In order to develop recommendations for the Commission, the conference focused on the roles of the boards and specialty and medical societies to determine how assessment, learning, and improvement in practice can be relevant, meaningful, and integrated with the way physicians practice. A white paper summarizing the conference and final recommendations is being considered by the Council at the suggestion of the attendees. The Commission is expected to release a draft report for public comment in November 2018. A final report will be sent to the ABMS in February 2019.

Report from the ABMS Committee on Continuing Certification

The Committee on Continuing Certification (3C) is charged with reviewing existing MOC programs to ensure the ABMS member boards meet the 2015 Standards for the Program for MOC, which evaluates the effectiveness of different approaches to MOC and identifies innovations to share among the boards.

In 2017, 3C reviewed the Professionalism and Professional Standing (Part I) component of the member boards' Programs for MOC, seeking to understand the boards' current processes for assessing professionalism and responding to potential lapses. Additionally, the member boards have been sharing information with 3C about pilot projects undertaken to enhance the experience and value of their MOC programs for their diplomates.

Report from the ABMS meeting with medical societies to address physician concerns about MOC

On December 4, 2017, staff from the ABMS held a meeting with members of the CMSS, the Specialty Society CEO Consortium (S2C2), state medical societies, and other stakeholders, including a member of the Council on Medical Education, to discuss the MOC programs of its member boards. The meeting focused on the critical issues and concerns physicians have raised about MOC, what the ABMS member boards are doing to resolve these concerns, and how these organizations can work together to create a future continuing board certification program that is relevant and valuable to stakeholders, board certified physicians, and the patients they serve.

State medical and specialty societies voiced their members' concerns about the complexity, relevance to practice, and the time and indirect cost burden associated with MOC programs. They also noted that physician frustration with MOC programs has led to legislative initiatives in many states that would prevent hospitals from requiring physicians to recertify. The state medical society leaders and their members expressed a desire to have ongoing input into the development of the continuing certification programs, a commitment to action and transparency from the member boards, and improved communication. In addition, they requested more consistency across the boards' continuing board certification programs in order to establish best practices across specialties that also indicate the programs' impact in improving patient care. All attendees agreed on the need to jointly develop solutions to avoid a decline in the value of board certification and the erosion of public trust in the ability of the profession to self-regulate.

The following "Statement of Shared Purpose" was agreed to by those present:

> "ABMS certifying boards and national medical specialty societies will collaborate to resolve differences in the process of on-going certification and to fulfill the principles of professional self-regulation, achieving appropriate standardization, and assuring that on-going certification is relevant to the practices of physicians without undue burden.

"Furthermore, the boards and societies, and their organizations (ABMS and CMSS), will undertake necessary changes in a timely manner, and will commit to ongoing communication with state medical associations to solicit their input."

On December 5, 2017, leaders from the CMSS membership, ABMS, ABMS member boards, and additional guests met to discuss innovative approaches for continuous medical education. The ABMS member boards discussed 170 innovations they are working on to address continuous learning for physicians. Many of the innovations included input from various outside stakeholders and focused on greater consistency amongst the member boards. The innovations included alternatives to the high-stakes examinations with a focus on longitudinal learning for physicians in their relevant practice areas. Many of the member boards outlined current (or planned) learning modules that would be seamless for physicians, and they provided a gap analysis. There was also discussion by some member boards about reducing the exam fees and the need for the member boards to be more "customer friendly" when dealing with their diplomates. The member boards are interested in bidirectional communication going forward.

Update on new innovative CME models

The AMA and the ACCME have been collaborating on a strategy to more closely align the two organizations' requirements, simplify the system, and eliminate any barriers that would constrain innovation in educational development and the delivery of CME.[10] Both organizations want to ensure the education community has the permission to provide more CME options to physicians that integrate new technology and are adaptable to their learning style, accessible, and relevant. A proposal that was developed with various groups (including staff, volunteers, and the leadership from accredited organizations and state medical societies) about how to simplify the system to better support the evolution of CME was adopted by the AMA and ACCME and went into effect in September 2017.

The ABMS and its member boards are also collaborating with academic medical centers, specialty societies, and other continuing professional development/continuing medical education (CPD/CME) stakeholders to help board certified physicians find quality certified CME activities linked to components of the ABMS Program for MOC.

ABMS Continuing Certification Directory

The ABMS "Continuing Certification Directory," formerly called the "MOC Directory" (continuingcertification.org/) continues to offer physicians access to a comprehensive, centralized, web-based repository of CME activities that have been approved for MOC credit by ABMS member boards. During the past two years, the directory has increased its inventory and now indexes 600-plus activities from more than 60 CME providers to help diplomates from across the specialties meet MOC requirements for Lifelong Learning and Self-Assessment (Part II) and Improvement in Medical Practice (Part IV).

The following types of activities are currently included in the directory: internet enduring activities, journal CME, internet point of care, live activities, and performance improvement CME. All CME activities are qualified to award credit(s) from one or more of the CME credit systems: *AMA PRA Category 1 Credit™*, AAFP Prescribed Credit, ACOG Cognates, and AOA Category 1-A.

The directory includes a wide variety of activities addressing emerging issues such as physician well-being and safe opioid prescribing initiatives as well as a full suite of AMA STEPS Forward™ Practice Improvement Strategies. STEPS Forward offers more than 40 online modules, plus

resources, case studies, and other content around patient care, work flow process, leading change, professional well-being, technology, and finance. The ABMS has invited the CPD/CME communities to submit for inclusion in the directory any certified CME activities that support the development of high-functioning physicians. For example, the most recent call for activities (abms.org/news-events/abms-call-for-physician-well-being-cme-activities/) focuses on improving physician well-being.

The ACCME continues to collaborate with the American Board of Internal Medicine (ABIM), American Board of Anesthesiology (ABA), and American Board of Pediatrics (ABP);allows accredited CME providers to identify CME activities that also meet the MOC requirements for each of the member boards (ABIM, ABA, and ABP); and facilitates reporting of learner data from the accredited provider to the relevant member board (accme.org/news-publications/news/accreditation-council-cme-american-board-anesthesiology-and-american-board). The collaborations are designed to expand the number and diversity of accredited CME activities that meet the member boards' MOC Part II requirements. This simplifies a physician's search for approved activities (cmefinder.org/). CME providers are using the ACCME Program and Activity Reporting System (PARS) to attest that their activities comply with board requirements. The ACCME maintains a list of accredited and certified CME activities registered for ABIM MOC, ABA MOC, and ABP MOC. The ABIM currently has more than 6,200 activities that have been certified for CME credit and registered for MOC points. Many of these activities are available across specialties, while some are specialty specific. The AMA transmits JAMA Network data to the ACCME for ABIM and is considering expansion to additional boards in the future.

Elimination of the secure, high-stakes examination for assessing knowledge and cognitive skills in MOC

Twenty-one ABMS member boards (87.5%) have moved away from the secure, high-stakes exam, and more than two thirds of the boards (71%) have launched, or will soon be launching, assessment pilots that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that promote learning and are less stressful (Table). A number of them are combining the longitudinal assessment approach with CertLink™, a technology platform developed by the ABMS to support its boards in delivering more frequent, practice-relevant, and user-friendly competence assessments to physicians (abms.org/initiatives/certlink-platform-and-pilot-programs/). The platform provides the technology to enable the boards to create assessments focused on practice-relevant content; offers convenient access on desktop, tablet, or smartphone (depending on the board's program); provides immediate, focused feedback and guidance to resources for further study; and provides a personal dashboard that displays areas of strength and weakness. The member boards that are developing CertLink™ pilot programs include the American Board of Colon and Rectal Surgery (ABCRS), American Board of Dermatology (ABD), American Board of Medical Genetics and Genomics (ABMGG), American Board of Nuclear Medicine (ABNM), American Board of Otolaryngology (ABOto), American Board of Pathology(ABPath), and American Board of Physical Medicine and Rehabilitation (ABPMR).

Other ABMS member boards that have been piloting new innovative assessment approaches have received positive feedback on their pilots. For example, the ABA surveyed its physicians in December 2016 to collect their feedback on year one of the redesigned Maintenance of Certification in Anesthesiology Program® (known as MOCA 2.0®). Nearly 75 percent of the physicians who responded reported that the MOCA Minute® pilot served them well as an assessment tool. Additionally, nearly 62 percent of survey respondents rated the experience better or much better than their experience with the traditional MOCA exam. Furthermore, physicians who participated in the 2014 and 2015 MOCA Minute pilot outperformed non-participants on the

MOCA Exam, according to a study published in the November 2016 issue of *Anesthesiology*.[11] In January 2017, the ABA expanded its longitudinal assessment program to include diplomates maintaining subspecialty certificates.

In January 2017, the ABP launched a pilot of its proposed longitudinal assessment approach called Maintenance of Certification Assessment for Pediatrics (MOCA-Peds) (abp.org/mocapeds). Nearly all 5,000 diplomates—approximately 98 percent of those eligible—enrolled in the 2017 MOCA-Peds pilot. At the end of each quarter, the ABP surveyed pilot participants about their experiences. Highlights from the first two surveys showed that 92 percent of participants had a satisfactory experience with the information technology platform, and nearly 80 percent agreed or strongly agreed that the MOCA-Peds questions were relevant to general pediatrics.[12] Based on this feedback, the ABP plans to replace the 10-year secure exam with MOCA-Peds beginning in 2019.

In 2018, the ABIM began offering a new two-year assessment option to provide physicians more choice, relevance, and convenience in meeting the assessment requirement of its MOC program. These "Knowledge Check-Ins" will allow diplomates to take shorter assessments in a location of their choice. The ABIM will first pilot the Knowledge Check-In for physicians certified in internal medicine or nephrology. The shorter assessments will become available to other specialties in 2019 and 2020 as an additional option along with the traditional 10-year MOC exam.

Several member boards are considering or have integrated journal article-based core questions into their assessments. The American Board of Obstetrics and Gynecology (ABOG) launched its MOC Pilot Program (abog.org/new/abog_mocimp.aspx) in 2016; more than 2,000 physicians opted to participate. In a survey of pilot participants conducted in 2017, 93 percent of the 1,268 respondents affirmed that the journal article assignments—a core element of the pilot—are beneficial to their clinical practice. Additionally, 87 percent of respondents agreed that if the ABOG fully adopts the pilot, it will make MOC more valuable to clinical practice, and 89 percent agreed that it will make MOC more relevant to clinical practice.[13] The ABOG studied the pilot results through 2017 and will decide whether to permanently adopt the changes to its MOC program in 2018.

Preliminary analysis from the American Board of Ophthalmology's (ABO) new Quarterly Questions™ program (diplomatedigest.com/single-post/2018/02/06/Article-Based-Learning-and-Assessment-in-Quarterly-Questions), launched in 2017, has been extremely favorable, earning the support of ABO diplomates as an approach to learning and assessment. Nearly 20 percent of ABO's active diplomate population participated in the program's optional pilot year, with 94 percent reporting that the article-based questions were useful for learning new, relevant information. Eighty-five percent of participants said the information they learned while completing the activity would help them provide better care to their patients in the future, and 99 percent said they would recommend the program to a colleague.

Other member board efforts include more diplomate input into exam blueprints; modularization of exam content that allows for tailoring of assessments to reflect physicians' actual areas of practice; access during the exam to resources similar to those used at the point of care; remote proctoring to permit diplomates to be assessed at home or in the office; and performance feedback mechanisms. All boards will also provide multiple opportunities for physicians to retake the exam. These program enhancements will significantly reduce the cost diplomates incur to participate in MOC by reducing the need to take time off or travel to a testing center for the assessment; ensure that the assessment is practice relevant; emphasize the role of assessment for learning; assure opportunities for remediation of knowledge gaps; and reduce the stress associated with a high-stakes test environment.

Progress with improving MOC Part IV, Improvement in Medical Practice

The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) requirements, including those offered at the physician's institution and/or individual practices, in order to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements. In addition to improving alignment between national value-based reporting requirements and continuing certification programs, the boards are implementing a number of activities related to registries, systems-based practice, and practice audits.

Registries

The ABMS member boards are increasingly incorporating the use of patient registries into their continuing certification process. Registries target quality concerns and provide physicians with meaningful, actionable information that helps align their MOC activities with federal and state quality incentive programs. While many member boards have been providing physicians the opportunity to earn MOC credit for participating in externally developed patient registries, some boards are designing performance improvement initiatives supported by registry data. Many of the member boards also recognize participation in registries developed by their professional societies as satisfying their IMP requirements.

- In 2017, the ABO began piloting a program that enables ophthalmologists to create customized quality improvement (QI) projects using the data supplied through the American Academy of Ophthalmology's IRIS® Registry. After numerous improvement projects were successfully completed, ABO transitioned the pilot into a permanent program in October 2017. Ophthalmologists can use the monthly reports to identify areas for improvement, set specific goals for each measure, outline the steps (changes in care delivery processes) to achieve these goals, and evaluate their success by analyzing subsequent monthly performance reports. Ophthalmologists receive MOC credit for approved, completed projects.

- The ABOto has partnered with the American Academy of Otolaryngology-Head and Neck Surgery for the past two years to develop a qualified clinical data registry, Reg-ent. This registry is able to extract data from an otolaryngologist's electronic health records (EHRs) for multiple purposes, including reporting quality measures for Merit-based Incentive Payment System (MIPS) as payment shifts to performance under the Quality Payment Program. The ABOto will be able to extract data from Reg-ent to provide feedback to board certified otolaryngologists and document improvement, thereby meeting MOC requirements without requiring data entry by the physicians.

- More than 3,000 physicians are using the American Board of Family Medicine (ABFM) PRIME Registry, which extracts patient data from the practice EHR and converts it into actionable measures that are presented in an easy to use dashboard. The PRIME Registry is a qualified clinical data registry that is approved to propose measures to the Centers for Medicare & Medicaid Services (CMS). The ABFM's PRIME Registry offers tools that simplify and automate reporting for MIPS and CMS's Comprehensive Primary Care Plus or CPC+, and enables physicians to use their measures data to create and implement a QI plan in their practice to simplify continuous certification and align it with MIPS reporting requirements. The ABFM is also developing a new tool, the Population Health & Assessment Engine, to integrate social determinants of health data with clinical data in the registry to help physicians understand the impact of social determinants on individual patients and the populations they serve and to improve intervention and care.

Interoperability between clinical data registries and EHRs continues to be a priority for specialty society registry hosts. CMSS published the *Registry Primer* to serve as background and a resource guide on clinical registry development and implementation (https://cmss.org/732-2/). CMSS member societies are also exploring a Clinical Data Registry Collaborative, which is planning a pilot project to identify and match patient-centric data elements from two or more data registries in their current hosting environment. CMSS plans to engage with the National Quality Registry Network and the National Quality Forum, which are exploring similar interoperability challenges.

Systems-based practice

The ABMS member boards are aligning MOC activities with other organizations' QI efforts to reduce redundancy and physician burden while promoting meaningful participation. Twenty-one of the boards encourage participation in organizational QI initiatives through the ABMS Multi-Specialty Portfolio Program™ (described below). Many boards encourage involvement in the development and implementation of safety systems or the investigation and resolution of organizational quality and safety problems. For physicians serving in research or executive roles, some boards have begun to give IMP credit for having manuscripts published, writing peer-reviewed reports, giving presentations, and serving in institutional roles that focus on QI (provided that an explicit Plan-Do-Study-Act [PDSA] process is used). Physicians who participate in QI projects resulting from morbidity and mortality conferences and laboratory accreditation processes resulting in the identification and resolution of quality and safety issues can also receive IMP credit from some boards.

Practice Audits

Several ABMS member boards have developed online practice assessment protocols that allow physicians to assess patient care using evidence-based quality indicators. Other initiatives include:

- Free tools to complete an IMP project, including a simplified and flexible template to document small improvements, educational videos, infographics, and enhanced web pages.
- Partnering with specialty societies to design quality and performance improvement activities for diplomates with a population-based clinical focus.
- Successful integration of patient experience and peer review into several of the boards' IMP requirements; one board has aggressively addressed the issue of cost and unnecessary procedures with an audit and feedback program.
- Integration of simulation options.
- A process for individual physicians to develop their own improvement exercises that address an issue important to them, using data from their own practices, built around the basic PDSA process.

ABMS Multi-Specialty Portfolio Program

The ABMS Multi-Specialty Portfolio Program (Portfolio Program™) offers health care organizations a way to support physician involvement in their institution's quality and performance improvement initiatives by offering credit for the IMP component of the ABMS Program for MOC (mocportfolioprogram.org). Originally designed as a service for large hospital institutions, the Portfolio Program is extending its reach to physicians whose practices are not primarily in institutions. This includes non-hospital organizations such as academic medical centers, integrated delivery systems, interstate collaboratives, specialty societies, and state medical societies. Recent additions among the 93 current sponsors include the American College of Cardiology, American Hospital Association, and American College of Obstetricians and Gynecologists.

More than 2,600 types of QI projects have been approved by the Portfolio Program, focusing on such areas as advanced care planning, cancer screening, cardiovascular disease prevention, depression, immunizations, obesity, patient-physician communication, transitions of care, and patient-safety related topics including sepsis and central line infection reduction. Many of these projects have had a profound impact on patient care and outcomes. For example, during the past two years, Portfolio Program initiatives at the Children's Hospital of Philadelphia have been responsible for inpatient hospital days for oncology patients with fever and neutropenia decreasing by more than 35 percent, preventable readmissions for neurology patients decreasing by approximately 80 percent, and rates of urinary catheterization for febrile infants decreasing by 65 percent. Additionally, rates of pneumococcal immunization among patients with chronic kidney disease have increased by 79 percent, and the application of evidence-based practices to evaluate and manage children with attention deficit disorder and hyperactivity has increased by 50 percent. There have been nearly 19,700 instances of physicians receiving MOC IMP credit through participation in the program. Twenty ABMS member boards participate in the program.

Update on the emerging data and literature regarding the value of MOC

The Council on Medical Education has continued to review published literature and emerging data as part of its ongoing efforts to critically review MOC and OCC issues. Although there is still frustration with the MOC process and its cost,[14] many improvements have been made to the MOC Program, such as making the process more efficient, convenient, and cost-effective, and less burdensome. In addition, important peer-reviewed studies published during the last year demonstrate the benefits of participating in a continuous certification program. These studies are summarized below.

Many of the ABMS member boards have been enhancing the MOC Part III examinations to ensure the exam is practice-relevant. A study by Gray et al. analyzed whether the ABIM MOC exams from 2010-2013 reflected practice conditions during either office visits or hospital stays for each of 186 condition categories within internal medicine. The study showed that the majority of exam questions generally reflected what occurs in practice, with 69 percent of the questions on these exams harmonizing with conditions in practice.[15] A study by Lipner et al., involving 825 physicians initially certified by the ABIM or who took the ABIM MOC exam in 2012 to 2015, compared the results of a closed book exam to an open book exam that allowed the use of electronic resources typically used at the point of care. The study showed that inclusion of an electronic resource with time constraints did not adversely affect test performance and did not change the specific skill or factor targeted by the exam.[16]

One study looked at the benefits derived from taking the MOC Part III examination. More than 2,500 emergency physicians who took the American Board of Emergency Medicine (ABEM) ConCert high-stakes examination in 2015 participated in a voluntary post-examination survey in 2015. When asked about the benefits of preparing for the exam and maintaining ABEM certification, the majority of emergency physicians (more than 90 percent) reported they either gained medical knowledge or reinforced knowledge they already had, making them better clinicians. Most of them also found career benefits to remaining ABEM certified, including greater employment choices, higher financial compensation, and higher esteem from other physicians.[17]

A number of recently published studies evaluate the effectiveness and value of IMP activities (MOC Part IV).

- A study conducted by the University of Michigan Health System Adolescent Health Initiative evaluated whether a MOC Part IV project could improve the delivery of confidential care to

minor adolescent patients seen in outpatient primary care practices. This study showed that this Part IV project was an effective way to change physician practice and improve the delivery of confidential care to minor adolescents seen for wellness visits. The study also showed that another major benefit was that it served as the primary mechanism to get physicians in non-adolescent specialties engaged in improving care for adolescents. In addition, participation broadly increased participating primary care physicians' knowledge of best practices in adolescent care, which may lead to wider improvements for adolescents in the practice as a whole.[18]

- A study of pediatric gastroenterologists who participated in a MOC Part IV activity showed significant improvements in clinical care documentation and processes as well as improvements in patient outcomes for various endoscopic procedures. In addition, parents had a much greater understanding of the informed consent process. An analysis of data taken from web-based MOC QI modules also showed significant practice variation across several processes and demonstrated how the web-based MOC activities improved them.[19]

- In a study that examined whether organization-developed MOC performance improvement modules (PIMs), such as the PIMs created by the ABP, improve the quality of pediatric care, the PIMs were linked to better care for children. Pediatricians improved care for attention-deficit/hyperactivity disorder, asthma, and influenza. Hand hygiene also improved.[20]

- A study of hypertension Performance in Practice Modules completed by family physicians from July 2006 through 2013 showed that these physicians significantly improved the quality of care for patients with hypertension, including improving blood pressure control and diet and exercise counseling, after completing the activity.[21]

- A study undertaken at Nationwide Children's Hospital evaluated the effectiveness of integrating QI training within the institution by developing a course called "Quality Improvement Essentials" in 2012. The results of surveys were positive, indicating increased and maintained QI competency among staff. Approximately 40 percent of the physicians who participated in the course converted their course project to receive MOC Part IV credit.[22]

- A study by Jennings, et al., evaluated a QI project in a community emergency department (ED) aimed at decreasing the use of head computed tomography (CT) scans in children. The study showed that pediatricians who participated in the MOC activity reduced the use of unnecessary head CT scans for children with head injuries in the ED. In addition, coaching and mentoring from a regional hospital participating in the MOC Portfolio Program (Seattle Children's Hospital) had a significant effect on the successful QI effort at the community setting.[23]

- Shaw et al. described how pediatric physicians' increased participation in MOC Part IV QI activities at the Children's Hospital of Philadelphia is improving patient care (e.g., asthma management, patient flow, and cardiac arrest outcomes).[24]

Recently published articles describe improvements made to the continuing certification process.

- One article describes how the American Board of Allergy and Immunology's (ABAI) Part III continuous assessment program will replace the ABAI's 10-year high-stakes examination beginning in 2018. This process will be an open-book and web-based program that will focus on adult learning theory methods to reduce the cost and burden on diplomates.[25]

- Two articles discuss how improvements being made to the MOC process make continuing certification more meaningful and acceptable to physicians. The ABIM and ABP have worked closely with their specialty societies to increase the number of CME programs that count for MOC. In addition, the ABIM and ABP have tested and evaluated new assessment models to replace the 10-year high-stakes examinations.[26, 27]

- An article by Juul et al. highlights the development of geriatric psychiatry subspecialty certification. The article focuses on how the American Board of Psychiatry and Neurology (ABPN) is attempting to meet the need for more geriatric psychiatrists by strategically developing a flexible approach to MOC that includes options for taking combined examinations which cover their diplomates' specialty and/or subspecialty. Other ABPN MOC requirements are the same as those for recertification in general psychiatry only or in a single subspecialty.[28]

- An article by Carlos et al. provides an overview of how the American Thoracic Society developed a core curriculum focusing on adult pulmonary, critical care, and sleep medicine and pediatric pulmonary medicine that can be integrated into the MOC programs offered by the ABIM and ABP. The guiding principles outlined in this article may aid other societies that are considering launching similar initiatives to meet the needs of their members.[29]

- An article by McMillan et al. addresses the importance of focusing on behavioral and mental health in pediatric resident training and the efforts being made by the ACGME and ABP to improve this area of need. This article also identifies how MOC will be used to try to improve learning.[30]

Three articles describe quality measurement that is being used in clinical care improvement, regulation, accreditation, public reporting, surveillance, and MOC. A 2015 quality metrics (QUALMET) survey assessed the commonalities and variability of selected quality and productivity indicators, including MOC participation, currently used by 112 U.S. academic radiology departments. MOC participation was found to be varied and a requirement of employment for nearly half of the survey respondents. The study suggests that MOC is currently the best metric to evaluate whether a radiologist has up-to-date knowledge and is familiar with quality and safety practices.[31] A policy statement published by the American Academy of Pediatrics recommended that national policymakers "harmonize and align measures used in national/state reporting programs, including payment programs, such as state Medicaid and private payers, accreditation bodies, regulatory agencies, and MOC programs to reduce reporting burden on physicians."[32] An article by Price and Lang presents a QI model for the clinical practice of allergy and immunology that can be used by physicians to develop and implement practice-based QI activities that improve processes and outcomes of care for patients.[33]

Recent articles also evaluate self-regulation, professionalism, and perceptions about MOC. A review of retrospective cohort studies between MOC and clinical processes or outcomes, published from 2007 to 2016, shows that although methodological challenges remain, a rapidly growing body of literature provides evidence that MOC is associated with better care or has been an incentive for physicians to collaborate in systematically improving patient care and outcomes.[34] A review article summarizes the challenges of teaching and assessing professionalism in radiology, how professionalism is part of MOC and the American Board of Radiology's competency assessment, and how a greater understanding of professionalism as part of competency assessment is needed.[35] A study conducted by the Seattle Children's Hospital showed that, of 123 physicians who participated in a MOC project and completed a survey, 97 percent of the survey respondents view

Part IV favorably. Participation was associated with modest improvements in perceptions of QI engagement and attitude, application of QI methods, and patient care.[36]

More than 60 sessions at the ABMS annual QI Forum held during the 2017 ABMS Conference (abmsconference.com/2017/session-descriptions) focused on continuing certification, initial certification, health policy research, patient safety, and improvement in medical practice. Posters presented by Portfolio Program sponsors and other health care researchers underscored best practices and research in continuing certification and QI activities (abmsconference.com/2017/poster-session). One example highlighted a program at the University of Michigan Health System in which more than 40 QI projects are available for physician participation, including improving the rate of foot exams for adult diabetic patients, reducing the number of non-medically indicated planned deliveries, and improving the clinical management of overweight and obese pediatric patients.

Stakeholders from the fields of medical education and assessment also met to develop a collaborative research agenda and strategy to study learning and assessment throughout a physician's career during the 2017 ABA/ABMS Research Summit entitled, "Improving Health and Healthcare Systems: Defining a Research Agenda for Learning and Assessment across the Continuum of a Physician's Career" (abmsconference.com/2017/session-descriptions/).

The Council on Medical Education is committed to monitoring emerging data and the literature to identify improvements to the MOC program, especially those that improve physician satisfaction with MOC as well as those that enable physicians to keep pace with advances in clinical practice, technology, and assessment.

OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC): AN UPDATE

The American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. Today, 18 AOA-BOS specialty certifying boards offer osteopathic physicians the option to earn board certification in a number of specialties and subspecialties. As of December 2016, over 29,000 osteopathic physicians held active board certification through the AOA (with some of these physicians holding multiple certifications).

OCC was implemented on January 1, 2013, by all 18 specialty certifying member boards of the AOA-BOS.[37] All osteopathic physicians who hold a time-limited certificate are required to participate in the following five components of the OCC process in order to maintain osteopathic board certification:

- Component 1 - Active Licensure: physicians who are board certified by the AOA must hold a valid, active license to practice medicine in one of the 50 states, District of Columbia, or U.S. territories, and adhere to the AOA's Code of Ethics.
- Component 2 - Life Long Learning/Continuing Medical Education (CME): requires that all recertifying diplomates fulfill a minimum number of hours of CME credit during each three-year CME cycle (15 certifying boards require 120 hours; three certifying boards require 150 hours). A minimum of 50 credit hours of this requirement must be in the specialty area of certification. Self-assessment activities are also designated by each of the 18 specialty certification boards. For osteopathic physicians who hold subspecialty certification(s), a percentage of their specialty credit hours must be in their subspecialty certification area.

- Component 3 - Cognitive Assessment: requires provision of one (or more) psychometrically valid and proctored examinations that assess a physician's specialty medical knowledge as well as core competencies in the provision of health care.
- Component 4 - Practice Performance Assessment and Improvement: requires that physicians engage in continuous quality improvement through comparison of personal practice performance measured against national standards for their respective medical specialty.
- Component 5 - Continuous AOA Membership.

Specific requirements for each specialty are available at: osteopathic.org/inside-aoa/development/aoa-board-certification/occ-requirements/Pages/default.aspx.

Although osteopathic physicians who hold non-time-limited (non-expiring) certificates are not required to participate in OCC, there are requirements to maintain active certification status: they must continue to meet licensure, membership, and CME requirements (120-150 credits every three-year CME cycle, 30 of which are in AOA CME Category 1A).

In April 2016, the AOA empaneled a Certifying Board Services Task Force charged with the following tasks:

1. Improve customer experience through user-friendly processes.
2. Continuously increase quality and enhance standards of high-stakes examinations.
3. Simplify and align the OCC process across all specialties.
4. Serve as a focus group on technological enhancements.

In July 2016, the AOA House of Delegates approved a resolution calling for the AOA to study and evaluate all components of OCC. The Task Force reported its findings and recommendations regarding the five OCC components to the BOS at its annual meeting on November 6, 2016. The Task Force's recommendations focus on making the OCC process less onerous and apply current and new evaluation processes that take advantage of the latest concepts in certification and supporting technology. The BOS drafted resolutions based on the Task Force's recommendations and submitted these to the AOA Board of Trustees for approval at its February 2017 meeting. The resolutions were approved by the AOA Board of Trustees and the individual boards are now working on implementation plans for the updated OCC components.

STATE LEGISLATION RELATED TO THE USE OF MOC

MOC is intended to be a career-long process of learning, assessment, and performance improvement that is meant to demonstrate physicians' proficiency within a chosen discipline, but is separate from and not required for state medical licensure. Many hospitals have independently made the decision to require recertification for the granting of privileges, and various quality organizations and insurers use MOC to help identify commitment to professionalism and continuous performance improvement. These requirements are within their legal rights. However, AMA policy discourages such mandates. The AMA has adopted the following related policies:

- Policy H-275.924, "Maintenance of Certification," (15) states, "The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation."

- Policy D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification," (34) states that the AMA, "through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state

legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure."

Some states are proposing or have enacted legislation that prohibits the use of MOC as a criterion for licensure, privileging, employment, reimbursement, and/or insurance panel participation. Nine states (Arizona, Georgia, Kentucky, Maryland, Maine, Missouri, Oklahoma, Tennessee, and Texas) have enacted laws addressing MOC requirements. With the exception of Texas, where the enacted legislation has implications for hospitals' and health plans' use of MOC, the laws passed to date prohibit the use of MOC for initial and renewal licensure decisions. At the time of filing, 18 state legislatures (Alaska, Florida, Iowa, Indiana, Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New York, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Utah, Washington, and Wisconsin) were actively considering MOC-related legislation.

The AMA Council on Legislation has developed, and the AMA Board of Trustees has approved, model state legislation intended to prohibit state boards of medicine and osteopathic medicine from requiring physicians to maintain certification for licensure or license renewal; prohibit hospitals from denying staff privileges or admitting privileges to a physician solely based on the physician's lack of participation in MOC or OCC; and prohibit insurers from denying reimbursement to a physician, or preventing a physician from participating in the insurer's network, based solely on the physician's lack of participation in MOC or OCC. The model bill is on file with the AMA Advocacy Resource Center, which will assist any interested state medical association in pursuing such legislation or any other legislation consistent with AMA policy.

DIRECT-TO-CONSUMER ADVERTISING OF THE ABMS MOC PRODUCT

Society relies on members of the medical profession to establish standards for entering the profession and to assure that they are maintaining competence throughout their careers.[38] Patients expect that their physician's certification reflects ongoing education and practice improvement. Board certification makes a public statement about a physician's capabilities to provide quality care in his or her chosen specialty. Patients, families, and others have a right to know a physician's certification status, and they should also be able to access this information through multiple channels and in formats that are easily understood.

Although the AMA opposes direct-to-consumer marketing of drugs and devices, Resolution 318-A-17 focuses on a different aspect of marketing. Health professionals, both physicians and non-physicians alike, are generally allowed to advertise to the public their training, education, experience, and expertise. Twenty states have enacted legislation prohibiting deceptive or misleading advertising, communication, or other deceptive or misleading conduct concerning health professionals' skills, education, training, professional competence, or licensure.

Some physicians may advertise that they are board certified or board eligible. The AMA opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of ABMS- or AOA-BOS-board certified physicians in any medical specialty, or takes advantage of the prestige of any medical specialty for purposes contrary to the public good and safety (H-275.926 (1), "Medical Specialty Board Certification Standards"). Similarly, the AMA's "Truth in Advertising" campaign highlights the need to improve transparency, clarity, and reliability for the patient and public. Through this campaign, the AMA developed materials including a model bill, the "Health Care Professional Transparency Act," which includes a drafting note with sample language for use by state and specialty societies that wish to pursue legislation governing advertising about physician certification status (ama-assn.org/truth-advertising). The

campaign provides medical societies with tools and resources to develop and advocate for legislation to help ensure that patients are promptly and clearly informed of the training and qualifications of their health care practitioner.

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education is committed to ensuring that MOC and OCC support physicians' ongoing learning and practice improvement and serve to assure the public that physicians are providing high-quality patient care in their practice settings. The AMA will continue to advocate for a certification process that is evidence-based and relevant to clinical practice as well as cost-effective and inclusive to reduce duplication of work. During the last year, the Council has continued to monitor the development of MOC and OCC and work with the ABMS, ABMS member boards, AOA, and the state and specialty medical societies to identify and suggest improvements to the MOC and OCC programs. Since the AMA will continue to work with these organizations and key stakeholders and a council member will be closely involved in the ABMS Commission and in the development of the Commission's recommendations for the future continuing board certification process, a study with the goal of establishing a program that will certify physicians is not warranted at this time.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolutions 316-A-17 and 318-A-17 and the remainder of the report be filed.

1. That our American Medical Association (AMA) continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so. (Directive to Take Action)

2. That our AMA, through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission. (Directive to Take Action)

Fiscal Note: $2,500

TABLE. IMPROVEMENTS TO THE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) PART III, SECURE, HIGH-STAKES EXAMINATION*

American Board of:	**Current Examination Format**	**New Models/Innovations**
Allergy and Immunology (ABAI) abai.org	Computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years.	In 2018, ABAI-Continuous Assessment Pilot Program will be implemented in place of current exam: • A 10-year program with two five-year cycles. • Diplomates take exam where and when it is convenient. • Open-book exam with a total of approximately 80 questions per year. • Mostly article-based with some core questions during each six-month cycle. Diplomates are required to answer three questions for each of ten journal articles in each cycle. The articles will be posted in January and July and remain open for six months. Articles can be printed or downloaded for review. • Questions can be answered for each article independently. Diplomate feedback on each question will be required. • Opportunity to drop the two lowest six-month cycle scores during each five-year period to allow for unexpected life events. • Ability to complete questions on PC, laptop, MAC, tablet, and smart phone formats by using the new diplomate dashboard via the existing ABAI Web Portal page.
Anesthesiology (ABA) theaba.org	1) MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment and provide more extensive, question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise. 2) Piloting MOCA Minute™—a longitudinal assessment tool that requires diplomates to answer 30 questions per calendar quarter, or 120 per year, in lieu of taking a 10-year exam. *All diplomates with time-limited certification that expired on or before Dec. 31, 2015 and diplomates whose subspecialty certificates*	Analysis of the pilot data is underway to determine whether participants accessed the links to additional resources, learned the material, and improved performance in the content knowledge areas represented in the MOCA Minute Pilot.

	expired on or before December 31, 2016, must complete the traditional MOCA® requirements before they can register for MOCA 2.0®.	
Colon and Rectal Surgery (ABCRS)[1] abcrs.org	Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years.	• Exploring ways to modify the exam experience to provide a more consistent evaluation process and to replace the exam as it presently is administered. The ABCRS is developing a CertLink™-based longitudinal assessment pilot to evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam. • The first diplomates enrolled are those sitting for the ABCRS certifying exam in September 2017. These diplomates start CertLink™ MOC in the Spring of 2018. Other diplomates will be able to enroll shortly thereafter.
Dermatology (ABD)[1] abderm.org	• Computer-based secure modular exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. • Test preparation material available six months before the exam at no cost. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams. • Examinees are required to take the general dermatology module, consisting of 100 clinical images to assess diagnostic skills, and can then choose among 50-item subspecialty modules.	• The ABD successfully completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices. • The ABD is developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Emergency Medicine (ABEM) abem.org	ABEM's ConCert™, computer-based, secure exam administered at a proctored test center once a year. Diplomates must pass the exam once every 10 years.	The ABEM is monitoring recent efforts within the ABMS board community that have focused on pilots that assess knowledge, judgment, and skills using longitudinal assessments rather than an every-10-year exam. The alternative assessment method would have to show that its learning and assessment advantage is better than the current ABEM exam.
Family Medicine (ABFM) theabfm.org	• Computer-based secure exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. • Improving relevance of recertification	Changes to the ABFM exam are not being considered at this time.

	exam by using national study of care content in family medicine practices. • Providing feedback to residents and practicing physicians about the "anatomy" of the exam and their particular knowledge gaps. Effort has resulted in significant improvement in passing rates and improved feedback regarding relevance.	
Internal Medicine (ABIM) abim.org	• Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. • Introduced grace period for physicians to retry assessments for additional study and preparation if initially unsuccessful.	In 2018,the ABIM plans to offer two assessment options: 1) Certified physicians (Internal Medicine and Nephrology with more specialties to roll out in 2019 and 2020) will be eligible to take the Knowledge Check-In, a new two-year open-book (access to *UpToDate*®) assessment with immediate performance feedback. Assessments can be taken at the physician's home or office, or at a computer testing facility instead of taking the long-form exam every 10 years at a testing facility. Those who meet a performance standard on shorter assessments will not need to take the 10-year exam again to remain certified. 2) Diplomates can also choose to take a long-form assessment given every 10 years. This option is the same as the current 10-year exam, but it will include open-book access (to *UpToDate*®) that physicians requested. *ABIM is also working with specialty societies to explore the development of collaborative pathways through which physicians can maintain board certification.*
Medical Genetics and Genomics[1] (ABMGG) abmgg.org	Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Neurological Surgery (ABNS) abns.org	• The 10-year secure exam can be taken from any computer, i.e., in the diplomate's office or home. Access to reference materials is not restricted; it is an open book exam. • On applying to take the exam, a diplomate must assign a person to be his or her proctor. Prior to the exam, that	In 2018, an adaptive MOC cognitive learning tool will be available: • The tool will consist of updated knowledge that has evolved since the diplomate's last certification, and the tool will be shorter, relevant, and more focused than the prior exam.

	individual will participate in an on-line training session and "certify" the exam computers.	• The open book knowledge-based exam will provide updated evidence-based core neurological surgery knowledge in a web-based format. • The web-based learning tool can be mastered in the diplomates' home or office anytime 24/7. • Immediate feedback to each question and references with links and/or articles will be provided.
Nuclear Medicine[1] (ABNM) abnm.org	Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Obstetrics and Gynecology (ABOG) abog.org	The secure, external assessment is offered in the last year of each ABOG diplomate's six-year cycle in a modular test format, and they are allowed to choose two selections that are the most relevant to their current practice.	Studying the results of a pilot program launched in 2016 and 2017 to integrate the self-assessment and external assessment MOC requirements which allowed diplomates to continuously demonstrate their knowledge of the specialty. The pilot allowed diplomates to earn an exemption from the current computer-based exam in the sixth year of the program if they reach a threshold of performance during the first five years of the self-assessment program.
Ophthalmology (ABO) abop.org	• Quarterly Questions™ replacing DOCK (high-stakes, 10-year) exam with longitudinal assessment program. • Will deliver 50 questions (40 knowledge based and 10 article based) remotely at home or office through computer, tablet or mobile apps. The questions should not require preparation in advance, but a content outline for the multiple choice questions will be available. Users will receive instant feedback and recommendations for resources related to gaps in knowledge. • Key ophthalmic journal articles with questions focused on the application of this information to patient care are provided. The journal portion will require reading five articles from a list of 30 options.	In 2019, Quarterly Questions™ will replace the DOCK Examination for all diplomates.
Orthopaedic Surgery (ABOS) abos.org	• Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July. • Diplomates without subspecialty certifications are allowed to take	Piloting a virtual practice evaluation to evaluate diplomates on their own cases without requiring travel. Diplomates must submit medical records on 12 selected cases similar to an oral exam with the exam performed in a virtual platform.

	practice-profiled exams in orthopaedic sports medicine and surgery of the hand. • General orthopaedic questions were eliminated from the practice-profiled exams so diplomates are only tested in areas relevant to their practice. • Detailed blueprints are being produced for all exams to provide additional information for candidates to prepare for and complete the exams. • Eight different practice-profiled exams offered to allow assessment in the diplomate's practice area.	
Otolaryngology[1] (ABOto) aboto.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Pathology[1] (ABPath) abpath.org	• Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August). • Remote computer exams can be taken anytime 24/7 that the physician chooses during the assigned two-week period (spring and fall) from their home or office. • Physicians are allowed to choose from more than 90 modules, covering numerous practice areas for a practice-relevant assessment. *Diplomates must pass the exam once every 10 years.*	Participating in the ABMS Longitudinal Assessment pilot utilizing the CertLink™ platform.[1]
Pediatrics (ABP) abp.org	1) Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. 2) Piloting Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), a new testing platform with shorter and more frequent assessments that include: • A series of questions released through mobile devices or a web browser at regular intervals. • Twenty multiple choice questions that are available quarterly and may be answered anytime during the quarter. • Immediate feedback and references. • Resources (i.e., internet, books) that can be used when taking the exam. • Allows for questions to be tailored to the pediatrician's practice profile.	In 2019, MOCA-Peds will roll out to all certified pediatricians in subsequent years. Those who wish to continue taking the exam once every five years in a secure testing facility will still be able to do so.

	• Physicians will provide feedback on individual questions so the exam can be continuously improved.	
Physical Medicine and Rehabilitation (ABPMR)[1] abpmr.org	• Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. • Releasing MOC 100, a set of free practice questions pulled directly from the ABPMR exam question banks to help physicians prepare for the exam. • Working with the specialty society to produce clinical updates that integrate with the longitudinal assessment tool.	Developing a CertLink™-based longitudinal assessment pilot to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam.
Plastic Surgery (ABPS) abplasticsurgery.org	• Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. • Modular exam to ensure relevance to practice. • Offers an MOC Study Guide with multiple choice question items derived from the same sources used for the exam.	Piloting online delivery of MOC exam in place of centralized in-person testing center to reduce costs and time away from practice. Diplomates will be given immediate feedback on answers and offered an opportunity to respond again. If successful, this pilot may replace the high-stakes exam.
Preventive Medicine (ABPM) theabpm.org	In-person, pencil-and-paper, secure exam administered at secure test facility. MOC exams follow the same content outline as the initial certification exam (without the core portion). *In 2016, new multispecialty subspecialty of Addiction Medicine was established.* In 2017, Addiction Medicine subspecialty certification exam was administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.	Changes to the ABPM exam are not being considered at this time.
Psychiatry and Neurology (ABPN) abpn.com	• Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. • Developing MOC exams with committees of clinically active diplomates to ensure relevance to practice. • Enabling diplomates with multiple certificates to take all of their MOC exams at once and for a reduced fee. • Grace period so that diplomates can retake the exam.	Implementing a Part III pilot program to allow physicians who read lifelong learning articles and demonstrate learning by high performance on the questions accompanying the article, to earn exemption from the 10-year MOC high-stakes exam.
Radiology (ABR) theabr.org	Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	Developing a pilot that may replace the current 10-year traditional exam, with an Online Longitudinal Assessment (OLA) model that will be piloted and include modern and more relevant adult learning concepts to provide psychometrically valid sampling of the

		diplomate's knowledge. • Diplomates will create a practice profile of the subspecialty areas that most closely fit what they do in practice, as they do now for the modular exams. • Diplomates will receive weekly emails with links to questions relevant to their registered practice profile. • Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time. • Diplomates will learn immediately whether they answered correctly or not and will be presented with the question's rationale, a critique of the answers, and brief educational material. • Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.
Surgery (ABS) absurgery.org	• Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. • Transparent exam content, with outlines, available on the ABS website and regularly updated. • Coordinating with the American College of Surgeons and other organizations to ensure available study materials align with exam content.	In 2018, the ABS will begin offering shorter, more frequent, open-book, modular, lower-stakes assessments required every two years in place of the high-stakes exam. The new assessment is being introduced for general surgery, with other ABS specialties launching over the next few years. For 2018, diplomates will select from four practice-related areas: general surgery, abdomen, alimentary tract, or breast. More areas are planned for the future based on feedback from diplomates and surgical societies. Diplomates will take the assessment through their own computer at a time and place of their choosing within the assessment window, be provided with immediate feedback, and have two opportunities to answer a question correctly.
Thoracic Surgery (ABTS) abts.org	• Remote, secure, computer-based exams can be taken any time 24/7 that the physician chooses during the assigned two-month period (September-October) from their home or office. Diplomates must pass the exam once every 10 years. • Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates.	The ABTS developed a web-based self-assessment tool (SESATS) that includes all exam material, instant access to questions, critiques, abstracts and references.

Urology (ABU) abu.org	• Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. • Clinical management emphasized on the exam. Questions are derived from the American Urological Association (AUA) Self-Assessment Study Program booklets from the past five years, AUA Guidelines, and AUA Updates. • Diplomates required to take the 40-question core module on general urology, and choose one of four 35-question content specific modules. • ABU provides increased feedback to reinforce areas of knowledge deficiency.	

*The information in this table is sourced from ABMS Member Board websites and is current as of March 27, 2018.

[1]Seven ABMS member boards are utilizing CertLink™, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment pilots, some of which launched in 2017. More information is available at: abms.org/news-events/american-board-of-medical-specialties-announces-development-of-new-web-based-platform/ (accessed 1-8-18).

APPENDIX

CURRENT AMA POLICIES RELATED TO MOC AND OCC

H-275.924, "Maintenance of Certification"
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in MOC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
(CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 319, A-17 Reaffirmed in lieu of: Res. 322, A-17 Modified: Res. 953, I-17)

D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification"
Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.
(CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16 Modified: CME Rep. 02, A-17 Reaffirmed: Res. 316, A-17 Reaffirmed in lieu of: Res. 322, A-17)

H-275.926, "Medical Specialty Board Certification Standards"
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic

Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
(Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15)

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REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (A-18)
Expanding UME Without Concurrent GME Expansion
(Reference Committee C)

EXECUTIVE SUMMARY

Over the past ten years the establishment of new medical schools and the expansion in class size of existing medical schools has helped create a growing physician workforce, which is considered essential to providing health care to a growing and aging patient population. This expansion, however, has also created a perceived "bottleneck" in the transition from medical school to residency training, as the growth of entry-level residency training positions has not been commensurate with the increase in the number of graduates. American Medical Association (AMA) Policy D-305.967 (31), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," directs our AMA to "study the effect of medical school expansion that occurs without corresponding graduate medical education expansion." This report is in response to that directive.

Analysis of existing graduate medical education (GME) data and projections suggests that, while there will be continued growth of United States medical school graduates (USMGs), there is still substantial room for placement of USMGs into GME, with an excess of 4,500 positions relative to graduates for the next several years. Although there are more entry-level GME positions than USMGs, there are other physicians vying for these same training opportunities. Approximately half of international medical school graduates (IMGs), either U.S. citizens (US IMGs) or foreign nationals (non-US IMGs) participating in the National Resident Matching Program, successfully match into positions. As competition for the pool of positions grows, applicant behavior causes stress for both applicants and the programs to which they apply. Applicants apply to more programs, and program directors must vet an ever-increasing number of applicants.

This report:

- Provides an update on recent numbers of medical students, graduates, and residency positions
- Summarizes recent residency applicant behavior and results in terms of matching into residency programs
- Describes recent state and medical school efforts to expand GME positions
- Describes the AMA's national SaveGME campaign

The report concludes with a discussion regarding a changing GME environment, suggestions to help allay the concerns of students about matching, and potential policy changes for medical schools to consider.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-18

Subject: Expanding UME Without Concurrent GME Expansion

Presented by: Lynne Kirk, MD, Chair

Referred to: Reference Committee C
(Sherri S. Baker, MD, Chair)

INTRODUCTION

American Medical Association (AMA) Policy D-305.967 (31), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," directs our AMA to "study the effect of medical school expansion that occurs without corresponding graduate medical education expansion." This report is in response to this directive.

This portion of the policy was appended through Resolution 320-A-16, "Expanding GME Concurrently with UME," which was introduced by the Resident and Fellow Section at the 2016 Annual Meeting of the AMA House of Delegates (HOD). Testimony before Reference Committee C during the HOD meeting was overwhelmingly in favor of Resolution 320-A-16. Multiple individuals noted that the number of new medical schools and enrollment in existing institutions have expanded substantially of late, without a corresponding increase in the number of entry-level graduate medical education (GME) positions. Concern was voiced that the number of U.S. seniors successfully completing their undergraduate medical education (UME) at either allopathic or osteopathic medical schools likely will approach or surpass the total number of available U.S. GME positions within the next one to two decades. It was further acknowledged that the Accreditation Council for Graduate Medical Education (ACGME) is examining this important issue, with discussions that consider mitigating barriers to establishing training programs in specialties and locations that are underserved. Some testimony requested the addition of a second resolve to ask the AMA to advocate for expansion in resident and fellowship positions in proportion to expansions in medical school student populations and the health needs of the populace. Other testimony proposed limiting the number of U.S. medical school graduates (USMGs) per year. Additional discussion referenced the need for a national workforce plan that appropriately addresses specialty and geographic shortages. Testimony in opposition to the addition of the proposed second resolve focused on concerns that advocating for U.S. medical schools to limit class sizes could be construed as restraint of trade. Both the Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) have the authority to set standards for schools, but they must approve any school that meets those standards; they cannot arbitrarily prohibit the establishment of new schools. While medical schools may have a moral obligation to consider the issue of the narrowing gap between the number of USMGs and the number of residency positions, it is not a legal obligation.

This report: 1) provides an update on recent numbers of medical students, graduates, and residency positions; 2) summarizes recent residency applicant behavior and results in terms of matching into residency programs; 3) describes recent state and medical school efforts to expand GME positions; 4) describes the AMA's national SaveGME campaign; and 5) concludes with a discussion

concerning a changing GME environment, recommendations to help allay student concern about matching, and potential policy changes for medical schools to consider.

BACKGROUND

Concerns regarding the number of GME positions available to medical school graduates, known as post-graduate year 1 (PGY1) positions, have been increasing over the past several years.

In 2006, the Association of American Medical Colleges (AAMC) issued a call for expanding the number of medical school graduates, due to data suggesting an imminent physician shortage. The AAMC recommended a 30 percent increase (over 2002–2003 levels) in first-year medical school enrollment in LCME-accredited schools by the 2015–2016 academic year. Using the baseline of the 2002–2003 first-year enrollment (16,488 students), a 30 percent increase corresponds to an increase of 4,946 students. The AAMC forecast in 2017 that the 30 percent goal would be attained by 2017-2018 and exceeded in future years.[1] Osteopathic medical schools, which are accredited by COCA, also have grown in number and in the number of enrollees and graduates.[2] The number of LCME- and COCA-accredited schools, first year enrollment, and corresponding allopathic and osteopathic graduates is presented in Table 1, at the end of this report.

The rate of growth in the number of USMGs currently is greater than the rate of growth in PGY1 positions. Analysis of existing data and projections suggests there is still substantial room for placement of USMGs into GME, with an excess of 4,500 positions relative to graduates, as shown in the Figure at the end of this report.[3,4]

One analysis found that 99% of U.S. MD graduates ultimately do find careers in medicine.[5] The percent of U.S. MDs matching into PGY1 positions through the National Resident Matching Program (NRMP) has been consistently at 94% since at least 2008; only 500 to 600 U.S. MD graduates do not find a position through the NRMP's Supplemental Offer and Acceptance Program (SOAP), which assists in placing unmatched applicants into unfilled positions.[6] Other, infrequent opportunities exist post-SOAP for students to find positions in unfilled programs. Nonetheless, medical students continue to experience anxiety over the possibility of graduating from medical school without a training position, a necessary requirement for a clinical career in medicine.

Although there are more PGY1 positions than USMGs, it is important to consider that other physicians also are vying for these training opportunities. Approximately half of international medical school graduates (IMGs), either U.S. citizens (US IMGs) or foreign nationals (non-US IMGs) participating in the NRMP, successfully match. A much smaller proportion find positions through SOAP.

There are a number of reasons why USMGs do not match into PGY1 positions; the Council on Medical Education has written several recent reports on this topic (CME 3-A-16, "Addressing the Increasing Number of Unmatched Medical Students," and CME 5-A-17, "Options for Unmatched Medical Students"). One contributing factor is that not all positions are equally desirable to every applicant because of specialty and practice location preferences. For example, an average overall growth rate of two percent does not necessarily mean that there are enough positions in dermatology for all the applicants who wish to train in dermatology or wish to train in dermatology in the state of Georgia. The apprehension born of the perception of fewer available positions, often misreported in the popular press,[7] is coupled with a sense of increasing competitiveness, which may be caused in part by the increase in the number of DOs participating in the NRMP (in the 2013 Match, DOs made up 7.9 percent of matched applicants, versus 10.6 percent in 2017). The number of osteopathic students choosing to match into allopathic programs via the NRMP was increasing

even before the transition to the Single Accreditation System, through which the ACGME will accredit both allopathic and osteopathic programs. This increase will continue during the transition of osteopathic program positions into the NRMP, which will be completed in July 2020.

One of the unintended consequences of this perceived bottleneck is that residency applicants have increased their number of program applications in an attempt to improve the likelihood of receiving an invitation to interview and eventually secure a residency. Table 2, at the end of this report, provides the average number of program applications per applicant through the Electronic Residency Application Service (ERAS) and the average number of applications received by programs. An NRMP analysis of U.S. MD seniors participating in the 2017 Match in the 20 largest specialties found that MD seniors who ultimately successfully matched applied to a median number of 35 programs, resulting in a median number of 16 offered interviews. MD seniors who ultimately did not match applied to a median number of 54 programs, resulting in a median number of six offered interviews.[8] Data from the 2013 Match shows comparable numbers: successfully matched MD seniors applied to a median number of 29 programs, yielding 15 interview offers. Unmatched MD seniors applied to a median number of 50 programs, yielding seven interview offers.[9] These data suggest that simply applying to more programs does not necessarily result in more interview opportunities. In addition, analyses by the AAMC provide information on the point of diminishing returns in the number of applications sent by U.S. MD applicants, by USMLE Step 1 score and specialty.[10]

STATE AND MEDICAL SCHOOL EFFORTS

Recently, some individual schools, medical systems, and states have begun to address the discrepancy between rapidly expanding UME enrollment and GME expansion, often in tandem with efforts to meet the health care needs of local populations.

Texas

In 2017, the Texas state legislature passed Bill 1066, "Requirement to Plan GME Needs in Conjunction with Medical School Planning," which requires that all new public allopathic and osteopathic medical schools in the state provide to the Texas Higher Education Coordinating Board an assessment of the adequacy of the projected number of first-year residency positions that may be available for graduates of the new medical school. If a shortage is projected, the medical school will be required to submit a plan to increase the number of PGY1 positions in the state to reasonably accommodate the number of graduates from all MD and DO medical school programs in Texas and "provide adequate opportunity for those graduates to remain in the state for the clinical portion of their education." Submission of the assessment, and, if necessary, the plan to increase PGY1 positions, is a prerequisite for the board's approval of the medical school.[11]

Not only does this bill serve Texas's needs by ensuring UME expansion within the state is coupled with GME expansion, allowing newly graduated physicians the opportunity to remain in Texas for their training, but it also establishes a legislative strategy to assure UME expansion is coupled with corresponding GME expansion so that the newly admitted medical students have the theoretical opportunity to complete GME training in the state. It does not, however, address the expansion of already existing medical schools. The law also does not affect future planned private medical schools. In addition, although the plan must specify that there will be adequate PGY1 positions in the state, the proposed medical school itself is not required to sponsor the GME programs. The plan regards total state numbers, not type of program or location, and is not specific to an institution. If the state's total number of existing residency positions is expected to meet the needs of the total

number of medical school graduates, the medical school does not have to submit a plan for developing additional GME positions.

The Texas Medical Association (TMA) is working to address a loophole in the current law. New medical schools are required to submit a GME plan to demonstrate the projected availability of training positions for the total number of students in the inaugural class. Most schools, however, start with a relatively small number in the inaugural class, with plans to expand the class size after achieving full accreditation status. The result is that the full GME needs of their students are neither identified nor planned for from the beginning. The TMA will likely consider a proposed amendment that would stipulate that medical schools must submit a plan to meet the GME needs for the school's planned target class-size.

Kaiser Permanente

Kaiser Permanente, a large, integrated, population-based health care delivery system in the Western U.S., has been one of the largest private contributors to GME funding through its integrated residency programs. Kaiser currently hosts residency positions in five regions (Northern and Southern California, the Pacific Northwest, Colorado, and Hawaii). These collective programs support 900 full-time equivalents of residents in over 30 specialties. Residents in the Kaiser Permanente system are hosted primarily through Kaiser itself (600 residents), but affiliate programs also send residents to train within the Kaiser system for some duration of time. In total, 3,000 individuals per year rotate through the Kaiser system for training.[12] Kaiser has been very successful in retaining trainees following completion of residency training, with one-third to one-half of trainees staying and practicing in the Kaiser system. Savings on physician recruitment are then used to support Kaiser's resident complement.[13]

Following its success in establishing diverse and sustainable residency training positions, Kaiser is building a medical school in Southern California. The inaugural class of 2019 is expected to have 48 students, with a full complement of 192 enrolled by 2022. Initial plans for student education include early exposure to patients and integration into the robust network of clinical opportunities available within the Kaiser system.[14]

Local assistance

Creating a new GME program from scratch is a daunting process, but more information has become available about the process. Consultants with GME experience are available to assist. One institution recently published a plan for starting a new residency program, with step-by-step guidelines.[15] The state of Indiana has worked with at least two consultant groups to develop its plan to expand GME.[16]

SAVEGME CAMPAIGN

The AMA has long advocated for both the preservation of GME funding and additional monies to support future physician workforce needs, as noted in, for example, Council on Medical Education Report 5-A-16, "Accountability and Transparency in Graduate Medical Education Funding." The SaveGME website (savegme.org), originally oriented toward medical students and physicians, was revamped with a public-facing aspect in 2017. The revitalized website was then shared across social media platforms and various advocacy groups including the Patients Action Network and the Physicians Grassroots Network. This campaign emphasized the value of residents to patient care, including the provision of 40 percent of charity care nationwide as well as the importance of residency programs to innovations in health care delivery and patient safety initiatives. The new

website includes videos, statistics, demographics, and other material to support the SaveGME campaign. From March through October 2017, there were 78,827 visits to the SaveGME.org website and 1,816,821 video views. Social medial platforms proved useful in spreading the message, with over 12.5 million impressions on Facebook and Twitter. Over 2,300 letters were sent via the site to legislators by 720 individuals, representing a 16-fold increase compared to the year prior in communication to legislators.[17]

CURRENT AMA POLICY

Currently, the AMA has several policies or directives that concern the lack of appropriate growth in GME positions; these are listed in the Appendix.

SUMMARY

Without expansion in the number of PGY1 positions available to recently minted medical school graduates, eventually the number of USMGs seeking positions will exceed what is available. Lacking this expansion, some potential applicants likely will seek training elsewhere. Non-US IMGs, a group that long has trained in the U.S. and greatly added to the U.S. physician workforce in numbers and diversity, as well as specialty and geographic focus, may choose to train in other countries where there are more opportunities and fewer immigration barriers (CME Report 3-I-17, "Impact of Immigration Barriers on the Nation's Health"). The reduction in the size of one applicant pool likely will prolong the period during which there is increasing competition for positions, but still more available positions than USMGs. Despite this temporary reprieve, medical students perceive increasing competition and suffer anxiety engendered by the risk of graduating with substantial educational debt but without a residency position. Medical schools should increase their efforts to guide students concerning educational debt, specialty choice, and potential career paths, in order to better prepare students entering a physician workforce that may have constraints in its capacity to grow. In this context, and in anticipation of this country's future health care needs, efforts to expand UME without thoughtful provision of GME opportunities is careless at best and negligent at worst.

RECOMMENDATIONS

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of this report be filed.

1. That Policy D-305.967 (31), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

2. That our American Medical Association (AMA) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans. (Directive to Take Action)

3. That our AMA encourage legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates. (Directive to Take Action)

4. That our AMA encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion. (Directive to Take Action)

Fiscal note: $1,000.

TABLE 1. MEDICAL SCHOOLS, FIRST YEAR ENROLLMENT, GRADUATES, AND TRAINEES IN FIRST YEAR POSITIONS FOR ACADEMIC YEARS 2012-2013 THROUGH 2017-2018

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Number of allopathic medical schools†	136	140	141	142	145	147
Number of colleges of osteopathic medicine‡	26	29	29	30	36	48
MD 1st-Year Enrollment†	20048	20583	20608	21128	21396	21338*
DO 1st-Year Enrollment‡	5986	6636	7012	7219	7575	8113
MD Graduates†	18147	18057	18668	18820	19402¥	
DO Graduates‡	4806	4997	5323	5472	6038	
Total U.S. Graduates	22953	23054	23991	24292	25440	
Annual Graduate Growth Rate (%)		.44	4.06	1.25	4.72	
PGY1 Applicants Matched in NRMP∞	25246	25687	26252	26836	27688	29040
Residents in ACGME PGY1 Positions£	26018	26649	27122	27949	28658	
Annual ACGME PGY1 Growth Rate (%)		2.42	1.77	3.05	2.54	
Applicants Matched in NMS (Osteopathic Match)§	1891	2022	2135	2206	2162	1640
Annual Osteopathic Match Growth Rate (%)		6.93	5.59	3.32	-1.99	-24.14

† LCME database, includes schools with first year enrollment.

‡ AACOM data, includes branch campuses and remote teaching sites with first year enrollment: http://www.aacom.org/docs/default-source/data-and-trends/ApplEnrollGrad2011-2016.pdf?sfvrsn=39. Accessed December 21, 2017; http://www.aacom.org/docs/default-source/data-and-trends/2016-17_FYEnroll_Gender_RE_COM.pdf?sfvrsn=12. Accessed December 21, 2017; https://www.aacom.org/docs/default-source/data-and-trends/2017_fall_enrollment_report.pdf. Accessed December 21, 2017.

*AAMC matriculant data: https://www.aamc.org/download/321442/data/factstablea1.pdf 2017-2018. Accessed February 12, 2018. 1st year enrollment data include students repeating the first year, as opposed to matriculant data.

¥ LCME database; schools estimated the number of graduates in February 2017.

∞ National Resident Matching Program, Results and Data: 2017 Main Residency Match®. National Resident Matching Program, Washington, DC. 2017, and Advance Data Tables: 2018 Main Residency Match http://www.nrmp.org/main-residency-match-data/ Applicants match during the current academic year to become first year residents in the following academic year.

£ Brotherton SE, Etzel SI. Graduate Medical Education, 2016-2017. JAMA. 2017;318(23):2368–2387. doi:10.1001/jama.2017.16203

§ National Matching Service. May include those with prior training. Applicants match during the current academic year to become first year residents in the following academic year. https://natmatch.com/aoairp/aboutstats.html. Accessed February13, 2018.

TABLE 2. AVERAGE NUMBER OF APPLICATIONS THROUGH ERAS FOR ACADEMIC YEARS 2013-2014 THROUGH 2017-2018

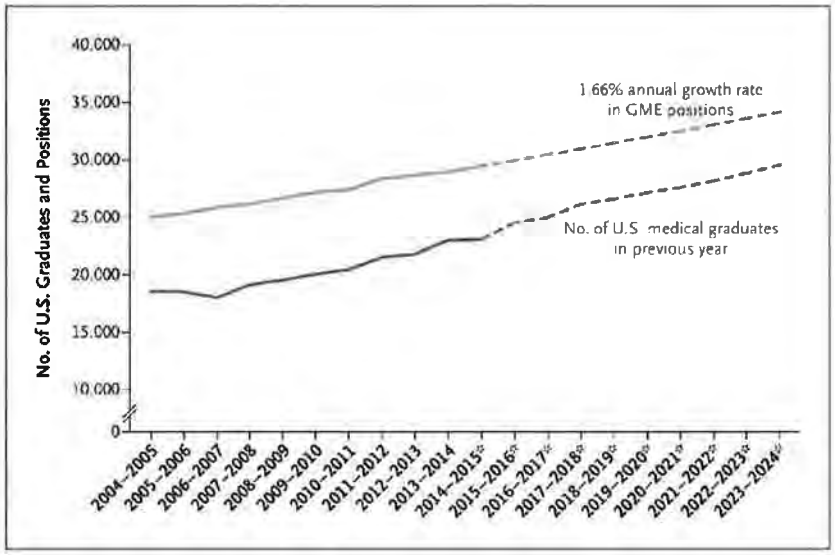
Average number of applications sent by applicant*	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018
USMG	43.8	47.2	49.3	55.0	58.0
IMG	113.4	119.1	123.1	131.5	135.5
All applicants	74.3	78.6	80.7	87.7	90.1
Average number of applications received by program**					
USMG	285.9	306.6	327.9	367.2	386.8
IMG	576.6	601.5	606.3	654.3	639.5
All applicants	862.2	907.8	933.9	1021.1	1025.7

*https://www.aamc.org/download/359232/data/all.pdf Accessed August 15, 2017. USMG includes U.S. MDs and DOs, of any graduating class.

**https://www.aamc.org/download/359236/data/all.pdf Accessed October 13, 2017. USMG includes U.S. MDs and DOs, of any graduating class.

FIGURE

Actual and Projected Growth in Numbers of U.S. Medical School Graduates and Graduate Medical Education (GME) Entrants, Based on 1.66% Annual Growth in GME Positions.



Mullan F et al. N Engl J Med 2016;373:2397-2399.

From the New England Journal of Medicine, Mullan F, Salsberg E, Weider K, Why a GME Squeeze Is Unlikely. Volume No. 373, Pages 2397-2399. Copyright 2018 Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society.

APPENDIX: RELEVANT AMA POLICY

D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"
Our AMA will: (3) Actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997); (4) Strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation; (8) Vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME; (15) Encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site; (17) Work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region; (18) Supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes; (26) Encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy"
Our AMA will: (2) Work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US; (3) Work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997; (4) Actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages; (5) Lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.

H-310.917, "Securing Funding for Graduate Medical Education"
Our AMA: (4) Encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

H-305.988, "Cost and Financing of Medical Education and Availability of First-Year Residency Positions"
Our AMA: (2) In studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future.

H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage"
Our AMA: (2) Encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

H-200.954, "US Physician Shortage"
Our AMA will: (8) Continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification; (9) Work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.

D-310.977, "National Resident Matching Program Reform"
Our AMA: (11) Will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs; (15) Encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.

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REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (A-18)
Evaluation of Clinical Documentation Training
(Reference Committee C)

EXECUTIVE SUMMARY

Widespread concern exists related to the quality of clinical documentation training provided to medical students and residents. American Medical Association (AMA) Policy D-295.314, "Study of Current Trends in Clinical Documentation," consequently directs our AMA to "study the effectiveness of current graduate and undergraduate education training processes on clinical documentation." A primary concern is that many medical students lack sufficient access to their training institution's electronic health record (EHR) system. Although the medical education community agrees that it is essential that students become familiar with clinical documentation and the EHR, some institutions restrict access to the EHR because of potential legal liability related to the risk of errors made by students' ability to copy and paste notes. Residents generally have adequate access to their institution's EHR, although there remain concerns about the adequacy of the clinical documentation training they receive. There are also concerns about the effects of the EHR on student- or resident-patient relationships, in that students or residents may be more engaged with the chart and computer than with the patient. In addition, students may receive poor role modeling from faculty, as well as from the entire care team, on appropriate use of and best practices for EHRs.

This report describes:

- Literature concerning the quality of clinical documentation and effects on patient care and safety, as well as reimbursement;
- Training and evaluation of training in incorporating the EHR into the physician/patient encounter in undergraduate and graduate medical education;
- Training and assessment of training of clinical documentation accuracy in undergraduate and graduate medical education; and
- Relevant work of the Accelerating Change in Medical Education Consortium.

A literature review on training for incorporation of the EHR into the physician/patient encounter and of the accuracy of clinical documentation in the EHR reveals that few published research studies are constructed to provide a useful evaluation of training results. Fewer studies provide a reflection upon the value and effectiveness of the training provided. It therefore is difficult to provide a conclusive summary of the most effective manner in which to train medical students and residents on the EHR. Confounding and uncontrollable circumstances are always a risk in evaluation of educational programs occurring in natural settings. Additionally, as many institutions and medical schools use their own clinical documentation systems or have modified an "off-the-shelf" system, results can be hard to generalize to other settings.

This report includes recommendations to encourage EHR training that includes feedback on the value and effectiveness of the training and that is demonstrated to be useful in clinical practice. In addition, the report recommends that professional development resources be made available to faculty to assure appropriate modeling of EHR use during physician/patient interactions.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-18

Subject: Evaluation of Clinical Documentation Training

Presented by: Lynne Kirk, MD, Chair

Referred to: Reference Committee C
(Sherri S. Baker, MD, Chair)

INTRODUCTION

American Medical Association (AMA) Policy D-295.314, "Study of Current Trends in Clinical Documentation," directs our AMA to "study the effectiveness of current graduate and undergraduate education training processes on clinical documentation."

This policy stemmed from Resolution 702-A-16, introduced by the Medical Student Section. Testimony before Reference Committee C during the Annual 2016 Meeting of the AMA House of Delegates highlighted the unprepared state of many medical school graduates for effective clinical note-taking, which could result in inaccurate notes and potentially negative patient outcomes. This report, which is in response to Policy D-295.314, will: 1) describe concerns about quality in clinical documentation and effects on patient care and safety, as well as reimbursement; 2) describe training and evaluation of training in incorporating the electronic health record into the physician/patient encounter in undergraduate and graduate medical education; 3) describe training and assessment of training of clinical documentation accuracy in undergraduate and graduate medical education; and 4) summarize relevant work of the Accelerating Change in Medical Education Consortium.

BACKGROUND

Concerns about clinical documentation proficiency of medical students and residents

There has been widespread concern about the quality of clinical documentation of physicians, focusing on the training provided medical students and residents. A primary concern is that many medical students lack sufficient access to their training institution's electronic health record (EHR) system. (Note: Much of the literature uses either the term electronic medical record or electronic health record. This report will use the term EHR for both terms.)

Medical students' inconsistent access to the EHR can result in students graduating without well-developed skills, forcing first-year residents to spend time familiarizing themselves with the EHR while they are learning to care for patients for the first time without direct supervision.[1] Although the medical education community agrees that it is essential for students to become familiar with documentation and the EHR, some institutions restrict access to the EHR because of potential legal liability related to the risk of errors made by students' ability to copy and paste notes in the EHR. In addition, the Centers for Medicare & Medicaid Services (CMS) has rules regarding the use of student documentation to support billing for services which, if not followed, can add potential legal liability.

To prevent institutions from running afoul of CMS rules, the Association of American Medical Colleges has recommended that EHR systems include rigorous controls to safeguard physicians from inadvertently copy/pasting a note created by a medical student, which would have been out of compliance with CMS payment regulations. Until recently, if a student documented an evaluation and management service (E/M), the teaching physician had to verify and re-document the physical examination and the medical decision-making activities of the services. The physician could only refer to a student's documentation related to the review of system and/or past/family and/or social history.[2] Beginning in March 2018, CMS "allows the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work." As CMS notes, however, "the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work."[3] While this update in policy may encourage some medical schools and clinical teaching sites to allow more medical students to access the EHR, institutions are advised, as a best practice, to "[i]nvest in provider education to create high-quality documentation with EHR tools."[4]

Students' use of copy and paste functions (CPF) in the EHR is widespread and has raised concerns about potential lapses in patient quality of care and medical ethics. Third-year medical students at one medical school were surveyed about their use of CPF in the EHR, as well as observations of other professionals using CPF. All students frequently used the EHR for documenting their patient notes. Although very few (10 percent) believed it acceptable to copy and paste from other providers' notes, 83 percent believed it acceptable to copy and paste from their own notes, 22 percent have copied from residents' notes, and 13 percent have copied from attendings' notes. Although using CPF is a common practice, 46 percent believed that notes written using CPF are less accurate than notes written without it, and 45 percent believed that CPF causes problems in patient care. Only 42 percent of students were aware of their school's policy concerning copy and paste (students are prohibited from copying others' notes, but are permitted to copy their own note from a previous day if it is altered to reflect the patient's current condition).[5]

Besides concerns about inappropriate use of CPF in the EHR by medical students, clerkship directors worry about the effect of the EHR on student-patient relationships, in that students are more engaged with the chart and computer than with the patient. In addition, students are receiving poor role modeling from faculty, as well as from the whole care team, on appropriate use of and best practices for EHRs.[6]

Similar concerns are also relevant when reviewing residents' use of the EHR. In a survey at a large integrated health system, program directors were questioned about their confidence in their first-year residents' abilities to perform 13 core entrustable professional activities (EPAs) six months into their first year of training. Overall, 62 percent of their residents were assessed. Confidence in the residents' ability to perform the activities without supervision ranged from 38 percent to 98 percent. Sixty-nine percent of first-year residents were considered to be able to perform EPA 4, "Enter and discuss orders and prescriptions," without supervision, while 98 percent were considered able to document a clinical encounter in the patient record without supervision.[7]

Although residents have been found to make fewer errors than attending physicians in the EHR, at least at the time of transition from paper to electronic documentation,[8] other research has pointed out the need for education in clinical documentation and coding practices for residents. A retrospective chart review in 2014 of surgery residents at one institution found 28 percent of the reviewed charts had inaccuracies in one or more of the following categories: admission diagnoses,

surgical diagnoses, in-hospital complications, or comorbidities. The average reimbursement of the charts with inaccuracies was $7,849 compared to $8,418 for the corrected versions, a 12.4 percent difference. The authors suggest that hospitals may incur significant loss in revenue due to errors in clinical documentation by residents and that educational training for surgical residents in clinical documentation and hospital-specific coding practices could prove financially advantageous.[9]

Published literature describing training in clinical documentation accuracy in the EHR and the use of the EHR and computers during the physician/patient encounter is relatively rare, especially given the concerns that clinical documentation inaccuracy and poor physician/patient interactions can affect patient care and safety.

TRAINING IN AND ASSESSMENT OF THE EHR IN THE PHYSICIAN/PATIENT ENCOUNTER

In 2012, the Alliance for Clinical Education, a consortium of clerkship directors across clinical disciplines, published guidelines for medical student documentation in the EHR.[10] These guidelines note the importance of students becoming competent in EHR use prior to graduation and acknowledged that such education is infrequent. The final guideline states that medical schools should develop competencies for charting in the EHR and state how these competencies would be evaluated. The guidelines lay out opportunities for EHR training throughout the curriculum, providing a framework for institutions developing such curriculum for their students. Wald and colleagues have also outlined curriculum objectives that could be incorporated into EHR training in undergraduate medical education.[11]

In 2014, Hersh and colleagues outlined competencies across the content of clinical informatics for medical education. These included several competencies related to EHR use, which they have begun implementing for their students at Oregon Health & Science University School of Medicine (OHSU), a member of the Accelerating Change in Medical Education Consortium.[12]

Overall, in both undergraduate and graduate medical education, there is broad support for increased education and training in the use of the EHR. Several expert groups have recommended specific objectives and competencies for such curricula. However, there are fewer reports of implementation of these curricula and assessment of their outcomes. Few studies have been conducted to examine the effectiveness of training in the use of the EHR in encounters between medical students/residents and patients. Often studies in educational environments lack the ability to control confounding factors; enroll enough participants; and include objective, third-party observers.

Assessment of training provided for medical students

OHSU has been one of the leaders in introducing medical students to the EHR as part of an objective structured clinical examination (OSCE). During the OSCE, the student interacts with a standardized patient (SP) and accesses a simulated EHR. The student's performance is evaluated by a faculty member either in the room or behind a two-way mirror. The EHR-OSCE assesses EHR skills rather than medical knowledge, which include not only what information is placed into the EHR but also the positioning of the computer/monitor throughout the examination.

The University of Texas Health Science Center at San Antonio (UTHSCSA) has adopted the OHSU EHR-OSCE. Although not designed to evaluate the effectiveness of EHR training, a paper comparing the performance of students of the two schools suggests that some differences in performance may be the result of the timing of the training. Students from UTHSCSA had better

overall performance compared to OHSU students. In particular, UTHSCSA students' performance improved over the course of the year, while OHSU students' EHR skills failed to improve as the year progressed. UTHSCSA students received didactic EHR training in the weeks immediately preceding the OSCE, while OHSU students received training up to 14 months prior to the OSCE. The authors of the study suggest that this intervening period at OHSU caused EHR skills to atrophy and also increased students' exposure to negative role-modeling while observing clinicians using the EHR.[13]

Han, Waters, and Loop designed a study to measure the effectiveness of an online self-study module for medical students and other health care professionals.[14] The module includes sections on education, computer placement, and provider-patient interactions in the presence of the EHR. The module emphasizes the potential of using the computer as a visual aid in patient education, along with appropriate placement of the computer to promote a positive open triadic position, and presents methods to maximize the provider-patient relationship while involving the patient in the EHR process. The researchers were able to use SP encounter videos of medical students before the introduction of the module into the second year curriculum as a pre-test and compared SP videos of students who completed the module. In addition, SP evaluations of the encounters were compared, and students were also reevaluated three months later. Students who had taken the module demonstrated better EHR communication skills compared to the pre-module students, SPs' evaluations were more positive, and three months later students had retained their skills.[14]

Educators at the University of Arizona College of Medicine - Phoenix assessed whether EHR ergonomics training enhances students' ability to use the EHR during SP encounters. They compared the performance of students in three groups, all of whom took a pre-survey on computer use: 1) students who received two hours of basic EHR training and had no EHR available during SP encounters; 2) students who received the EHR training and were expected to use the EHR available during SP encounters; and 3) students who received the EHR training, were expected to use the EHR during SP encounters and received additional ergonomic training. Ergonomic assessment data were collected from students, faculty, and SPs in each session. A post-survey was administered to all students, and data were compared across all three groups to assess the impact of EHR use and ergonomic training. The results revealed a significant positive effect for the third group, in that EHR use improved with EHR ergonomic training—specifically, those who had the ergonomic training felt that they were able to use the EHR more effectively to engage with the patient, better articulate the benefits of using the EHR, better address patient concerns, more appropriately position the EHR device, and more effectively integrate the EHR into the patient encounter.[15]

Assessment of training provided for residents

Fogarty, Winters, and Farah developed a workshop conducted with 139 residents and faculty supervisors on the challenges and opportunities of working with the EHR in practice, covering the introduction of patient-centered behaviors and presenting videos demonstrating common behaviors and improvements. Possibly exemplifying the difficulty of conducting research into educational innovations, only 39 of the 139 participants completed both the baseline and post-intervention assessment.[16]

In another study, a standardized, streamlined note template was added to the EHR at a free-standing children's hospital. Comparing the notes written in the EHR with the template to notes written during the same time period a year earlier, notes using the template were statistically shorter and trainees finished their notes later in the day, although there were no differences in the total amount of time to write notes (238 vs. 225 minutes, p=.32). Overall, the standardized note template was well-received by residents, despite some ambivalence about EHR functionality. As

another possible example of the difficulty of research in these settings, the authors point to an unexpected confounder of the study, i.e., more notes were written post-template implementation. This likely reflects an increase in the patient census and accompanying number of notes to be written without an increase in resident coverage.[17]

Other research looked at a family medicine residency program that developed a longitudinal primary care medical home (PCMH) case-based EHR curriculum. The EHR training was grounded in clinical cases, including a step-by-step breakdown of the PCMH clinic visit, and delivered throughout the three-year residency program; residents were scheduled for a three-hour training session each trimester, with an EHR self-assessment of six core skills taken at the end of each session. Researchers compared the self-assessments of residents who attended more training (eight or more sessions, average=nine) to those who attended fewer than eight (averaging 5.3 sessions). The results showed that low-exposed residents improved the most over time, and high-exposed residents reported overall higher post-test scores at training completion.[18]

In another study at a family medicine residency program, 36 residents volunteered for random assignment into either a simulation-based training program or a lecture-based training group, which covered tips on using the EHR (such as "reserve templates for documentation," "tell your patients what you're doing while you're doing it," "look at your patients," etc.). The study included a pre-test simulation of six SPs, a post-test simulation of another six SPs, and evaluation by physician observers and by SPs. No difference was found between the two groups. Both groups had improved in their use of the EHR as evaluated by physician observers and SPs, and the residents rated themselves as more competent in the post-training phase. The authors of the study postulate that the six pre-test simulated encounters provided a major training effect for volunteers motivated to learn. [19]

TRAINING IN AND ASSESSMENT OF CLINICAL DOCUMENTATION ACCURACY

Assessment of training provided for medical students

Although there are studies documenting students' use of the EHR and assessing accuracy, assessment of the training provided students is lacking or at least not available in the published literature. One study did make an interesting comparison of the level of accuracy in the EHR performance of 222 third-year medical students during their internal medicine clerkships and subsequent performance on their end-of-clerkship professionalism assessments versus their end-of-year gateway OSCE clinical skills scores for communication and history taking. Overall, 31 percent of students had one error in the EHR, and 13.5 percent had two to six errors. Most errors were in structured data entry. Error rate was correlated with poor performance as assessed at the end of clerkship. However, there was no assessment of the method by which the students learn the EHR, which was 15 online tutorials completed over 71 minutes.[20]

One study underscores the ability of medical students to accurately use the EHR in that it describes students as credentialed trainers at one academic health center that underwent a transition from one EHR system to another. Six selected medical students went through a six-week course that included instruction on adult learning theory, change management, and conflict resolution. They were assessed through written and oral examinations with the EHR vendor and institutional training leaders. The students then trained over 1,000 providers during a two-month time period. The trainers were given extremely high marks on the post-training survey, averaging 3.93 on a 4-point Likert scale for both mastery of material and communication skills (4 being excellent, 1 being poor). The authors noted that the institution saved considerable money using in-house trainers while providing the students a valuable financial and career opportunity.[21]

Assessment of training provided for residents

Researchers at OHSU assessed the 1.5-day training on its EHR system that internal medicine residents receive at the beginning of residency. Training included instruction on real-world task completion relevant to interns' clinical practice. One month after this training, interns participated in a dedicated exercise to test their ability to perform a set of 28 defined EHR use-related competencies with the OHSU simulation version of the EHR. All interns were found to have missed at least one safety issue, and overall there was wide variation in the amount and quality of data imported to generate notes. The researchers concluded that the results highlight the inadequacies of standard EHR training in the setting of advanced EHR use for data acquisition and documentation and noted that simulation may also help inform EHR redesign by reflecting accurate use patterns.[22]

An example of the difficulty of performing educational evaluation research in real-world settings is demonstrated by a study that attempted to compare the effect of two different interventions on the quality of EHR clinical documentation of internal medicine residents at two medical schools. The educational quality improvement intervention project did not improve the quality of clinical documentation. The authors noted that they were not able to combine the scores of residents at the two schools, leading to small sample sizes, and that one rater scored documentation much higher than other raters. Calibration did not occur beforehand.[23]

Although another study at OHSU was designed to assess whether EHR simulation improves EHR use in an ICU by comparing residents who went through the simulation once to those who participated twice, what occurred between the two sessions may account for much of the improvement found. Specifically, after residents were given the EHR of a case study:

> Participants … presented the case to a member of the study team and were graded on the number of patient safety issues identified. After the exercise, every participant underwent an immediate, standardized debriefing session on action items missed and received suggestions to improve their skills for EHR use. Beginning with the laboratory data, participants were shown the important trends in renal function and blood counts, as well as a tutorial regarding the graphing functions available. From there, assessment and evaluation of the medication administration report was completed, with discussion of appropriate dosing of medications and finding therapeutic drug monitoring assessments. This would be followed by reviewing vital signs, beginning with the most commonly used screen to assess vitals and using two other screens that display the same information in different contexts. Participants were shown possible customizability options and graphing functions within the vital signs pages as well as specific information found only in these screens. Next, participants would review ventilator data and discuss lung protective and low tidal volume ventilation, as well as how to assess appropriateness of an individual patient's ventilator settings. Volume status and intake/output reports were then viewed and specific issues surrounding volume status in ARDS were discussed. Finally, participants were given time to ask questions, re-review any functions of the EHR, and discuss any concerns regarding participation in the simulation exercise.[24]

Not surprisingly, given the thoroughness of the debriefing session, residents who then were presented a second case study, one to four weeks later, improved their rate of overall recognition of patient safety issues compared to the first case study (39.9 percent vs. 63.4 percent).

In another study, researchers designed an intervention bundle to improve pediatric resident progress notes written in an EHR and to establish the reliability of an audit tool used to evaluate notes (which is not typical of much of this type of research). The bundle consisted of establishing

note-writing guidelines, developing a note template, and educating residents about the guidelines and using the template. The residents received classroom teaching about best practices and instruction in use of the template. Raters were trained to score notes through practice sessions during which they all scored the same note and compared findings. Overall, improvement was mixed, with reduced vital sign clutter and other visual clutter within the note, but no significant reduction in input/output clutter, lab clutter, or inclusion of the medication list.[25]

Noting that much of clinical documentation training for medical students, residents, and practicing physicians lacks key constructs in self-efficacy, namely, vicarious learning (peer demonstration) and mastery (practice), researchers devised a study to improve clinical documentation quality that compared two different models of training.[26] One model, provided to internal medicine residents, used two components of self-efficacy: 1) social persuasion, e.g., emphasizing the importance of complete and accurate documentation for patient welfare and providing feedback to participants based on performance on a clinical documentation quality pretest as well as participation in the training session and 2) psychological/emotional states, e.g., discussing frustrations physicians have complying with increasing regulation, the monetary impact of incomplete or inaccurate documentation, and time management issues, as well as providing dinner as part of the training. The other model, administered to another group of residents, included two additional components of self-efficacy: 3) vicarious experience, e.g., video recordings of physicians discussing documentation, including solutions to problems, examples of good documentation shared, and experiences of documentation during the first training session (the pretest) were shared and discussed during the second session and 4) mastery experience, e.g., each participant had the opportunity to accurately and correctly document diagnoses in five problem areas from 10 sample records. This study used sophisticated data analysis and concluded that training using all four components of self-efficacy showed substantially greater positive impact on improved clinical documentation and self-efficacy compared to the two-component training. This study was not using, it appears, an EHR as part of the training, but the training model could be modified to those systems and likely is currently in use.

WORK OF THE ACCELERATING CHANGE IN MEDICAL EDUCATION CONSORTIUM

To help fill gaps in medical education and as part of its larger strategic focus to improve the nation's health, the AMA launched the "Accelerating Change in Medical Education" initiative in 2013. After awarding initial grants to 11 medical schools from across the country, the AMA brought these schools together to form the AMA Accelerating Change in Medical Education Consortium—a unique, innovative collaborative that allowed for the sharing and dissemination of groundbreaking ideas and projects. In 2016 the AMA awarded grants to another 21 schools. Today, the 32-member consortium, which represents almost one-fifth of allopathic and osteopathic medical schools, is delivering forward-thinking educational experiences to approximately 19,000 medical students—students who will provide care to a potential 33 million patients annually. As consortium members continue to implement bold ideas and demonstrate a deep commitment to creating the medical schools of the future, their solutions are being disseminated to the greater academic community. These pioneering efforts are facilitating the widespread adoption of new ideas. A number of schools in the consortium have taken the lead in finding new and inventive approaches to instructing students on the use of EHRs.

New York University School of Medicine (NYU), for example, has recently fully integrated teaching note-writing into its pre-clerkship "doctoring" course. What had initially been taught at the end of the course is now taught alongside other subjects, e.g., communication skills, cultural competency, clinical reasoning, and so forth. During the first week of school, first-year students begin writing notes with actual patients. At the end of each clerkship, clinical note-writing is now

included in the OSCE. Although there has been no formal evaluation, integration of note-writing into the pre-clerkship syllabus has enhanced note-writing performance in the clerkship phase of training and on the comprehensive clinical skills exam at the end of clerkships. (Ruth Crowe, MD, PhD, assistant professor, NYU Department of Medicine, personal communication).

Recognizing that many medical students are starting residency without the experience of working effectively with EHRs, the Indiana University School of Medicine and the Regenstrief Institute (RI) developed the Regenstrief EHR Clinical Learning Platform as part of the AMA's "Accelerating Change in Medical Education" initiative. This virtual EHR was developed to ensure medical students and other health care trainees gain real-world experience using EHRs during their training. It includes over 11,000 real, pseudonymized patient records. Learners can search and access patient data, document patient encounters, enter individual/unique actions, see actions entered across practice settings, receive alerts, place orders, and pull logs and reports.[27]

The platform is currently in use in six medical schools/medical education programs. Schools are able to control the type of content students can access, as well as how students use the information in the platform. Some schools grade students on their ability to use the system. Although the platform was not designed to instruct students on how to write a patient note, correct documentation can be taught depending upon how a particular course adopts the platform into its curriculum. The RI team is evaluating machine learning and natural language understanding technology for the evaluation of student documentation. The first phase of this study employs supervised machine learning techniques to hopefully classify notes into good, bad, and mediocre sets. If this first phase is successful, the intent of subsequent studies will be to create automated and meaningful student documentation evaluation. (Blaine Takesue, MD, Research Scientist, Regenstrief Institute, and assistant professor of clinical informatics, Indiana University School of Medicine, personal communication)

RELEVANT AMA POLICY

Policy H-310.953, "Practice Options and Skills Curriculum for Residents," directs our AMA to "assist medical societies and residency programs in the development of model curricula for resident physicians and those entering practice regarding practice options and management skills, including information on CPT and ICD coding."

Policy H-315.969, "Medical Student Access to Electronic Health Records," states that our AMA: "(1) recognizes the educational benefits of medical student access to electronic health record (EHR) systems as part of their clinical training; (2) encourages medical schools, teaching hospitals, and physicians practices used for clinical education to utilize clinical information systems that permit students to both read and enter information into the EHR, as an important part of the patient care team contributing clinically relevant information; (3) encourages research on and the dissemination of available information about ways to overcome barriers and facilitate appropriate medical student access to EHRs and advocate to the Electronic Health Record Vendors Association that all Electronic Health Record vendors incorporate appropriate medical student access to EHRs; (4) supports medical student acquisition of hands-on experience in documenting patient encounters and entering clinical orders into patients' electronic health records (EHRs), with appropriate supervision, as was the case with paper charting; (5) (A) will research the key elements recommended for an educational Electronic Health Record (EHR) platform; and (B) based on the research--including the outcomes from the Accelerating Change in Medical Education initiatives to integrate EHR-based instruction and assessment into undergraduate medical education--determine the characteristics of an ideal software system that should be incorporated for use in clinical settings at medical schools and teaching hospitals that offer EHR educational programs; (6)

encourage efforts to incorporate EHR training into undergraduate medical education, including the technical and ethical aspects of their use, under the appropriate level of supervision; and (7) will work with the Liaison Committee for Medical Education (LCME), AOA Commission on Osteopathic College Accreditation (COCA) and the Accreditation Council for Graduate Medical Education (ACGME) to encourage the nation's medical schools and residency and fellowship training programs to teach students and trainees effective methods of utilizing electronic devices in the exam room and at the bedside to enhance rather than impede the physician-patient relationship and improve patient care."

SUMMARY AND RECOMMENDATIONS

A review of the published literature on training in incorporating the EHR into the physician/patient encounter, and in the accuracy of clinical documentation in the EHR, reveals that few published research studies are constructed so that they can provide a useful evaluation of the results of the training. Fewer studies provide a reflection upon the value and effectiveness of the training provided. Assessments and comparisons are made and likely future revisions are planned for the training programs, but that is not shared. It is therefore difficult to provide a conclusive summary of the most effective manner in which to train medical students and residents on the EHR. Confounding and uncontrollable circumstances are always a risk in evaluation of educational programs in the "real world." In addition, as many institutions and medical schools use their own clinical documentation systems or have modified an "off-the-shelf" system, results can be hard to generalize to other settings.

Some general observations can be made, however:

1. Any training should provide students, residents, and physicians with institutional policy regarding copy and paste functions or any other functions that have local guidelines.

2. Ergonomic training in the use and placement of a computer during the physician/patient encounter can be effective and should not be neglected.

3. Basic study methodology should always be considered: Use theory to develop hypotheses, guide the research, and organize the data analysis. Timing can affect evaluation results; without practice, newly acquired skills will atrophy. Pre-test sessions are a form of training—the more provided, the greater the risk in seeing no differences between study groups. Small sample sizes and poor training of evaluators can lead to inconclusive findings. Incentives should be designed to reduce drop out of learners for post-training assessment. Employing only one measure of evaluation is inadequate. Evaluation should include more than trainees' self-assessment; standardized patients and trained observers should also provide feedback. Expect volunteers in studies to be motivated to learn, whether in the control or intervention group. Be prepared to use post-hoc study controls, in case uncontrollable extraneous events affect results.

4. Studies utilizing simulation, OSCEs, standardized patients, one-on-one training, and a more "hands on" approach as part of the intervention generally appear to have better results. While peer instruction is important, the more opportunities trainees have to use the system themselves and receive immediate feedback, the better.

5. Publishing information on what does not work is just as helpful as providing information on what does work. Programs should use study results to "close the loop," i.e., act on the results and make ongoing improvements.

The Council on Medical Education therefore recommends the following recommendations be adopted and the remainder of this report be filed.

1. That Policy D-295.314, "Study of Current Trends in Clinical Documentation," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

2. That our American Medical Association (AMA) encourage medical schools and residency programs to design clinical documentation and electronic health records (EHR) training that provides evaluative feedback regarding the value and effectiveness of the training, and, where necessary, make modifications to improve the training. (Directive to Take Action)

3. That our AMA encourage medical schools and residency programs to provide clinical documentation and EHR training that can be evaluated and demonstrated as useful in clinical practice. (Directive to Take Action)

4. That our AMA encourage medical schools and residency programs to provide EHR professional development resources for faculty to assure appropriate modeling of EHR use during physician/patient interactions. (Directive to Take Action)

Fiscal Note: $1,000.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-18

Subject: Study of Declining Native American Medical Student Enrollment

Presented by: Lynne Kirk, MD, Chair

American Medical Association (AMA) Policy D-200.985 (5), "Strategies for Enhancing Diversity in the Physician Workforce," reads as follows:

> 5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

This section of the policy was appended through Resolution 313-A-17, "Study of Declining Native American Medical Student Enrollment," which was introduced by the AMA Minority Affairs Section at the 2017 Annual Meeting of the AMA House of Delegates (HOD).

Testimony before Reference Committee C during the meeting reflected limited but supportive testimony on this item focused on the need for increased diversity of the physician workforce to support access to patient care among underserved populations. It was noted that existing AMA policy on diversity dovetails with the intent of this resolution, and that the decline in the number of Native Americans entering medical school is worrisome and may hold future negative ramifications for access to care. Accordingly, Reference Committee C recommended adoption of Resolution 313 to the HOD, and the HOD accepted this recommendation. This report is in response to this policy.

BACKGROUND

The concern regarding Native American student enrollment and the Native American physician workforce is supported by Native American population health outcomes data, Native American health care accessibility data, student enrollment data, workforce data, and the quest for a culturally diverse and culturally competent physician workforce able to meet the health care needs of people from all ethnic backgrounds. The estimated 5.2 million American Indians and Alaska Natives (AI/ANs) living in the U.S. have long experienced lower health status when compared with other Americans. Between 1999 and 2014, premature mortality rates increased for AI/AN populations, while decreasing for blacks, Hispanics, Asians, and Pacific Islanders during the same period. The rates are particularly high for young adult AI/AN individuals. Lack of access to health care and mental health resources is believed to be a causative factor.[1] Lower life expectancy and a disproportionate disease burden exist for a variety of reasons, including inadequate education, lack of economic development and investment, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions. Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of AI/AN deaths (2008-2010). AI/AN

individuals born today have a life expectancy 4.4 years shorter than the U.S. population as a whole[2] and seven years shorter than non-Hispanic whites.[3] In a 2016 U.S. Government Accountability Office report to Congress, difficulties in filling health care provider vacancies and long wait times for primary care appointments were noted to be contributing factors to the health care disparities facing AI/ANs.[4] A survey by the Harvard School of Public Health found that 23% of AI/ANs surveyed experienced discrimination when seeking health care, and 15% avoided seeking healthcare for themselves or their family because of concern that they would be discriminated against.[5]

The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, states there is "ample opportunity—and pressing need—for physicians practicing a wide range of specializations." The IHS website lists numerous job openings across multiple medical specialties and geographic locations.[6] Federal law requires that absolute preference be given to AI/AN applicants. Out of the total active MD workforce (approximately 850,000) in the U.S., 0.4% (3,400) are self-identified as AI/AN.[7]

In addition to the positive impact on the educational environment through, for example—(1) cultural competence in care delivery; (2) intellectual benefits; and (3) interpersonal benefits for patients, learners and faculty[8]— increasing AI/AN medical school enrollment would translate into an increase in the AI/AN physician workforce. A workforce increase of this nature could positively impact AI/AN population health and improve access to physician services. A report from the Health Resources and Services Administration on physician workforce characteristics found that minority physicians have a greater propensity to practice in physician shortage areas (although the report did not specifically address AI/AN physicians or the AI/AN population).[9] Another review on this subject concluded that underrepresented minority health professionals have been consistently more likely to deliver health care to the underserved; this study did include AI/AN providers but did not specifically address AI/AN physicians in the findings or conclusions.[10] There are few conclusive data demonstrating that increasing the number of AI/AN medical students (and ultimately AI/AN physicians) would result in increased numbers of physicians who serve AI/AN communities. A literature search uncovered only one study, published in 1989, which concluded that most AI/AN physicians, while residing in areas with significant AI/AN populations, were primarily serving non-AI/AN patient populations.[11] Collecting data on AI/AN physician practice patterns has proven difficult for a number of reasons, including the organization of providers to serve AI/AN needs. The Indian Self Determination and Education Assistance Act, also known as Public Law 93-638, allows the IHS to provide funds directly to tribes for administration and delivery of health services.[12] An unintended consequence of this law has been to make collection of provider data difficult. A comprehensive study is currently underway to determine the practice setting and populations served by AI/AN physicians (personal communication with the study author, Siobhan Wescott, February 22, 2018).

When considering the available information on this topic, it is important to note that most data on AI/AN medical student enrollment and the physician workforce rely on an individual's self-identification as American Indian, Native American, or Alaska Native. There is no established definition of AI/AN. The U.S. government relies on each of the 567 recognized tribes to set the standards for inclusion as a member of the tribe and official status of AI/AN or Native American.[13] Inconsistency in criteria for recognition of AI/AN status may result in inaccuracies and inconsistencies in data. Some data sources also allow individuals to self-identify as "multiple race/ethnicity," which may lead to underreporting of AI/AN data.

MEDICAL SCHOOL ENROLLMENT OF AI/AN STUDENTS

Among the ethnic groups traditionally considered to be underrepresented in medicine, AI/AN ethnicity is the least represented among U.S. allopathic medical students. Data from the Association of American Medical Colleges (AAMC) show that in 2016 a total of 20 schools reported at least one applicant who self-identified as AI/AN. The percentage of AI/AN applicants to these schools ranged from 0.9% to 3.8% of the total applicant pool. AAMC enrollment data for academic year 2016-17 show that 223 students, or 0.25% of the total allopathic medical school enrollees, self-identified as AI/AN. The majority of these students were enrolled in medical schools in Oklahoma (20), New Mexico (17), Minnesota (17), Texas (16), North Dakota (15), and Arizona (10). For the allopathic medical school graduating class of 2016, 31 individuals, or 0.16%, self-identified as AI/AN.[14] Since 2002, the number of AI/AN applicants and matriculants to allopathic medical schools has been relatively consistent, despite the increase in the overall number of applicants and enrollees.

Data for osteopathic medical schools show that in 2016, a total of 51 applicants, or 0.3%, self-identified as AI/AN. Over the last 15 years, the number of AI/AN applicants to osteopathic schools has remained relatively constant (between 38 to 69 annually). Nine AI/AN students, or 0.1% of the total enrollee pool, matriculated into osteopathic schools in 2016. Data were not available for AI/AN enrollment in individual osteopathic medical schools in 2016, but the greatest numbers of applications were to schools located in Arizona (31), Pennsylvania (32) and Oklahoma (29).[15] These data likely include students who applied to multiple programs.

Data regarding allopathic and osteopathic AI/AN applicants and enrollment are shown in the table at the end of this report. There are no data on the number of AI/AN applicants who applied to both allopathic and osteopathic programs. Of note, while both the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation have standards requiring medical schools to achieve diversity in enrollment, the standards do not specify what groups the schools must include in their respective definitions of diversity and efforts to achieve diversity outcomes.[16] [17]

Although the absolute numbers of applicants and matriculants, albeit small, have remained relatively constant over the last 15 years, the growth in total medical school applications and enrollment has resulted in a declining percentage of AI/AN applicants and matriculating students. This has occurred despite the emphasis on increasing diversity in matriculants to medical school and the physician workforce; an acceptance rate for AI/AN (44.9%) that exceeds all other racial and ethnic groups, including whites; and increases in the applicant and matriculation rates for other groups traditionally identified as underrepresented in medicine.[18] These data indicate that efforts to recruit AI/AN students to enter health professions education are inadequate.

MEDICAL SCHOOL AND HEALTH PROFESSIONS PROGRAMS TO SUPPORT AI/AN ENTRY INTO HEALTH CARE CAREERS

The relative decline in AI/AN applicants and matriculants has occurred despite focused efforts by institutions in states with large AI/AN populations. Several medical schools, alone or in collaboration with other schools, have implemented programs to encourage and support AI/AN students into the health professions.

For example, the North Dakota School of Medicine and Health Sciences has developed the Indians Into Medicine Program (INMED™), a comprehensive program designed to assist American Indian students who aspire to be health professionals and to meet the needs of tribal communities.

Established in 1973, the program aims to address three major problems: 1) too few health professionals in AI communities, 2) too few AI health professionals, and 3) the substandard level of health and health care in AI communities. INMED support services include academic and personal counseling for students, assistance with financial aid applications, and summer enrichment sessions at the junior high through professional school levels. Each year, more than 100 AI students attend INMED's annual summer enrichment sessions at the junior high, high school, and medical preparatory levels. These summer programs bolster participants' math and science backgrounds and introduce them to health careers.[19]

The state of Oklahoma is home to two medical schools as well as a significant AI population. The University of Oklahoma supports a summer enrichment program which aims to identify and support minority students, including AI students, who aspire to enter medical school.[20] In 2014 the Oklahoma State University Center for Health Sciences, which houses the Oklahoma State University College of Osteopathic Medicine (OSUCOM), launched an Office for the Advancement of American Indians in Medicine and Science (OAAIMS) to recruit more American Indian high school and college students into medicine and science careers. Through mentoring and targeted programs, the initiative aims to increase the number of American Indians practicing medicine and working in the science fields. Ultimately, efforts made by the OAAIMS are intended to provide Native American students the means to be successful in these fields by offering hands-on experiences that combine Native culture, medicine, and science.[21] Programs include a culturally-based scientific expedition experience for high school students, residential camps with simulation exercises, and a number of outreach programs on-site with tribal partnerships. These focused efforts have been effective, as OSUCOM's latest incoming class of 2017 included 17 students who self-identified as AI/AN.[22]

The University of Minnesota Medical School (UMMS) founded its Duluth campus in 1972 specifically for the purpose of serving the needs of rural Minnesota and Native American communities and to be a national leader in improving health care access and outcomes in rural Minnesota and AI/AN communities. The UMMS also launched the Center for American Indian and Minority Health in 1987.[23] The purpose of the Center is to raise the health status of American Indians and Alaska Natives by: 1) recruiting and educating Native American medical students, 2) increasing awareness of American Indian health care issues, and 3) conducting research that serves the health interests of Native American communities.

Five medical schools in the southwest—the Universities of Arizona (Phoenix and Tucson), Colorado, New Mexico, and Utah—identified a collective need to increase student diversity, particularly with regard to AI/AN students. These five schools created the "4 Corners Alliance," and, in collaboration with the Association of American Indian Physicians, invite pre-med/health American Indian students to a free two-day Pre-Admissions Workshop (PAW) annually. The PAW aims to provide students with the information and skills necessary to succeed in the medical and health professions school admission process.[24]

Medical schools also have developed programs to address AI/AN health. For example, the University of Washington School of Medicine offers an Indian Health Pathways Certificate Program for medical students. The program's goals are to: 1) prepare both native and non-native medical students for careers in AI/AN health, 2) encourage research on AI/AN health issues, and 3) enhance curriculum on AI/AN health issues at the University of Washington School of Medicine.[25]

On a national level, the IHS supports AI/AN entry into the health professions and opportunities to explore career paths in AI/AN health care. Scholarships are available through the IHS Scholarship program, which has awarded more than 7,000 health professions scholarships since 1978. The IHS

website provides links to allow potential students to arrange IHS externships (with salary), and to coordinate AI/AN clerkship opportunities for medical students. In addition, post-graduation financial support is available through the IHS, with a loan repayment program of $20,000 per year of commitment (maximum $40,000) for health professions education loans, as well as a supplemental loan repayment program. The IHS also participates in the National Health Service Corps loan repayment program, with awards up to $50,000 for a two-year commitment.[26]

The University of Wisconsin, in collaboration with tribal organizations in Wisconsin and the Great Lakes Region, supports an outreach program, We are Healers, which aims to inspire AI youth to envision themselves as health professionals through stories of Native role models.[27]

Two organizations specifically provide support for AI/AN students aspiring to become physicians: the Association of American Indian Physicians (AAIP) and the Association of Native American Medical Students (ANAMS). The AAIP, whose mission includes promoting education in the medical disciplines, supports workshops, summer programs, scholarship programs, internships, and fellowships aimed at increasing the number of AI/AN students entering the health professions.[28] The ANAMS, whose mission is to assist with the recruitment, retention, and support of AI/AN students into medicine and other health careers, provides information on a number of scholarship opportunities available to AI/AN students.[29]

The causes of the declining percentages of applicants and matriculants are not clear, but in part may be explained by the pre-secondary education success of and college education opportunities for AI/AN students. AI/AN students have the highest high school dropout rates among all racial and ethnic groups tracked by the National Center for Educational Statistics (NCES).[30] Additionally, the college enrollment rate (23%) for AI/AN 18- to 24-year-olds is the lowest of all ethnic and racial groups tracked by the NCES.[31]A recent survey of AI/ANs found that for almost half of respondents, college attendance was never discussed during adolescence and young adulthood.[3] Overall, the AI/AN college graduation rate of 9.3% is well below the national average of 20.3%. The relative ineffectiveness of health professions pipeline programs for AI/AN has been described in the literature, possibly attributable to less rigor in primary and secondary education in science and mathematics.[32]

RELEVANT AMA POLICY AND ACTIVITIES

A list of relevant AMA policies on this issue is shown in the appendix. These include:

- D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"
- H-350.970, "Diversity in Medical Education"
- H-350.979, "Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession"
- H-350.960, "Underrepresented Student Access to US Medical Schools"

Aside from policy, since 2002 the AMA has supported the Doctors Back to School™ (DBTS), designed by the AMA Minority Affairs Consortium (today the Minority Affairs Section, or MAS) to highlight the need to expand the pipeline of underrepresented minorities (i.e., black, Latino, Native American) in medicine and eliminate minority health disparities. Through DBTS, physicians and medical students return to their communities to 1) pique young minority students' interest in medicine by introducing them to "real-life" role models and 2) raise awareness of the need for more underrepresented minorities in the physician workforce. To date, DBTS has engaged more than 100,000 underrepresented minority youth. To expand the reach of the program and

number of volunteers, the MAS has developed partnerships with other AMA sections (e.g., Medical Student Section); medical societies/associations (e.g., American Society of Anesthesiologists; Association of American Medical Colleges); coalitions (e.g., Commission to End Health Care Disparities); nonprofit organizations (e.g., National Minority Quality Forum), and diversity pipeline programs in medicine (e.g., Tour for Diversity; Mentoring in Medicine).

Each year, the MAS also partners with the AMA Foundation's Physicians of Tomorrow scholarship program to offer the Minority Scholars Award to underrepresented minority medical students, with $10,000 awards toward their tuition expenses. Up to two students can be nominated by each medical school dean. In recent years, awards have been disbursed to 20-25 recipients annually. Since the inception of the program in 2004, 11 recipients have self-identified as Native Alaskans.

SUMMARY

Despite the current level of support, outreach, and pipeline programs as noted above, the number of AI/AN applicants/matriculants to medical schools remains quite low and essentially unchanged over the last 15 years, even as the total enrollment in U.S. medical schools has markedly increased.

Although AI/AN students who are able to succeed in pre-medical training have ample opportunity and high rates of success in gaining entry into medical schools, the current primary and secondary education infrastructure and socioeconomic factors for AI/AN students may be inadequate to promote successful entry in larger numbers into college-level education. While health professions pipeline programs to promote AI/AN entry are in place at a number of institutions, and these programs are showing success at the local level to promote medicine as a career path for AI/AN students, they are limited in size and scope and have not been successful to date in increasing AI/AN diversity in overall medical school enrollment or the physician workforce. Future initiatives might benefit from focused efforts to improve preparation of AI/AN students for entry into post-secondary education, particularly in the areas of science and mathematics.

TABLE: AI/AN APPLICANTS AND ENROLLMENT AT U.S. ALLOPATHIC AND OSTEOPATHIC MEDICAL SCHOOLS

Year	Allopathic medical schools			Osteopathic medical schools		
	AI/AN applicants	AI/AN matriculants	Total matriculants	AI/AN applicants	AI/AN matriculants	Total matriculants
16-17	127	54	21,025	54	21	7,575
15-16	115	55	20,627	30	20	7,219
14-15	117	53	20,343	39	26	7,012
13-14	110	43	20,055	38	30	6,636
12-13	108	52	19,517	46	32	5,986
11-12	101	46	19,230	40	27	5,788
10-11	114	55	18,665	40	32	5,428
09-10	111	51	18,390	43	23	5,227
08-09	131	66	18,036	51	39	4,950
07-08	152	67	17,759	59	34	4,528
06-07	147	70	17,880*	63	22	4,055
05-06	95	38	17,435*	59	22	3,908
04-05	107	53	17,109*	63	28	3,646
03-04	85	38	17,118*	60	18	3,308
02-03	112	56	16,488	55	26	3,079

Allopathic data extracted from data tables found on the AAMC website, unless otherwise noted.

Osteopathic data extracted from data tables found on the AACOM website.

* Data from Barzansky B, Etzel S. Medical Schools in the United States, *JAMA* annual data publications. Data are for first year enrollment, not matriculants.

APPENDIX: RELEVANT AMA POLICY

D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.
6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
(CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17)

H-350.970, "Diversity in Medical Education"
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide

education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion. (BOT Rep. 15, A-99 Reaffirmed: CME Rep. 2, A-09 Reaffirmed in lieu of Res. 311, A-15)

H-350.979, "Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession"
Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and pre-collegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.
(CLRPD Rep. 3, I-98 Reaffirmed: CLRPD Rep. 1, A-08)

H-350.960, "Underrepresented Student Access to US Medical Schools"
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students. (Res. 908, I-08 Reaffirmed in lieu of Res. 311, A-15)

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REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-18)
Mental Health Disclosures on Physician Licensing Applications
(Resolution 301-A-17, Resolve 3)
(Reference Committee C)

EXECUTIVE SUMMARY

Concern is growing among the profession and the public about physician and medical student depression, burnout, and suicide. Resolution 301-A-17, Resolve 3, "Mental Health Disclosures on Physician Licensing Applications," introduced by the Resident and Fellow Section and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to amend Policy H-275.970, "Licensure Confidentiality," to address this concern. The AMA has expressed strong support of physical and mental health care services for medical students and physicians, but there is a long-standing and deeply ingrained stigma endured by physicians seeking care for either physical or mental health issues, partly due to concerns of career and licensure implications. In addition to concern related to stigma, which is linked to deterred or deferred care seeking, there is a lack of understanding of impairment vs. illness.

This report considers concerns that have been raised about the presence and phrasing of questions on licensing applications related to current or past impairment. These questions may be discouraging physicians from seeking appropriate treatment because of fear of stigmatization, public disclosure, and the effect on one's job due to licensing or credentialing concerns. Many medical and osteopathic licensing boards recognize that the manner in which they evaluate the fitness of potential licensees has the potential to create a barrier that prevents licensees from seeking help. Some state boards, such as the Oregon and Washington State Medical Boards, have taken steps to address these barriers. In addition, the Federation of State Medical Boards has established a Workgroup on Physician Wellness and Burnout. The workgroup is confronting the barriers physicians face in seeking treatment for symptoms of burnout related to the presence and phrasing of questions on licensing applications about mental health, substance abuse, and leave from practice. The workgroup is also seeking to draw an important distinction between physician "illness" and "impairment" as well as determine whether it is necessary for the medical boards to include probing questions about a physician applicant's mental health on licensing applications in the interests of patient safety.

This report comprises:

- A review of the current licensure application process.
- Research that describes why some physicians may be discouraged from seeking treatment for mental health conditions.
- An interpretation and definition of "psychiatric conditions" and "impairment."
- A summary of physician health programs' reporting requirements.
- A summary of actions being taken at the national and state levels to evaluate physician wellness and burnout as well as confidentiality about seeking treatment for mental health conditions.
- A review of AMA policy on this topic.
- Proposed recommendations to current AMA policy to strengthen and streamline the AMA's position on this important topic.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-18

Subject: Mental Health Disclosures on Physician Licensing Applications (Resolution 301-A-17, Resolve 3)

Presented by: Lynne M. Kirk, MD, Chair

Referred to: Reference Committee C (Sherri S. Baker MD, Chair)

Resolution 301-A-17, Resolve 3, "Mental Health Disclosures on Physician Licensing Applications," introduced by the Resident and Fellow Section and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to amend Policy H-275.970, "Licensure Confidentiality," by addition and deletion to read as follows:

> H-275.970, "Licensure Confidentiality"
> The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician's practice of medicine or presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~ (Modify Current HOD Policy)

At the Annual 2017 Meeting of the AMA HOD, Reference Committee C heard supportive testimony on this item from a wide variety of stakeholders, reflecting growing concern among the profession and the public related to physician and medical student depression, burnout, and suicide. The AMA has expressed strong support of physical and mental health care services for medical students and physicians. Council on Medical Education Report 1-I-16, "Access to Confidential Health Services for Medical Students and Physicians,"[1] addressed the long-standing and deeply ingrained stigma endured by physicians seeking care for physical or mental health issues, partly due to concerns of career and licensure implications. Despite several existing HOD policies that support this request, testimony reflected additional concerns related to stigma, deterred or deferred care seeking, and the belief that there is a lack of understanding of impairment vs. illness. For these reasons, the HOD recommended that Resolution 301, Resolve 3, be referred for further study.

BACKGROUND

The role of state medical and osteopathic boards and patient safety

Medical and osteopathic licensing boards are state governmental agencies responsible for granting licenses to physicians to practice in the state. The primary responsibility of the boards is to determine that physicians are maintaining and advancing their knowledge and skills and providing quality patient care. Boards are also responsible for protecting the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine.[2] The boards do so by obtaining sufficient physician information to conduct rigorous and thorough application reviews before the practice of medicine is permitted.

The current licensure application processes

State medical licensing boards have traditionally made wide-ranging inquiries into applicants' past psychiatric histories as part of the application process.[3] Although the passage of the Americans with Disabilities Act (ADA) in 1990 raised serious doubts about the legality of these inquiries, the boards have been reluctant to abandon them, even though the American Bar Association and the American Psychiatric Association (APA) have since issued statements disapproving them.[3, 4]

Most initial and renewal medical licensure application forms include questions about mental health diagnoses or treatment, but there is substantial variation in reporting requirements among the boards.[5] For example, while some applications inquire only about current (within the previous 12 months) impairment from a medical or mental health condition (e.g., "Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?"), others include questions about current or past diagnosis or treatment of a mental health condition (rather than current impairment from such a condition).[6] Some states specifically inquire if the applicant has ever had a diagnosis of, or been treated for, bipolar disorder, schizophrenia, paranoia, or other psychotic disorder or for sexual disorders. Although state case laws have determined that specific questions about bipolar, psychotic, or sexual disorders are acceptable, professional organizations and court interpretations of the ADA recommend that the boards focus on current functional impairment instead of any history of diagnoses or treatment of illness.[7] To support this position, there are no data showing that a broad question on a licensure application that asks about diagnosis or treatment for mental illness identifies current impairment.[8]

The APA recommends that questions about the health of applicants should inquire only about the conditions that currently impair the applicant's capacity to function as a licensee and are relevant to present practice. The APA further recommends that the boards use the following language in their application form:

> "Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (Yes/No)"[4]

Interpretation and definition of "psychiatric conditions" and "impairment"

In 2011, the Federation of State Medical Boards (FSMB) adopted policy on physician impairment to provide guidance to boards for including physician health programs (PHPs) in their efforts to protect the public.[9] The policy represented a vision for medical boards and PHPs to effectively assist impaired licensees as well as those with potentially impairing illness based on best practices.

The FSMB policy on physician impairment states:

> "The diagnosis of an illness does not equate with impairment. Impairment is a functional classification which exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon. Illness, per se, does not constitute impairment. When functional impairment exists, it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of potential impairment may be resolved while the diagnosis of illness may remain."[9]

AMA policy states:

> "The AMA defines physician impairment as any physical, mental, or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program" (Policy H-95.955, "Physician Impairment").

The FSMB defines impairment as:

> "The inability of a licensee to practice medicine with reasonable skill and safety as result of:
> a) mental disorder; or
> b) physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or
> c) substance-related disorders including abuse and dependency of drugs and alcohol as further defined."[9]

The Federation of State Physician Health Programs (FSPHP) created a public policy regarding "illness vs. impairment." The following is an excerpt from this policy:

> "…[S]ome regulatory agencies equate illness (i.e. addiction or depression) as synonymous with impairment. Physician illness and impairment exist on a continuum with illness typically predating impairment, often by many years. This is a critically important distinction. Illness is the existence of a disease. Impairment is a functional classification and implies the inability of the person affected by disease to perform specific activities.
>
> "Most physicians who become ill are able to function effectively even during the earlier stages of their illness due to their training and dedication. For most, this is the time of referral to a state PHP. Even if illness progresses to cause impairment, treatment usually results in remission and restoration of function. PHPs are then in a position to monitor clinical stability and continuing progress in recovery…
>
> "Medical professionals recognize it is always preferable to identify and treat illness early. There are many potential obstacles to an ill physician seeking care including: denial, aversion to the patient role, practice coverage, stigma, and fear of disciplinary action. Fear of disciplinary action and stigma are powerful disincentives to doctors referring their physician colleagues or themselves. When early referrals are not made, doctors afflicted by illness often remain without treatment until overt impairment is manifest in the workplace."[9]

There is some variability among the boards regarding how their applications request information about "psychiatric conditions (diagnosis/illness)" and "impairment." Ideally, state and federal law should facilitate the effective interface between boards and PHPs in their efforts to support the rehabilitation of licensees with potentially impairing illness because it adds to public protection.

The FSMB encourages the boards, with input from their PHPs, to revisit their Medical Practice Acts routinely to ensure that they are kept updated in response to developments in the field.

PHPs' reporting requirements and patient confidentiality requirements

The FSMB recommends that two separate PHP tracks be established for program participants:

- Track "A" is for voluntary participants who enter the PHP without the board's mandate. These physicians should be afforded anonymity from the board as long as they do not pose a risk of harm to the public. Cases that pose a danger of harm to the public should be reported to the board with laws or regulations in place that allow that reporting.
- Track "B" physicians are mandated by the board to participate in a PHP. As such, their identities are known to the board.[9]

In addition, the FSMB recommends that PHPs employ FSPHP Guidelines (fsphp.org/sites/default/files/pdfs/2005_fsphp_guidelines-master_0.pdf) in selecting the providers/facilities to provide treatment for physicians with addictive and/or psychiatric illness.[9]

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule related to mental and behavioral health (hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html) provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health information. At the same time, the Privacy Rule recognizes that circumstances arise where health information may need to be shared to ensure that the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others.

Diagnosing depression for reimbursement can impact a physician's permanent credentials

Many physicians have expressed concern that a depression diagnosis could negatively impact their medical license.[10] The consequences of reporting to a licensing board stable and easily treatable conditions such as anxiety or depression can range from a physician simply being required to submit a letter from their primary care provider that documents fitness to practice, to being asked to appear before state board examiners, or to being required to undergo (and pay for) an examination by a board-appointed physician. Other consequences can include having to provide extensive or ongoing medical records, enrolling in a PHP, paying for inpatient or intensive outpatient treatment that is possibly followed by long-term monitoring, or agreeing to practice restrictions.[8]

Physicians may be discouraged from seeking treatment for mental health conditions

Even if physicians realize that they need help, many have reported substantial and persistent concern regarding the stigma, which inhibits both treatment and disclosure of mental health conditions on licensure applications.[8, 11] Those who disclose information about seeking mental health care have suffered delays in licensure and added scrutiny. The stigma of mental health is so pervasive that many physicians consider mental health issues to be a sign indicating that they are unable to cope with the rigor of the medical profession and that their ability to care for patients, therefore, is inferior to that of other physicians.[12, 13] Several surveys have shown that physicians are reluctant to enter into such disclosure because they fear this could expose them to examinations,

potentially inappropriate treatment and monitoring, or exclusion from employment opportunities, insurance coverage, or professional advancement.[14]

A 2016 survey of female physicians with a history of actual mental health diagnosis or treatment also provided insight into why this information is not routinely disclosed on licensure applications. The most common reasons listed were the beliefs that the condition did not pose any potential safety risk to patients (75 percent), was not relevant to clinical care (70 percent), and was not the business of the state medical board (63 percent).[8] In addition, many of the survey respondents (75 percent) agreed or strongly agreed that medical board questions about whether a physician has ever had a mental health diagnosis or treatment impacts decisions about seeking treatment.[8] The study also confirmed that more than two-thirds of physicians feel reluctant to seek out the same treatments they offer their patients for fear that they may be judged, deemed incompetent, or have their privacy and autonomy violated because of seeking help; these beliefs crossed all age and specialty categories.[8]

A similar study of licensure applicants showed that nearly 40 percent of physicians would be reluctant to seek formal medical care for treatment of a mental health condition because of concerns about repercussions to their medical license.[6] Although providing inaccurate information on a medical license application may result in denial or revocation, acknowledging a history of mental health treatment triggers a more in-depth inquiry by the medical board.

The lack of distinction between diagnosis and impairment further stigmatizes physicians who seek care and impedes treatment.[15] As a result, the traditional role of licensing boards can frustrate efforts to promote physician wellness.[12] Thus, physicians frequently seek treatment only when their psychological distress and suboptimal performance has gained the attention of insurance companies, police, and/or review boards.[13]

FSMB WORKGROUP ON PHYSICIAN WELLNESS AND BURNOUT

To address concerns about physician wellness, physician burnout, and suicide prevention, the FSMB established the Workgroup on Physician Wellness and Burnout on behalf of the state medical and osteopathic boards in 2016. In evaluating licensing and license renewal application questions that ask about health conditions, the workgroup is confronting the barriers physicians face in seeking treatment for symptoms of burnout related to the presence and phrasing of questions about mental health, substance use, and leave from practice.

The workgroup has been seeking to identify and highlight examples of effective and appropriate language in consideration of existing FSMB policies that draw an important distinction between physician illness and impairment.[9] The workgroup also is researching this issue to determine whether it is necessary for the boards to include on licensing applications probing questions about a physician applicant's mental health and whether the information these questions are designed to elicit in the interests of patient safety may be better obtained through means less likely to discourage the search for treatment among physician applicants.

The workgroup is in the process of finalizing its report and recommendations, and the FSMB will continue to update the public and the FSMB's partner organizations, including the AMA, of its progress.

FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS

The FSPHP's mission is to support PHPs in improving the health of medical professionals, thereby contributing to quality patient care. The FSPHP aims to:

- Achieve national and international recognition as a supporter of PHP programs;
- Promote early identification, treatment, documentation, and monitoring of ongoing recovery of physicians prior to the illness impacting the care rendered to patients; and
- Pursue consistent standards, language, and definitions among state physician health programs.

PHPs were originally developed to assist physicians suffering from alcohol or other addictions to receive treatment while being protected from losing their state medical licenses. In recent years, PHPs have also begun to intervene in other areas related to mental or physical health issues.

PHPs currently operate in 47 states and the District of Columbia; these programs function within the parameters of state regulation and legislation and provide many different levels of service to physicians in need. All state member PHPs must have compensated staff and/or a compensated medical director, and/or a voluntary committee chairperson/staff member, as well as the support of organized medicine in their state. Information about the full range of program structures and services offered by each state program is available at: fsphp.org/state-programs.

States have different reporting requirements related to impairment that have been agreed upon in their monitoring contracts with the state medical boards. Some of the programs offer a safe haven to encourage physicians to proactively seek and receive the health care services that they need, confidentially. For example, the North Carolina Physicians Health Program (NCPHP) can provide non-disciplinary and confidential assistance to ensure that the physician's identity is protected, provided that the physician's behavior has not negatively impacted patient care. The North Carolina Medical Board (NCMB) renewal question specifically states, "If you are an anonymous participant in the NCPHP and in compliance with your contract, you do not need to list any medical conditions related to that contract." Thus a licensee who reaches out to the NCPHP for help with depression or other mental health concerns is generally not required to disclose these concerns to the board. Physicians are allowed to remain anonymous so long as the NCPHP can establish that they are safe to practice, are not an imminent danger to the public, or have not committed sexual boundary violations.[16]

There are scenarios when an impaired physician is agreeable to referral to a PHP in which they may meet with safe haven or diversionary status, which does not require disclosure to a state medical board. Also, while a PHP will report a physician who meets the threshold of "public danger," they may not re-disclose the specifics of the physician's physical or mental health history. Due to the confidentiality requirements of the physician's health records, more than likely the reported physician will sign consents and be required to release the necessary medical information to the licensing board directly as needed and not via the PHP.

AMA POLICIES

Policies related to questions on licensure applications

Policy H-295.858 (2), "Access to Confidential Health Services for Medical Students and Physicians," states that "Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus

on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety."

Policy H-275.945, "Self-Incriminating Questions on Applications for Licensure and Specialty Boards," directs the AMA to "(1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information, (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards, and (3) encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked."

Policies related to management of psychiatric disorders

Policy H-275.970, "Licensure Confidentiality," directs the AMA "(1) to encourage specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) to encourage boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) to encourage state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) to encourage state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) to encourage state licensing boards to require that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine."

Policy H-95.955, "Physician Impairment," states that: "(1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems."

DISCUSSION

There is growing concern that the presence and phrasing of questions related to current or past impairment on licensing applications may be discouraging physicians from seeking appropriate treatment because of fear of stigmatization, public disclosure, and the effect on one's job due to licensing or credentialing concerns.[3] Resident physicians experience higher rates of depression than the general public, and distressed physicians who do not seek treatment, especially for conditions such as depression, anxiety, and burnout, may ultimately have an adverse effect on public safety

because they may be less likely to identify and treat similar conditions in their patients and more prone to medical errors in daily practice.[3, 17]

The medical and osteopathic licensing boards recognize that in their responsibility to evaluate the fitness of potential licensees, a potential barrier may exist that prevents current and potential licensees from seeking help. Some state boards have taken steps to address these barriers. The Oregon Medical Board initiated a program to reduce physicians' fear of reporting treatment on licensing or hospital credentialing applications. The board participates in the Health Professionals' Services Program, which was established in July 2010 as a statewide confidential referral resource for rehabilitation and monitoring. It prioritizes the identification of impaired physicians and encourages licensees struggling with burnout, depression, or substance abuse to seek professional treatment.[18] The Washington State Medical Board changed its initial medical license application in the mid-1990s to include a question that asks applicants if they have ever had a drug, alcohol, or mental health problem that is not already known to the PHP. This encouraged physicians to seek help anonymously. Currently, applicants are simply asked to disclose if they have any medical conditions that limit their ability to practice medicine.[19]

Some hospitals have responded to the focus on physician mental health by implementing programs to help residents and physicians improve their overall health.[20] The AMA, American Osteopathic Association, and the state and specialty medical associations are also positioned to help alleviate the added stress physicians may experience as they interact with their respective licensing boards. The AMA has developed the following online resources focused on improving physician wellness, preventing burnout, and increasing resilience:

- Physician Wellness: Preventing Resident and Fellow Burnout (stepsforward.org/modules/physician-wellness)
- Preventing Physician Burnout (stepsforward.org/modules/physician-burnout)
- Improving Physician Resiliency (stepsforward.org/modules/improving-physician-resilience)

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education is committed to ensuring that physicians seek the care they need for burnout, anxiety, depression, and substance-related disorders without fear of punitive treatment or licensure and career restrictions. The Council therefore recommends that the following recommendations be adopted in lieu of Resolution 301-A-17, Resolve 3, and the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-275.970, Part 5, "Licensure Confidentiality," by addition and deletion to read as follows:

   The AMA (5) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is currently suffering from any condition that impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~ (Modify Current HOD Policy)

2. That our AMA encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the American Psychiatric Association that reads, "Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)." (Directive to Take Action)

Fiscal Note: $1,000

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INTERNATIONAL MEDICAL GRADUATES SECTION
PRELIMINARY TIMELINE FOR RESOLUTIONS/REPORTS REVIEW
INTERIM MEETING – NOVEMBER 2018
NATIONAL HARBOR, MD

	DUE DATES
Deadline for Receipt of Resolutions	August 10
Virtual Congress--review reports/resolutions Provide email testimony to img@ama-assn.org	August 19-24
Governing Council teleconference	August 26
Virtual Congress final ratification of Reports and Resolutions via email	September 4-10
House of Delegates Handbook Deadline for Resolutions	September 21
House of Delegates Handbook Addendum deadline	October 5
Deadline at I-18 meeting site: (emergency resolutions only)	Saturday, Nov. 9 – 8 am

2018-2019 AMA COUNCIL/COMMITTEE LEADERSHIP OPPORTUNITIES

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For additional information, please contact Carolyn Carter-Ellis, Sr. Group Manager, IMGS, carolyn.carter-ellis@ama-assn.org (800) 262-3211, 5397

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
CPT Editorial Panel		BOT	Four Years/One or Two Terms	June	2019	Jayesh Shah, MD
CPT Advisory Committee		BOT	Two Years	November		
Residency Review Committees (28)		BOT	Two Years/Three Terms	April/As Needed	March 1, 2019	Ved Gossain, MD (IM)
American Boards (19 of 24)		BOT	Varied	As Needed	March 1, 2019	June-Anne Gold, MD
AAHC/URAC Board of Directors		BOT	Three-Years	June		
Accreditation Council for Graduate Medical Education		Nominated by BOT, Elected by ACGME	Three Years/Two Terms	June	March 1, 2019	Drs. Kiran Shah, Jayesh Shah, Milton Kramer
National Patient Safety Foundation		BOT	Three Years	June		Kiran Shah, MD
Practice Expense Advisory Committee (subcommittee of the RUC)		BOT	Four Years	June		Drs. Niranjan Rao, Jose David
AMA/Specialty Society RVS Update Committee		BOT	Three Years/Two Terms Two Years/Three Terms for Chair	June/December		Deepak Kumar, MD
AMA Foundation		BOT	Three Years/Two Terms	June/October		Jayesh Shah, MD
Accreditation Coun. for Contin. Med. Educ.		BOT	One Year/Six Terms	October		
Accreditation Council for Continuing Medical Education Review Committee		BOT	One Year/Six Terms	October		Gamini Soori, MD Ved Gossain, MD
Accreditation Review Committee for the Physician Assistant		BOT	Three Years/Two Terms	October		
Advisory Committee on Group Practice		BOT	Two Years	October		
American Board of Medical Specialties		BOT	Four Years/Two Terms	October		Gamini Soori, MD Ved Gossain, MD
Commission on Accreditation of Allied Health Education Programs		BOT	One Year/Six Terms	October		Jose David, MD
Educational Commission for Foreign Medical Graduates		BOT	Four Years/Two Terms	October		Drs. Soori, Wollschlaeger, Jayasankar, Milton Kramer, Appareddy

*Maximum tenure

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
E-Medicine Advisory Committee		BOT	Two Years	October		Keith Adams, MD
The Joint Commission		BOT	Three Years	October	2019	Drs. Kiran Shah, Keith Adams
Liaison Committee on Medical Education (students)		BOT	One Year/Six Terms	April		Milton Kramer, MD
National Board of Medical Examiners		BOT	Four Years/Two Terms	October		Mitra Kalelkar, MD
National Resident Matching Program		BOT	Three Years/Two Terms	October		Gamini Soori, MD, Nirav Shah, MD
ACGME Institutional Review Committee		Nominated by BOT, Elected by ACGME	Two Years	December		Gamini Soori, MD
JAMA Oversight Committee		BOT	Three Years/Two Terms	December		
Joint Commission PTACS Ambulatory Care Behavioral Health Home Care Hospital Long Term Care		BOT	Two Years/Three Terms	December	March 1, 2019	
U.S. AN Council		BOT	One Year/Ten Terms	December		

***Maximum tenure**

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
U.S. AN Review Board		BOT	One Year/Ten Terms	December		
Council on Constitution and Bylaws	Patricia L. Austin, MD (2018) Madelyn E. Butler, MD (2018) Jerome C. Cohen, MD, Vice Chair (2017) Pino D. Colone, MD (2020) Joy Lee (Student) (2017)* Cyndi Yag-Howard, MD (2018)* Nalim S. Ali MD (Resident) (2018) Susan Rudd Bailey, MD (ex officio) (2018) Bruce A. Scott, MD (2018) Collette R. Willins, MD, Chair, (2019)*	Candidates approved by BOT/Elected by HOD	Four Years/Two Terms	February	March 15, 2019	
Council on Ethical & Judicial Affairs	Dennis S. Agliano, MD, Chair (2018)* Marc Mendelsohn, MD (Resident) (2021)* Kathryn L. Moseley, MD,MPH,FAAP (2020)* Alexander Rosenau, DO,CPE (2022)* James E. Sabin, MD, Vice Chair (2019)* Peter A. Schwartz, MD (2023)* Lauren Schleimer, (Student) (2021)* Monique A. Spillman, MD, (2021)*	President/Elected by HOD	Seven Years/One Term	June	March 15, 2019	

Please call the IMG Staff Section at (312) 464-5397 to find out about more leadership opportunities.

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
Council on Medical Education	Jacqueline A. Bello, MD (2021) Carol D. Berkowitz, MD, Chair-Elect (2019) Cynthia A. Jumper, MD (2024) Lynne M. Kirk, MD, FACP, Chair (2019) Liana Puscas, MD (2021) Niranjan V. Rao, MD, (2022) Luke V. Selby, MD, (Resident) (2020)* Patricia Turner, MD, FACS, (2019) Arjun Gupta (Student) (2018)* John P. Williams, MD, (2023)	Candidates approved by BOT/Elected by HOD	Four Years/Two Terms	February	March 15, 2019	Jayesh Shah, MD, June-Anne Gold, MD
Council on Medical Service	Meena Davuluri, MD (Resident) (2023) Lisa B. Egbert, MD, (2021) W. Alan Harmon, MD (2020) James G. Hinsdale, MD, Chair-Elect (2019) Lynn L. C. Jeffers, MD (2024) Peter E. Lavine, MD (2022) Asa C. Lockhart, MD (2022) Peter S. Lund, MD (2018)* Sarah Smith (Student) (2018)* Paul A. Wertsch, MD, Chair (2018)* Lynda M. Young, MD, (2021)	Candidates approved by BOT/Elected by HOD	Four Years/Two Terms	February	March 15, 2019	

***Maximum tenure**

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
Council on Legislation	Seyed H. Aleali, MD (2018)* Edgar Scott Ferguson, MD, Chair (2018)* Christopher Clifford (Student) (2018)* Mary S. Carpenter, MD (2023) Marilyn J. Heine, MD (2022) Jerry D. Kenneth, MD, Vice Chair (2018)* Elizabeth A. Irish, Alliance Representative (2021) Gary W. Floyd, MD (2025) Linda B. Ford, MD, AMPAC Board Observer (2020) Heather Ann Smith, MD (2023) David T. Tayloe, Jr.,MD (2020) Willie Underwood, MD III (2019) Hans Arora, MD, Resident (2025)	BOT	One Year/Eight Terms	April	March 15, 2019	Drs. S. Jayasankar, Deepak Kumar, MD
Council on Science and Public Health	Robyn Chatman, MD, MPH, FAAFP, Chair-Elect (2019) John T. Carlo, MD (2025) Kira A. Geraci-Ciardullo, MD (2022) Noel Deep, MD (2023) Alexander Ding, MD (2024) Robert A. Gilchick, MD, MPH, FACPM, Chair (2018)* Christina Kratschmer, Student (2018)* Mary E. LaPlante, MD (2025) Michael Lubrano, MD (2023) Michael M. Miller, MD (2022) Bruce M. Smoller, MD (2023) David J. Welsh, MD (2024)	BOT	Four Years/Two Terms	April	March 15, 2019	June-Anne Gold, MD

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Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
Council on Long Range Planning & Development	Edmond Cabbabe, MD (2025)* Clarence P. Chou, MD (2024)* James A. Goodyear, MD (2021) Mary T. Herald, MD (2018)* Alfred Herzog, MD, Vice Chair (2019)* Matthew E. Lecuyer, Resident (2022)* Glenn A. Loomis, MD, Chair (2019)* Katherine Marsh, Student (2018)* Shannon P. Pryor, MD (2024)* Gary Thal, MD (2025)*	BOT & HOD Speaker	Four Years/Two Terms	April	March 15, 2019	Jayesh Shah, MD
American Medical Political Action Committee	Grayson W. Armstrong, MD (Resident), (2020)* Brook M. Buckley, MD, (2024)* Steven J. Fleishman, MD, (2022)* Linda B. Ford, MD (2020)* Benjamin Z. Galper, MD (2024)* Dev. A. GnanaDev, MD, (2020)* Ashtin B. Jeney, (Student) (2018)* Stephen A. Imbeau, MD, (2022)* Vidya Kora, MD, Chair (2018)* James L. Milam, MD (2022)* Michael Suk, MD (2024)* Lyle S. Thorstenson, MD (Secretary) (2020)*	BOT	Two Years/Four Terms		July 15, 2019	Deepak Kumar, MD

***Maximum tenure**

INTERNATIONAL MEDICAL GRADUATES SECTION
2017 INTERIM HOUSE OF DELEGATES MEETING
SUMMARY OF ACTIONS
HAWAII CONVENTION CENTER

IMG SECTION (IMGS) AUTHORED RESOLUTIONS

Reference Committee F

1. Resolution 601 - Physician Burnout And Wellness Challenges
   Resolution 604 - Physician and Physician Assistant Safety Net
   Resolution 605 – Identification and Reduction of Physician Demoralization

   Resolution 601 asked the AMA to advocate for health care organizations and state and county medical societies, to develop a wellness plan to prevent and combat physician burnout and improve physician wellness.

   Resolution 604 asked AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Such safety net services would be provided by doctorate level mental health clinicians experienced in treating physicians and funded by such entities as foundations, hospital systems, medical clinics, and donations from physicians and physician assistants.

   Resolution 605 asked AMA to recognize physician demoralization as a consequence of externally imposed occupational stresses, including but not limited to EHR-related and administrative burdens imposed by health systems or by regulatory agencies, as a problem among medical staffs. Resolution 605 also calls upon our AMA to advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization.

   Resolution 605 further asked AMA to develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness.

   HOD Action: Resolutions 601, 604, and 605 referred with report back at the 2018 Annual Meeting.

Reference Committee K

1. Resolution 955 – Minimization of Bias In the Electronic Residency Application Service Residency Application

   RESOLVED, That our American Medical Association ~~advocate for the formation of an~~ encourage the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) ~~Residency Application Bias Minimization~~ Advisory Committee to develop steps to minimize bias in the ERAS and the ~~examine this role of bias in~~residency training selection process. (Directive to Take Action); and be it f u r t h e r

   HOD Action: Adopted as amended.

2. Resolution 956 – House Physicians Category

   Resolution 956 asked the American Medical Association work with state legislators and other regulatory organizations to develop the category of "House Physicians" to help address the anticipated physician need and shortfall of available practitioners in underserved areas of the United States.

   There was strong testimony in opposition to this resolution.

   HOD Action: Resolution 956 not adopted.

Other House of Delegates Reports & Resolutions of Interest

3. Council on Medical Education Report 1 – Promoting and Reaffirming Domestic Medical School Clerkship Education

   Council on Medical Education Report 1, in response to Resolution 308-I-16, considers concerns that have been raised about the availability of clinical clerkship training sites due to continuing increases in the enrollment of U.S. allopathic and osteopathic medical schools and in the absolute numbers of U.S. medical schools—as well as the growing number of foreign medical schools that seek to place their students in clerkships in U.S. institutions. The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 308-I-16 and the remainder of the report be filed:

   That our American Medical Association (AMA):

   1) Work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: a) infrastructure and faculty development and capacity for medical school

expansion; and b) delivery of clinical clerkships and other educational experiences. (Directive to Take Action)

2) Encourage clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students. (Directive to Take Action)

3) Advocate for federal and state legislation/regulations to:
    a. Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA);

    b. Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and

    c. Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality, curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA. (Directive to Take Action) Encourage relevant stakeholders to study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level. (Directive to Take Action)

4) Work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students. (Directive to Take Action) 2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution’s own students educationally and/or financially

and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites. (New HOD Policy)

5) Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas. (New HOD Policy)

6) U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA. (New HOD Policy)

7) Existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. (New HOD Policy)

8) That Policies H-255.988 (6, 23, and 25), H-255.998, H-295.995 (30, 31), D-295.320, 37 D-295.931, and D-295.937 be rescinded, as described in Appendix C to this report. (Rescind HOD Policy)

HOD Action: Council on Medical Education Report 1 adopted and the remainder of the report filed.

Reference Committee on Amendments to Constitution and Bylaws

4. Resolution 006 – Physicians' Freedom of Speech – Minority Affairs Section

Resolution 006 addresses a physician's First Amendment right to free speech. This relates to physicians being disciplined or terminated by their employers for expressing their personal views on their social media accounts. This resolution asks the AMA to encourage the Council on Ethical and Judicial Affairs to amend Ethical Opinion 1.2.10, "Political Actions by Physicians" by adding in language that physicians should indicate that they are expressing their constitutionally guaranteed personal views, and not that of their employers, and that physicians should be allowed to express their personal opinions without being subjected to disciplinary actions or termination.

HOD Action: Resolution 006 referred.

AMERICAN MEDICAL ASSOCIATION
INTERNATIONAL MEDICAL GRADUATES SECTION
2018-2019 Governing Council Roster

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The Atlantic

The Burnout Crisis in American Medicine

Are electronic medical records and demanding regulations contributing to a historic doctor shortage?

Dola Sun

RENA XU | MAY 11, 2018 | HUMAN CAPITAL

During a recent evening on call in the hospital, I was asked to see an elderly woman with a failing kidney. She'd come in feeling weak and short of breath and had been admitted to the cardiology service because it seemed her heart wasn't working right. Among other tests, she had been scheduled for a heart-imaging procedure the following morning; her doctors were worried that the vessels in her heart might be dangerously narrowed. But then they discovered that one of her kidneys wasn't working, either. The ureter, a tube that drains urine from the kidney to the bladder, was blocked, and relieving the blockage would require minor surgery. This presented a dilemma. Her planned heart-imaging test would require contrast dye, which could only be given if her kidney function was restored—but surgery with a damaged heart was risky.

I went to the patient's room, where I found her sitting alone in a reclining chair by the window, hands folded in her lap under a blanket. She smiled faintly when I walked in, but the creasing of her face was the only

movement I detected. She didn't look like someone who could bounce back from even a small misstep in care. The risks of surgery, and by extension the timing of it, would need to be considered carefully.

I called the anesthesiologist in charge of the operating room schedule to ask about availability. If the cardiology department cleared her for surgery, he said, he could fit her in the following morning. I then called the on-call cardiologist to ask whether it would be safe to proceed. He hesitated. "I'm just covering," he said. "I don't know her well enough to say one way or the other." He offered to pass on the question to her regular cardiologist.

A while later, he called back: The regular cardiologist had given her blessing. After some more calls, the preparations were made. My work was done, I thought. But then the phone rang: It was the anesthesiologist, apologetic. "The computer system," he said. "It's not letting me book the surgery." Her appointment for heart imaging, which had been made before her kidney problems were discovered, was still slated for the following morning; the system wouldn't allow another procedure at the same time. So I called the cardiologist yet again, this time asking him to reschedule the heart study. But doctors weren't allowed to change the schedule, he told me, and the administrators with access to it wouldn't be reachable until morning.

I felt deflated. For hours, my attention had been consumed by challenges of coordination rather than actual patient care. And still the patient was at risk of experiencing delays for both of the things she needed—not for any medical reason, but simply because of an inflexible computer system and a poor workflow.

Situations like this are not rare, and they are vexing in part because they expose the widening gap between the ideal and reality of medicine. Doctors become doctors because they want to take care of patients. Their decade-long training focuses almost entirely on the substance of medicine—on diagnosing and treating illness. In practice, though, many of their challenges relate to the operations of medicine—managing a growing number of patients, coordinating care across multiple providers, documenting it all. Regulations governing the use of electronic medical records (EMRs), first introduced in the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009, have gotten more and more demanding, while expanded insurance coverage from the Affordable Care Act may have contributed to an uptrend in patient volume at many health centers. These changes are taking a toll on physicians: There's some evidence that the administrative burden of medicine—and with it, the proportion of burned-out doctors—is on the rise. A study published last year in Health Affairs reported that from 2011 to 2014, physicians spent progressively more time on "desktop medicine" and less on face-to-face patient care. Another study found that the percentage of physicians reporting burnout increased over the same period; by 2014, more than half said they were affected.

To understand how burnout arises, imagine a young chef. At the restaurant where she works, Bistro Med, older chefs are retiring faster than new ones can be trained, and the customer base is growing, which means she has to cook more food in less time without compromising quality. This tall order is made taller by various ancillary tasks on her plate: bussing tables, washing dishes, coordinating with other chefs so orders aren't missed, even calling the credit-card company when cards get declined.

Then the owners announce that to get paid for her work, this chef must document everything she cooks in an electronic record. The requirement sounds reasonable at first but proves to be a hassle of bewildering proportions. She can practically make eggs Benedict in her sleep, but enter "egg" into the computer system? Good luck. There are separate entries for white and brown eggs; egg whites, yolks, or both; cage-free and non-cage-free; small, medium, large, and jumbo. To log every ingredient, she ends up spending more time documenting her preparation than actually preparing the dish. And all the while, the owners are pressuring her to produce more and produce faster.

It wouldn't be surprising if, at some point, the chef decided to quit. Or maybe she doesn't quit—after all, she spent all those years in training—but her declining morale inevitably affects the quality of her work.

In medicine, burned-out doctors are more likely to make medical errors, work less efficiently, and refer their patients to other providers, increasing the overall complexity (and with it, the cost) of care. They're also at high risk of attrition: A survey of nearly 7,000 U.S. physicians, published last year in the Mayo Clinic Proceedings, reported that one in 50 planned to leave medicine altogether in the next two years, while one in five planned to reduce clinical hours over the next year. Physicians who self-identified as burned out were more likely to follow through on their plans to quit.

What makes the burnout crisis especially serious is that it is hitting us right as the gap between the supply and demand for health care is widening: A quarter of U.S. physicians are expected to retire over the next decade, while the number of older Americans, who tend to need more health care, is expected to double by 2040. While it might be tempting to point to the historically competitive rates of medical-school admissions as proof that the talent pipeline for physicians won't run dry, there is no guarantee. Last year, for the first time in at least a decade, the volume of medical school applications dropped—by nearly 14,000, according to data from the Association of American Medical Colleges. By the association's projections, we may be short 100,000 physicians or more by 2030.

Some are trying to address the projected deficiency by increasing the number of practicing doctors. The Resident Physician Shortage Reduction Act, legislation introduced last year in Congress, would add 15,000 residency spots over a five-year period. Certain medical schools have reduced their duration, and some residency programs are offering opportunities for earlier specialization, effectively putting trainees to work sooner. But these efforts are unlikely to be sufficient. A second strategy becomes vital: namely, improving the workflow of medicine so that physicians are empowered to do their job well and derive satisfaction from it.

Just as chefs are most valuable when cooking, doctors are most valuable when doing what they were trained to do—treating patients. Likewise, non-physicians are better suited to accomplish many of the tasks that currently fall upon physicians. The use of medical scribes during clinic visits, for instance, not only frees doctors to talk with their patients but also potentially yields better documentation. A study published last month in the World Journal of Urology reported that the introduction of scribes in a urology practice significantly increased physician efficiency, work satisfaction, and revenue.

Meanwhile, there's evidence that patients are more satisfied with their care when nurse practitioners or physician assistants provide some of it. This may be because these non-physicians spend more time than doctors on counseling patients and answering questions. In a perfectly efficient division of labor, physicians might focus on formulating diagnoses and treatment plans, with non-physicians overseeing routine health maintenance, discussing lifestyle changes, and educating patients on their medical conditions and treatment needs. Fortunately, over the next decade, employment of nurse practitioners and physician assistants in the United States is expected to grow by more than 30 percent; that compares with overall expected job growth of just 7 percent.

Yet the solution to health care's labor problem isn't simply to hire more staff; if not done right, that could make coordination even more cumbersome. A health-care organization's success, in the years ahead, will depend on its success at delegating responsibilities among physicians and non-physicians, training the non-physicians to do their work independently, and empowering everyone—not just doctors—to shape a patient's care and be accountable for the results.

Technology can make doctors' lives easier, but also a lot harder. Consider the internet: It's made information infinitely more attainable, but it takes time to find what one needs and to filter the accurate material from the inaccurate. The same goes for medicine. Technologies such as telemedicine, which allows for online doctor visits, can make health care more accessible and effective. But the use of EMRs, which is now federally mandated, is frequently cited as one of the main contributors to burnout. EMRs are often designed with billing rather than patient care in mind, and they can be frustrating and time-consuming to navigate. One attending doctor I know, tired of wading through a morass of irrelevant information, writes notes in the electronic chart but in parallel keeps summaries of his patients' medical histories on hand-written index cards.

One can imagine a better EMR system, built around what health-care providers need. Today, in the absence of more effective tools, medical colleagues rely on email to coordinate patient care—or phone, as in the case of my kidney patient. But email chains can get buried in an inbox, and phone calls are rarely practical for coordinating between more than two people at a time. Neither mode of communication gets linked to a patient's record, which means work is at risk of either getting lost or being replicated. But what if we were to integrate a tool into the electronic record that made clear what a patient's active medical issues were, assigned responsibility to providers for overseeing those issues, and helped them to coordinate with each other? A dynamic EMR that didn't just give physicians more information, but also helped them to prioritize, share, and act upon that information, would be far more useful than what currently exists.

As the world changes—as populations grow and technology advances—it is becoming essential that the workflow of medicine change alongside it. Fortunately for the patient with the failing kidney, the anesthesiologist was willing to get creative. Despite being unable to book the surgery, he unofficially reserved a slot for her and made the rest of his staff aware. The patient underwent the procedure the next morning, followed by her previously planned heart study. Everything worked out in the end. But I couldn't help thinking: It shouldn't be this hard to do the right thing.

ABOUT THE AUTHOR

RENA XU is a writer and resident physician in urologic surgery in Boston. Her work has also appeared in the *New England Journal of Medicine* and *The New Yorker.*

Twitter

WHAT HAS AMA ACHIEVED "ON THE HILL" FOR DOCTORS?

Vidya Kora, MD

Every year the American Medical Association convenes the National Advocacy Conference in Washington DC in February. Influential lawmakers from both sides of the aisle and thought leaders on health care and pundits share their views upcoming health care legislation.

AMA's ADVOCACY WINS FOR THIS YEAR:
1. Blocked Anthem/Cigna and Aetna/Humana mergers, effectively protecting over 500 million dollars in annual physician payments.
2. Preserved health insurance coverage and patient protections and blocked steep Medicaid cuts for providers. QPP/MACRA transition. AMA's advocacy efforts reduced reporting burdens, made favorable adjustments for small practices and raised low volume exemption - and as a result, unto 97% of physicians will avoid penalties in 2020.
3. Passage of AMA model bill on prior authorizations.
4. Progress on opioid epidemic objectives.
5. Bipartisan Budget Act of 2018.

A) In the new budget spending bill passed earlier this month, there was a provision to cut Medicare payments based on a two-year misvalued code policy. As a result of AMA's action alert on February 5, more than 3,000 emails were sent to Congress in less than 24 hours. On February 9, Congress passed a spending bill including a number of key important elements advocated by AMA.

B) Amendments to MACRA which provide flexibility to CMS to set cost weight at 10% for the next three years and to set performance threshold for the next three years.

C) It also clarifies that Part D drug costs are not subjected to MIPS adjustments.

D) IPAB (Independent Payment Advisory Board) was one of the components of the Affordable Care Act which organized medicine, including AMA, had opposed, has been repealed.

E) The bipartisan Budget Act also eliminates a mandate that EHR standards become more stringent over time.

F) The bipartisan Budget Act also provided funding for four years for CHIP.

G) The Budget Act reauthorized funding for community health centers, National Health Service Corps and teaching health center GME programs for two years.

H) The Budget Act avoided the physician payment cut by removing the misvalued code as an offset.

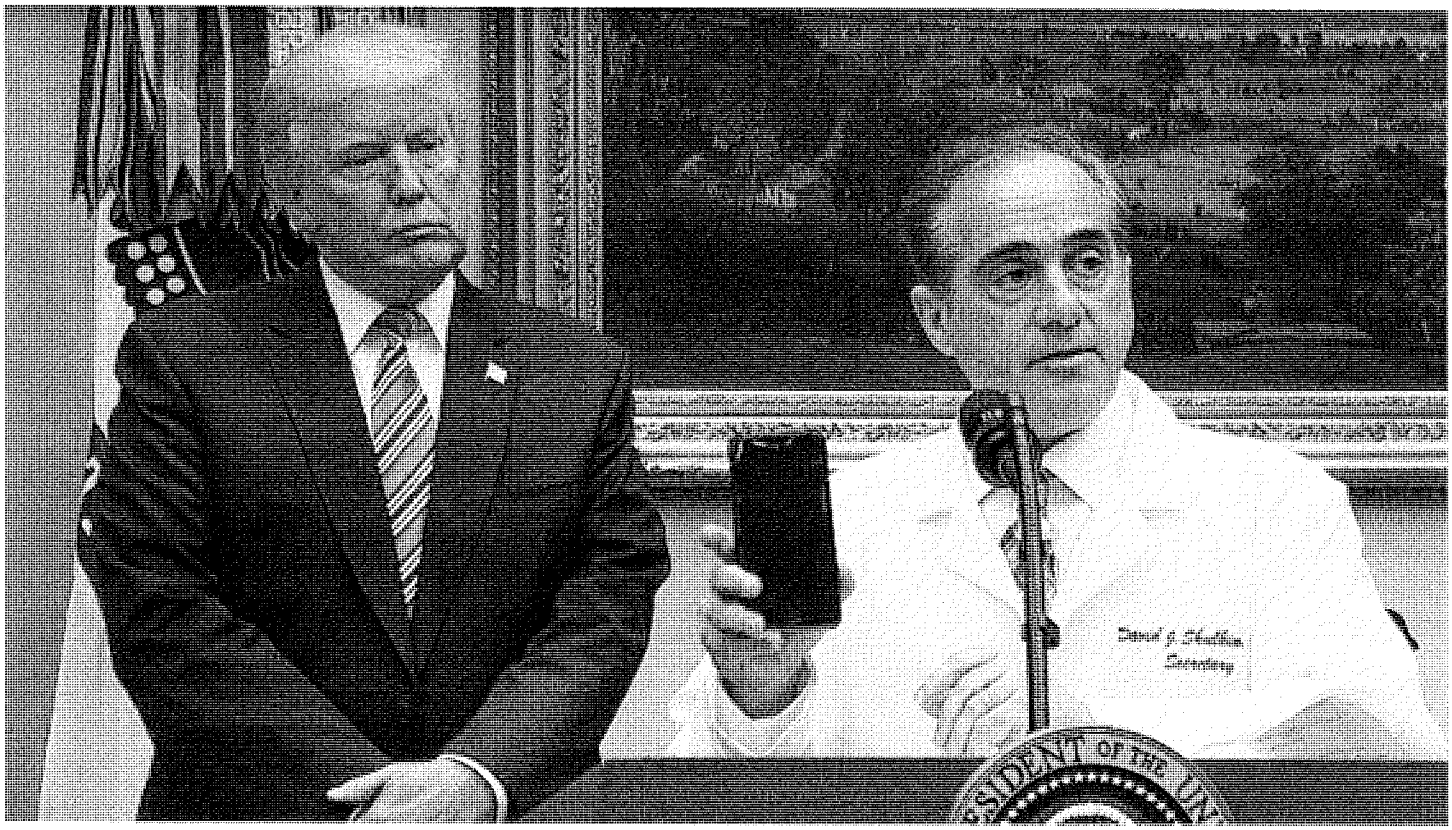
In addition to the provisions mentioned above, the other positive elements of the new spending bill include 6 billion dollar state grants for opioid epidemic initiatives, a 2 billion dollar increase in NHI funding, a 4.8 billion dollars in emergency Medicaid funding for Puerto Rico and U.S. Virgin Islands and a 4 billion dollar allocation to rebuild VA hospitals and clinics.

To add …. last week AMA scored yet another victory by working with Anthem and having Anthem rescind a proposed policy relating to physician use of payment Modifier 25 that was slated to take effect on March 1, 2018, across the company's commercial health insurance businesses. This provision would have decreased the fee for E/M Service appended with Modifier 25 along with minor surgical procedure by 25 to 50 percent. This 25 to 50 percent cut has now been rescinded and Anthem has decided not to proceed with this policy after extensive discussion with the AMA's leadership.

I urge our physician colleagues to become members of the AMA and be part of our struggle, and support the advocacy efforts of AMA, to amplify our voice.

VA finalizes interstate licensing rule that will 'open the aperture' for telehealth

by Evan Sweeney | May 10, 2018 2:25pm



The Department of Veterans Affairs finalized a much-anticipated rule that allows providers to treat patients across state lines using telehealth, a critical element of a virtual care initiative launched last year.

The new regulation will allow the health system more leeway to integrate telehealth visits as a routine part of patient care, according to Neil Evans, M.D., the chief officer for the Office of Connected Care, who told FierceHealthcare the rule "will really allow us to open the aperture" on existing telehealth initiatives.

Currently, VA patients can receive care via telehealth by going to one of more than 700 community clinics that feature specialty services like telemental health and postsurgical consultations. Up until Thursday, physicians around the country could treat patients that visited those clinics, but licensing regulations prohibited them from performing a virtual visit in a patient's home if it was outside the state where they held a medical license.

The new rule (PDF), scheduled to publish on the Federal Register on Friday, finalizes last year's proposal to override state licensing restrictions so clinicians can treat veterans anywhere in the country. The rule is a critical piece of the VA's Anywhere to Anywhere telehealth initiative, announced last August by former Secretary David Shulkin, M.D., alongside President Donald Trump.

The initiative, which "dramatically expands our current capabilities," Shulkin said at the time, features a new mobile app that allows patients to connect to clinicians using their smartphone.

RELATED: VA proposed rule would override state licensing restrictions to expand access to telehealth

The finalized rule is limited to VA-appointed providers, so it excludes clinicians that provide care through VA Choice program.

Two separate bills have also passed the House and Senate that, if reconciled and signed by the president, would codify similar changes into law. While the new regulation provides some immediate relief, VA leadership remains supportive of the legislation as a long-term fix.

"Frankly, the legislative solution is preferable to a regulatory solution," Evans told FierceHealthcare at the HIMSS18 conference in March. "It becomes law and there's some permanence to it."

New rule offers new opportunities

During fiscal year 2017, 12% of VA patients that recorded at least one care encounter with the system received a portion of their care via telehealth, according to Evans. That translated to more than 727,000 veterans engaging in some type of telehealth encounter totaling nearly 2.2 million visits.

But of the 12% that used telehealth in 2017, less than 1% received care at home. The leeway provided in the new rule is expected to boost that percentage.

"Strategically, we want to move more of this care into the home when it's appropriate," Evans said.

RELATED: FTC says VA telehealth rule would increase competition among providers

A big part of that push will be integrating telehealth into physician workflow by configuring the EHR to include the option for a telehealth visit. The VA also plans to build on an online scheduling app released last year that allows patients to book appointments online. At some point in the future, patients will be able to book a telehealth visit as well.

Already, some VA providers have been improvising with the new functionality of the Anywhere to Anywhere program, using virtual visits to enhance phone appointments or schedule follow-up care. Leveraging those experiences will be key since "adoption goes through the roof" among patients when physicians recommend any type of virtual modality, Evans said.

The agency also plans utilize its 10 telemental health hubs to provide in-home services to patients around the country.

"When that infrastructure is in place, I don't think providers really struggle to see the value [of telehealth]," Evans said.

"It's part of a new skill set for clinicians to understand not just what pharmaceuticals I should be prescribing, but what modalities should I be using to deliver this healthcare," he added.

Read More On

Telehealth Health Policy Mobile Apps Mobile Integrated Healthcare Department of Veterans Affairs David Shulkin Neil Evans Donald Trump VETS Act of 2017

More Medicare Part D beneficiaries reaching catastrophic phase, likely setting up calls for reform

Physician Practice Roundup—More doctors certify in obesity medicine; Future CMS policies to consider burden on small, rural practices

Health IT Roundup—ONC info blocking rule pushed to September; Wisconsin hospital sued for data breach

A Texas city had a construction boom. So the local hospital created an amputation team

HYATT REGENCY CHICAGO
GUEST MAP

Back to agenda

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- AMERICAN CRAFT KITCHEN & BAR — East Tower, Lobby Level
- ATLANTA *(International and City Suites)* — West Tower, Ballroom Level
- BELL DESK — East Tower, Skyway Level
- BIG BAR — East Tower, Skyway Level
- BURNHAM *(Founders Suites)* — West Tower, Third Floor
- BUSINESS CENTER, PACKAGE ROOM — East Tower, Exhibit Level
- COLUMBIAN *(Landmark Suites)* — West Tower, Concourse Level
- COLUMBUS HALL (ROOMS A-L) — East Tower, Ballroom Level
- COMISKEY *(Landmark Suites)* — West Tower, Concourse Level
- CONCIERGE — East Tower, Lobby Level
- CRYSTAL BALLROOM — West Tower, Lobby Level
- DUSABLE *(Founders Suites)* — West Tower, Third Floor
- EAST TOWER MAIN ENTRANCE — East Tower, Lobby Level
- EAST TOWER VALET — East Tower, Ballroom Level
- FIELD *(Founders Suites)* — West Tower, Third Floor
- FITNESS CENTER — West Tower, Skyway Level
- FRONT DESK — East Tower, Skyway Level
- THE GALLERY COLLECTION — West Tower, Skyway Level
- GIFT SHOP — East Tower, Concourse Level
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- GRAND SUITES — East Tower, Ballroom Level
- HAYMARKET *(Landmark Suites)* — West Tower, Concourse Level
- HERTZ — East Tower, Lobby Level
- HONG KONG *(International and City Suites)* — West Tower, Ballroom Level
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- THE LIVING ROOM — West Tower, Skyway Level
- MARKET CHICAGO — East Tower, Lobby Level
- McCORMICK *(Founders Suites)* — West Tower, Third Floor
- MICHIGAN *(Lakeshore Meeting Rooms)* — East Tower, Concourse Level
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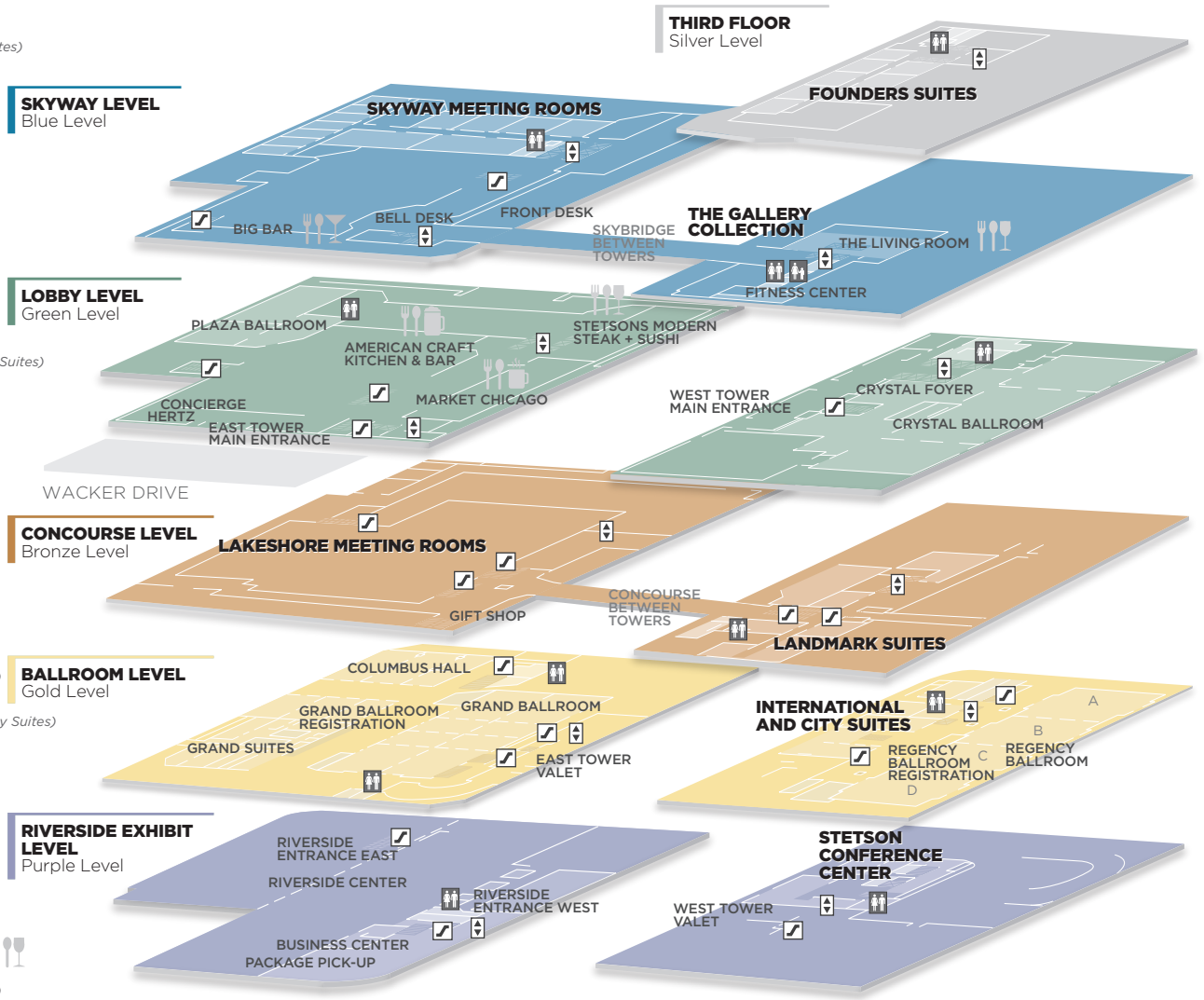
EAST TOWER

WEST TOWER



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CROSSING BETWEEN TOWERS: Cross between towers via the Skybridge or the Concourse. You may also cross from the lobby level via the crosswalk on Stetson Drive.

- ELEVATORS
- ESCALATORS AND STAIRS
- RESTROOMS
- MOTHER'S ROOM

Speakers' Letter

2018 Annual Meeting of the AMA House of Delegates
June 9–13, 2018 Hyatt Regency Chicago

Ladies and Gentlemen:

The following information is provided to aid your planning for the upcoming Annual Meeting in Chicago. We would particularly like to call your attention to childcare services that will be available in Chicago (see page 3), the elections (see page 3), seating availability in the House (see page 2), a planned orientation for new delegates (see page 16), and a note about the Surgeon General speaking to the House (see page 16).

Please call 312.464.4463, send an email to hod@ama-assn.org or visit ama-assn.org/annual-meeting if you have questions regarding any of the following items or questions on American Medical Association (AMA) policy. Watch the Annual Meeting website for updates to this *Speakers' Letter*.

Susan R Bailey, MD, Speaker
Bruce A Scott, MD, Vice Speaker

House of Delegates schedule

The 2018 Annual Meeting of the AMA House of Delegates (HOD) will meet June 9–13 at the Hyatt Regency Chicago. The AMA-HOD will convene at 2 p.m. Saturday, June 9 in the Grand Ballroom, and your Speakers ask that delegates be seated by 1:50 p.m. The opening session will start promptly at 2 p.m. and recess by 6 p.m.

On Sunday, June 10, the "Second Opening" of the AMA-HOD will be in session 8–8:30 a.m. to receive items of business, consider acceptance of late resolutions, and extract informational reports and items from the reaffirmation consent calendar. Afterwards reference committee hearings will follow:

Hearings from 8:30 a.m. to noon Sunday	
Reference Committee on Amendments to Constitution & Bylaws	Crystal Ballroom
Reference Committee B	Regency Ballroom B
Reference Committee C	Regency Ballroom C
Reference Committee D	Regency Ballroom D
Reference Committee G	Regency Ballroom A
Hearings from 1:30 to 5 p.m. Sunday	
Reference Committee A	Regency Ballroom A
Reference Committee E	Regency Ballroom D
Reference Committee F	Grand Ballroom

Additional business sessions of the AMA-HOD will convene at 2 p.m. Monday, June 11, and 9 a.m. Tuesday and Wednesday, June 12 and 13. The AMA-HOD will adjourn by noon on Wednesday. Your Speakers ask delegates to schedule departures for the afternoon of Wednesday so that they can give full consideration to the business debated that day.

Delegates and alternate delegates may request special accommodations (eg, an assistive listening device) by contacting the Office of House of Delegates Affairs by email at hod@ama-assn.org or phone 312.464.4344.

Note: All events are at the Hyatt Regency Chicago unless otherwise indicated.

Meeting details and reminders

Handbook distribution
The initial Handbook will be posted on the Annual Meeting website by May 11 as a single large document as well as in a set of smaller documents collated by reference committee. The Addendum will be posted about May 18, and when it is posted, both the original Handbook and the Addendum will be available separately along with a combined document that interleaves the Addendum with the Handbook. An abridged Handbook containing only the recommendations from reports and the resolve clauses from resolutions will also be available as a Word document.

Hardcopy Handbooks will be mailed by May 18 to delegates and alternate delegates who have previously received paper copies, with the Addendum scheduled to go out on or about May 25. Primary distribution of the Handbook and Addendum will be by download from the Annual Meeting website.

Registration
Registration for the AMA-HOD will be located in the Grand Foyer, which adjoins the Grand Ballroom. For security purposes, all attendees will be required to provide photo identification at the AMA Registration Desk in order to receive their credentials and other materials. Registration will open daily at 7 a.m. and run from Friday, June 8 through Wednesday, June 13.

Delegates and alternate delegates should check with their sponsoring society to ensure that their names have been submitted to the Office of House of Delegates Affairs well ahead of their arrival in Chicago. Under AMA bylaws all delegates and alternate delegates must be credentialed by the society that they will represent. Individuals whose credentials have not been confirmed prior to the Annual Meeting will have to be accompanied to the AMA Registration Desk by an officer of their society in order to register.

Recording of AMA-HOD meetings
Proceedings of AMA meetings may be recorded by audiotape, videotape or otherwise, for use by the AMA. Participation in/attendance at a meeting shall be deemed to confirm the participant's consent to recording and to the AMA's use of such recording.

Seating in the House of Delegates
Because of continued membership growth, the seating of new specialty societies, added regional student and sectional resident delegates and recent action to create parity in the number of constituent (state) society and national medical specialty society delegates, this year's Annual Meeting will have significantly more delegates than last year's meetings. The larger number of delegates requires additional reserved delegate seating and necessarily decreases the space available for open seating at the rear of the Grand Ballroom. For that reason we will provide two auxiliary listening areas with audio and video feeds from the House. The first will be nearly adjacent to the House in one of the Columbus Rooms, with priority for seating in that room given to alternate delegates. The second auxiliary space will be in Riverside Exhibit Hall; to access that area turn left at the bottom of the escalators leading to the staff area.

We expect the largest audience for Saturday's opening session, during which seating will be at a premium. While delegates have a designated seat, if you will be seated in the open seating area, please take only a single seat and move to the center of the row in order to accommodate everyone. During the opening session, we will be joined by a number of international guests as well as young scholars being recognized by the AMA Foundation. We thank you in advance for your patience and cooperation.

Meeting attire
Your Speakers have determined that business casual dress is appropriate for the Annual Meeting, although business attire is requested for those seated on the dais during HOD business sessions. Business attire is also proper for the inaugural and dinner-dance, with formal attire (black tie) optional.

Respectful behavior
At the first session of each AMA-HOD meeting, as provided in the HOD Reference Manual, delegates are asked to ratify a code of conduct that reaffirms a commitment to be courteous, respectful and collegial in the conduct of HOD business. Courteous and respectful dealings in all interactions with other delegates and with AMA staff are expected of all attendees at HOD meetings—including social events apart from HOD meetings themselves. Instances of unwelcome or inappropriate behavior should be brought to the attention of the Speakers. Delegates are reminded of their personal responsibility, while engaging with others, to consider how others will interpret their actions and words.

Childcare services
The childcare pilot test will continue at A-18 with service available from 7 a.m. to 7 p.m. starting on Thursday, June 7 and running through Tuesday, June 12; availability on Wednesday will run from 7 a.m. to noon. Reservations are required to ensure a spot and may be made through the meeting website. An hourly option has been added to the program for this meeting, with a four hour minimum. Hours and prices are as follows:

	Age up to 36 months	Age 3 years and older
Hourly (4 hour minimum)	$12/hr	$10/hr
Half day (7 a.m. to 1 p.m. **or** 1 to 7 p.m.)	$60	$50
Full day (7 a.m. to 7 p.m.)	$100	$90
Wednesday (7 a.m. to noon)	$45	$40

There is a $10 per child registration fee, and prices do not include meals. Additional information and registration are available at accentregister.com/Event/CEvents/6731. To assure space, pre-registration by May 31 is required. Onsite registration will be accepted only if space is available.

The vendor, Accent on Children, is fully licensed, and caregivers have considerable experience in working with children. Staff to child ratios range from 1:2 for infants to 1:8 for school-age children.

Airline and airport transportation discounts
United Airlines is offering a discount that is valid for 3 days prior to and 3 days after the official meeting dates. To obtain the discount when booking online at United.com, click on All Search Options and enter your origin, destination and travel dates. Then enter ZEPB957915 in the Promotions and Certificates offer code box. Available flights will be displayed, and the discounted fare will automatically be calculated after flights are selected. To obtain the discount over the phone, call United Airlines Meetings at 800.426.1122 and mention Z code ZEPB and agreement code 957915. A service fee will apply for phone transactions.

GO Airport Express offers airport shuttle services between O'Hare and Midway Airports and downtown Chicago hotels. A discounted fare is available through the link on the meeting website or visit airportexpress.com/reservations and enter "ama" in the Frequent User Login box.

Distribution of nonbusiness items
The "not-for-official-business" bag contains campaign literature, small gifts and other informational material approved by your Speakers. It is distributed at the Opening Session. Material for distribution to the AMA-HOD in the not-for-official-business bag should be delivered to the production area of the AMA Headquarters Office at the Hyatt Regency Chicago by 5 p.m. Thursday, June 7. As a general rule, 1300 copies of items are required for distribution throughout the AMA-HOD. For campaign gifts, at least 750 items are required for distribution in the delegates' seating area; distribution throughout the ballroom requires 1300 items. The decision as to the number of gifts is up to the candidate, but the $3,085 cap on expenditures for campaign memorabilia applies regardless.

Nominations and elections
The *2018 Election Manual* lists candidates for officer positions along with candidates for various council seats who were nominated by the Board of Trustees. A link to candidates' conflict of interest information also appears in the election manual as required by House policy. The election manual is freely accessible, but conflict of interest disclosures are available only to members, who must login to obtain access.

Balloting at A-18

Elections for officer and council positions will be held 7:30–8:45 a.m. Tuesday, June 12 in Columbus K–L. Elections are conducted under the supervision of the chief teller, the assistant election tellers and the Committee on Rules and Credentials. The polls will close 15 minutes before the AMA-HOD reconvenes that morning, and eligible delegates must be in line by 8:45 a.m. in order to vote.

Only duly credentialed delegates are permitted to cast a ballot. An alternate delegate who is seated for a delegate must first be properly re-credentialed as a delegate at the AMA Registration Desk in order to vote in an election. The change from alternate delegate to delegate must be approved by a duly authorized officer of the society in question; see bylaws 2.10.4 and 2.10.4.1.

The following races are scheduled:

- President-elect – vote for one, currently two candidates
- Speaker and Vice Speaker – vote for one each office; currently one candidate each office
- At-large trustee – vote for four, currently nine candidates
- Young physician trustee – vote for one, currently one candidate
- Council on Constitution and Bylaws – vote for three, currently three candidates
- Council on Constitution and Bylaws, Resident – vote for one, currently one candidate
- Council on Medical Education – vote for one, currently two candidates
- Council on Medical Service – vote for four, currently five candidates
- Council on Science and Public Health – vote for three, currently five candidates

Additional nominations are possible during the opening session, which could affect these elections. In the event that a new vacancy arises or a runoff election is required, paper ballots will be distributed to credentialed delegates seated in the House at the time ballots are distributed. House policy requires that all nominees complete a conflict of interest form prior to election. Individuals who anticipate the possibility of a nomination from the floor are urged to contact Roger Brown in the Speakers' Office (roger.brown@ama-assn.org, or phone 312.464.4344). Inquiries will be maintained in confidence.

CEJA nominations
President-elect Barbara L. McAneny, MD, will nominate two members for seats on the Council on Ethical and Judicial Affairs during the opening session on Saturday, June 9. One nomination will be for a full term on the Council, and the other will be for the resident seat. Both nominees' conflict of interest disclosures will be posted on the AMA website in the week preceding the opening of the House. This will allow the election to proceed on Saturday following the formal nomination by Dr McAneny. Please watch the meeting website or the candidate page in the days leading up to the AMA-HOD meeting.

Announcements of candidacy for future elections
Individuals who intend to seek election at the 2019 Annual Meeting are reminded that printed announcements may no longer be distributed in the meeting venue. Announcements provided to us before noon, Monday, June 11 will be projected on the last day of the meeting. An electronic announcement should be submitted to Roger Brown (roger.brown@ama-assn.org) in the Speakers' Office; the preferred format is JPG, but a PDF or PowerPoint slide is also acceptable. Announcements should be sized for 16:9 projection in the House. Submissions will be maintained in confidence until posted. Announcements will be posted online on an updated candidate page after the meeting.

Inauguration of Barbara L. McAneny, MD
The inaugural ceremony for President-elect Barbara L. McAneny, MD, will take place at 5 p.m. Tuesday, June 12 in the Crystal Ballroom, with a reception and dinner dance starting at 6:30 p.m. in the Grand Ballroom. Tickets are required for the dinner dance. Individuals should coordinate reservations, payment and seating with their sponsoring organization but may visit the meeting website to register online, or contact Registration Services in the AMA's Department of Meeting Services at 312.464.4582. Business or formal attire is requested for the evening.

Online member forums
As mentioned in the meeting information memo, each reference committee includes an online member forum. The forums can be accessed directly at ama-assn.org/hod-forums or via the meeting website. The site will be up no later than when the Handbook is posted, and items from the Addendum will be added as they become available. Instructions are found on the site. All members of the House with email addresses will have been sent an announcement when the online forum is launched. If you do not receive such a notice, please send an email to that effect to patti.wargo@ama-assn.org.

The forums will remain open for commenting up to the opening of the House, but comments posted after Sunday, June 3 are unlikely to be captured in the summary reports that will be posted on the meeting website.

Proceedings of the 2017 Interim Meeting
The draft of the *Proceedings of the House of Delegates* for the 2017 Interim Meeting (I-17) has been posted in downloadable format on the AMA website. Approval of the minutes from I-17 is an action item on Sunday morning. PolicyFinder has been updated to reflect actions from I-17 as captured in the *Proceedings*.

Conflict of interest policy
Sponsors of resolutions are reminded that the AMA-HOD has established policy (G-600.060) calling on delegates introducing an item of business to declare any commercial or financial conflict of interest at the time the resolution is submitted and that any such conflict of interest be included with the resolution.

Your Speakers have determined that this policy also applies to resolutions introduced by delegations. The sponsoring delegation must disclose the identity of any delegate or alternate delegate who has a commercial or financial interest with respect to matters addressed in the resolution. If a conflict is disclosed, the notation on the resolution will not contain an individual delegate's name, but will state in substance that, "In accordance with House policy regarding disclosure of conflicts of interest, the delegation has notified the Speaker that one or more delegates has a commercial or financial conflict of interest with respect to the matters addressed in this resolution." For resolutions already submitted, please notify the AMA Office of House of Delegates Affairs. A revised resolution containing the conflict of interest statement will be distributed.

HOD Reference Manual
The *House of Delegates Reference Manual: Procedures, Policies and Practices* provides comprehensive information about the AMA's policy development process. It describes AMA-HOD procedures and may be especially helpful to new delegates, but it is a good reference for all meeting participants. Visit ama-assn.org/sites/default/files/media-browser/public/hod/hod-reference-manual.pdf to access the manual.

2018 Interim Meeting planning
The 2018 Interim Meeting, with its focus on advocacy and legislation, will be held at the Gaylord National in National Harbor, Maryland, Nov. 10–13. Delegates and alternate delegates who are willing to serve on a reference committee at the Interim Meeting are asked to contact the Office of House of Delegates Affairs by stopping in the Headquarters Office or emailing hod@ama-assn.org to let us know about your preferences for a reference committee assignment. Five reference committees will convene at the Interim Meeting:

- Reference Committee on Amendments to Constitution and Bylaws: Ethics, bylaws
- Reference Committee B: Legislative advocacy
- Reference Committee F: AMA governance and finance

- Reference Committee J: Advocacy related to medical service, medical practice, insurance and related topics
- Reference Committee K: Advocacy related to science and public health and possibly medical education

Reference Committee C may be added to the list, depending on the volume of business related to medical education. If business is limited, these items will be considered in Reference Committee K.

Insofar as possible, we rely on volunteers to serve on the reference committees, and we strive to place volunteers on reference committees of their choosing. New appointments to Reference Committee F will be made just a few weeks after the Annual Meeting adjourns.

In addition, as is our custom, we will be holding a speaker-to-speaker session at I-18, which is open to anyone interested in discussing meeting processes. Suggestions for the agenda are always welcome and may be sent to hod@ama-assn.org.

Meetings and caucuses

OSMAP
The Organization of State Medical Association Presidents (OSMAP) will hold its semi-annual membership meeting and general session from 2 to 5 p.m. Friday, June 8 in Grand Ballroom A. All state medical association presidents, presidents-elect, past presidents and executive directors are welcome and encouraged to attend. An agenda and related meeting materials will be posted on the OSMAP web site (osmapandtheforum.org) prior to the meeting. If you have suggestions for the agenda, contact Brian O. Foy, OSMAP Executive Director, at bfoy11@yahoo.com. Immediately following the general session, OSMAP will host a reception in Grand Ballroom B. All OSMAP members and their invited guests are welcome to attend. RSVP not required.

Surgical Caucus Handbook review
The Surgical Caucus of the AMA will be meeting from 6:45 to 9:30 a.m. Saturday, June 9 in the Comiskey Room for a combined business meeting and handbook review session. Specialties participating in the Caucus are encouraged to send at least one representative to this meeting. Breakfast will be available starting at 6:30 a.m.

Academic Medicine Caucus
All AMA delegates and alternates with an academic appointment are invited to attend the AMA Academic Medicine Caucus, 5–6 p.m. Saturday, June 9 in the Water Tower Room, and/or 8:30–10 a.m. Monday, June 11 in Skyway 260.

Attendees will discuss issues of mutual concern and interest pertaining to academic medicine and review the report of Reference Committee C (on medical education). Come network with your colleagues and share your ideas on how the AMA can continue to provide leadership in medical education. Learn more about the AMA Academic Physicians Section, which serves as the voice of academic physicians to the AMA HOD.

Rural Medicine Caucus
Join others with an interest in rural medicine from 5 to 6 p.m. Sunday, June 10 in Columbus H to network with colleagues, share ideas on how the AMA might better serve rural physicians and patients, and discuss resolutions that attendees feel are applicable to practice in rural or other low-resource settings. Residents of rural areas have been shown to be generally sicker, poorer, and older than their counterparts in urban areas, and recent research shows that women do not have access to obstetric care in 54% of rural counties. These issues are further compounded by health care workforce shortages and decreased resource availability. The challenges rural patients and those who care for them face result in unique perspectives on the practice of medicine.

All meeting attendees, including delegates and alternate delegates, representatives of state or specialty societies, medical students, residents, section leaders, AMA staff, and board members are invited to attend. Please contact Jordan Warchol, MD, at JordanWarcholMD@gmail.com for more information.

Private Practice Physician Congress
The Private Practice Physician Congress will meet from 10 to 11:30 a.m. Monday, June 11 in Columbus I-J. All AMA members interested in the private practice of medicine, including young physicians, residents, fellows and medical students, are invited to join the meeting. The group includes primary care and specialty care physicians. For questions or comments please contact Zuhdi Jasser, MD, Chair, at zuhdi@jasserim.com or 608.721.7186; Tim McAvoy, MD, Vice-Chair, at timothymcavoy@yahoo.com or 414.573.0751; or Barb Hummel, MD, Secretary, at hummelb@ameritech.net or 414.690-6352.

Educational programming

Several education programs will be offered during the 2018 Annual Meeting. All members are welcome to attend any of the education sessions listed below, many of which are sponsored by the sections and special groups. These sessions will be offered Friday, June 8; Saturday, June 9; and Monday, June 11. (Additional information on section-sponsored events can be found below.)

Sessions certified by the AMA for CME credit are indicated by an asterisk (*).

> The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
> The American Medical Association designates each live activity for the maximum number of *AMA PRA Category 1 Credits*™ reflected with each session. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The deadline to claim credit for sessions certified by the AMA is July 31, 2018. The AMA Education Center can be accessed at cme.ama-assn.org/Education.aspx. Click on "Sign In" in the upper right hand corner of the screen, and enter your AMA username and password or create an account. Follow the instructions and complete the evaluation for each activity attended. Physicians will receive a CME certificate; non-physicians will receive a Certificate of Participation. Certificates will be saved in the "My Profile" section.

Attendees who have questions will find the AMA Education Center booth near the Grand Ballroom, where staff can assist learners in claiming credit or printing certificates. You may also contact the AMA Unified Service Center at 800.262.3211.

The American College of Surgeons has also certified one program for credit. It is indicated with a dagger (†). That session is not available on the AMA Education Center.

***Value-based care: Understanding models of risk (*2.5 AMA PRA Category 1 Credits*™)**
9 a.m.–Noon Friday, June 8, Crystal Ballroom A
Hosted by the AMA Integrated Physician Practice Section (AMA-IPPS)

> Value-based care is receiving growing and broad support within the medical community and in the policy arena on both sides of the aisle. Some physician organizations have already fully transitioned from fee-for-service to various risk models that support value-based care; but many are still trying to figure how to dip a toe in the water. In this program, experts detail five risk models (bundles, CPC+, MSSP, professional risk, and full risk); the skills and infrastructure needed to succeed; and the pros and cons of each. AMA-IPPS is partnering with America's Physician Group (formerly CAPG) to present a full morning of interactive programming to help learners of all levels make the next move in their "risk bearing" journey.

***Teamwork, communication, and patient safety: Elements of medical staff leadership in patient care (*1 AMA PRA Category 1 Credit™*)**
9:30–10:30 a.m. Friday, June 8, Crystal Ballroom B
Hosted by the AMA Organized Medical Staff Section (AMA-OMSS)

Medical staff leaders are key to ensuring a robust culture of patient safety. Your action, or inaction, influences how your staff approach errors and treat their colleagues when an event or near miss occurs. Through fostering a culture of accountability and openness within your medical staff, you can make a lasting impact on the effectiveness of your team and the quality of care delivered to your patients. Learn how to create this empowering culture within your medical staff and lead your colleagues and staff members to change the way they look at events.

Exploring the cutting edge of gene therapy in medicine
10–11 a.m. Friday June 8, Acapulco
Hosted by the AMA Medical Student Section (AMA-MSS)

Gene therapy, especially germline gene editing in humans, is a controversial issue that will become a widespread reality in the field of medicine. The AMA is at the forefront of providing ethical boundaries and practice recommendations for use of these technologies in medicine. Current AMA policies address stem cell and genetics research but do not address the use of genetic therapies, such as emerging technologies like CRISPR-Cas9. This informational session will explore the topic of gene therapy and initiate a discussion of the important scientific and ethical considerations when using this technology for therapeutic purpose.

***Blockchain in health care: Hype or here to stay? (*1 AMA PRA Category 1 Credit™*)**
10:45–11:45 a.m. Friday, June 8, Crystal Ballroom B
Hosted by the AMA Organized Medical Staff Section (AMA-OMSS)

What is blockchain and how can it provide opportunities for health care? At its core, blockchain technology is a shared system of recording and securely storing transaction records. Given the perceived benefits and accessibility of this novel system, health care technologists and professionals are exploring how blockchain can be used for secure medical and provider record sharing, protecting sensitive health information from hackers, and providing patients with more access and control over their health information. Join us to learn more about this emerging technology and how it will transform the way that you care for your patients.

A day in the life of me: Tackling prejudice against providers
11 a.m.–Noon Friday June 8, Acapulco
Hosted by the AMA Medical Student Section (AMA-MSS)

While patients have the right to refuse care, sometimes a patient's refusal of care may be based on overt or implicit bias against a physician. Institutional frameworks to address bias against physicians have arisen, but few healthcare centers have dedicated models to report and address these instances of discrimination, leaving its physicians and trainees vulnerable and unsupported. This session aims to shed light on patient and institutional bias against providers by exploring its prevalence in medicine, identifying what groups are most likely to face discrimination, and highlighting the need for awareness. Through a panel of individuals with various backgrounds, we will explore their perspectives and attendees will come away with a greater understanding of the many forms of prejudice.

How to negotiate your employment contract
1:20–2 p.m. Friday, June 8, Columbus I-J
Hosted by Academic Physicians Section (AMA-APS) and the Organized Medical Staff Section (AMA-OMSS)

Learn how to negotiate (or renegotiate) your employment contract and mentor medical students and resident/fellow physicians as they begin to explore their career options and enter into practice. Presenting will be Richard Levenstein, partner with the law firm Kramer, Sopko, and Levenstein.

After the smoke clears: Provider well-being after mass casualty incidents
1:30–2:30 p.m. Friday June 8, Acapulco
Hosted by the AMA Medical Student Section (AMA-MSS)

During any major traumatic event or mass casualty incident, the medical providers take the responsibility of patient care despite the severity of the situation. In the midst of chaos, the providers are focused on care. In the aftermath, the spotlight remains on the victims and the community, often overlooking the medical providers. However, many providers experience PTSD, anxiety, depression, and other psychological reactions that are not addressed after the trauma of the experience. During this session, we hope to discuss provider care and wellbeing when traumatic events occur. Ultimately, we aim to address: How do we care for providers who care for our communities during the most difficult of times?

***Understanding CMS's new BPCI Advanced Model (*1.5 AMA PRA Category 1 Credits™*)**
1:30–3 p.m. Friday, June 8, Crystal Ballroom A
Hosted by the AMA Integrated Physician Practice Section (AMA-IPPS)

The Center for Medicare & Medicaid Innovation (CMMI) recently announced the Administration's first new Medicare alternative payment model, Bundled Payments for Care Improvement Advanced (BPCI Advanced). This voluntary model includes 29 inpatient and 3 outpatient clinical episodes, and operates under a total-cost-of-care concept. Steven Farmer, MD from CMMI will discuss the BPCI Advanced model followed by a reaction panel of physician leaders who will consider the potential pros and cons from their organization's perspective.

***Stakeholders' forum: Educational implications of incorporating precision medicine into a population health model (*2.25 AMA PRA Category 1 Credits™*)**
3–5:30 p.m. Friday, June 8, Columbus E-F
Hosted by the Council on Medical Education

This forum will engage medical education stakeholders in a discussion of the educational implications of incorporating precision medicine into a population health model. How can precision medicine be used to affect overall population health? What is the role of physicians to ensure that precision medicine will not increase health care disparities when applied as a population health intervention? Which curricular models explore the interface between these models, and what are the implications for physician education? Please join the forum for this important discussion. For questions or more information please contact Karen Heins at karen.heins@ama-assn.org.

***Improving health outcomes for vulnerable patient populations (*1 AMA PRA Category 1 Credit™*)**
8:30–9:30 a.m. Saturday, June 9, Crystal Ballroom B
Hosted by all AMA Sections and Special Group

Health disparities are common among the elderly, LGBTQ and incarcerated populations. This program will look at the structural, socio-economic, and biological determinants of health among these three patient populations in order to gain insights that will lead to interventions that are more effective.

The featured speakers are Erick Eiting, MD, AMA Young Physicians Section representative, AMA Lesbian, Gay, Bisexual, Transgender, and Queer Advisory Committee; Dionne Hart, MD, delegate, AMA Minority Affairs Section Governing Council; and Paul Wick, MD, chair, AMA Senior Physicians Section Governing Council. The moderator is Helene Nepomuceno, chair, AMA Medical Student Section Governing Council.

***#MeToo: Sexual harassment and discrimination in medicine (*1 AMA PRA Category 1 Credit™*)**
9:45–10:45 a.m. Saturday, June 9, Crystal Ballroom B
Hosted by all AMA Sections and Special Group

Sexual harassment and discrimination are prevalent in all aspects of society. This session will help physicians, medical students, and organizations identify and mitigate harassment and discrimination in medicine. Learn how these issues impact patient care and how to reduce unconscious bias and inappropriate behavior in the workplace.

***From disruption to reform: Learn to spark change and move medicine forward (*1.25 AMA PRA Category 1 Credits™*)**
10:45 a.m.–Noon Saturday, June 9, Columbus C-D
Hosted by all AMA Sections and Special Group

It's an incredible challenge to stay current on issues and find time to advocate for patients. Making a difference doesn't have to take a lot of effort. With just a few key strategies, you have the power to influence the future of medicine. Learn about the most pressing issues in medicine and how to take smart action. We'll be talking about the issues the AMA is working on. This program will provide attendees with an understanding of the current political climate and the tools they need to enact political change at the grassroots level.

***Health care change agents: Traditional and non-traditional players fuel the fire (*1 AMA PRA Category 1 Credit™*)**
11 a.m.–Noon Saturday, June 9, Crystal Ballroom C
Hosted by all AMA Sections and Special Group

It seems every week another "non-traditional" player enters or combines with another in the health care space, i.e., Amazon and friends, CVS and Aetna, among others. As a practicing or academic physician, resident, or medical student, how can you sift through the noise, open your aperture, and evaluate the potential merit or demerit of other parts of the economy increasingly playing a role in healthcare? This event will allow attendees to engage in discussions with forward-thinking experts.

***Small changes, big results: Innovations in patient-centered technology (*1 AMA PRA Category 1 Credit™*)**
11 a.m.–Noon Saturday, June 9, Regency Ballroom A-C
Hosted by all AMA Sections and Special Group

With advancements in patient-centered technology, it can be difficult for physicians to navigate new options in this changing landscape. This session will examine key technological advances in patient care and highlight what physicians need to consider when implementing new technologies in their practice. They will also learn how to employ innovations from others in the field that improve care delivery, patient outcomes, and the physician experience.

***How to successfully transition out of medicine and into retirement (*1.5 AMA PRA Category 1 Credits™*)**
Noon–1:30 p.m. Saturday, June 9, Columbus K-L
Hosted by the AMA Senior Physicians Section (AMA-SPS) and the AMA Academic Physicians Section (AMA-APS)

For many senior physicians, retirement is welcomed after a lifetime of work and responsibilities. However, many physicians worry about their decision to retire for fear of losing their primary identity or purpose—especially challenging due to the at-times consuming nature of the profession of medicine. As life expectancy rises and more time is spent in the "retirement years," successful planning is critical to a full, active lifestyle. This program will look at incorporating minor behavior adjustments/modifications can help physicians cope with the changes of growing older and find meaning in this next phase of life.

The featured speaker is Luis T. Sanchez, MD, chair, Committee on Senior Physicians, Massachusetts Medical Society. Panelists are George C. Mejicano, MD, MS, chair, AMA-APS Governing Council and Cynda Ann Johnson, MD, MBA, member-at-large, AMA-APS Governing Council. The moderator is Richard Allen, MD, chair-elect, AMA-SPS Governing Council.

***Value-based contracting: The latest tips and strategies from the frontlines (*1 AMA PRA Category 1 Credit™*)**
8–8:59 a.m. Monday, June 11, Crystal Ballroom A
Hosted by AMA's Professional Satisfaction and Practice Sustainability group

Learn about the latest evolution of value-based payment contracts that include cost and quality metrics and risk-based payments. Through a dialogue moderated by an expert in health care legal and management consulting, this CME activity will enable you to learn from experienced physicians about the strategies used to ensure these arrangements work for your patients AND your practice. Upon completion of this session, you will be able to identify elements of value-based contracts best suited to your practice, recognize how a value-based contract may affect your practice and physicians, other clinicians and the patients within the practice, and discover valuable AMA resources on payment models and value-based contracts. Presenters include Moderator Bruce A. Johnson, JD, Shareholder, Polsinelli PC, Denver, Colorado; Michael Robertson, MD, Chief Medical Officer, Covenant Health Partners and Covenant ACO, Lubbock, Texas; and Justin Cohen, MD, Urologist, UroPartners, and PHO President, Advocate Condell Medical Center, Lake Forest, Illinois.

AMA Ambassador Program: Why you should join
8–8:59 a.m. Monday, June 11, Regency Ballroom D
Co-hosted by AMA's Social Media and Physician Engagement Groups

The AMA has officially launched an ambassador program, seeking to harness and share with the world the great work and enthusiasm of our AMA members. Attend this session to hear more about what it means to be an ambassador, why the program was launched, how you can get involved both online and off, and the benefits to you. You'll also see examples of your colleagues in action as AMA ambassadors!

***Preventing gun violence: What physicians can do now (*1.5 AMA PRA Category 1 Credits™*)**
8–9:29 a.m. Monday, June 11, Regency Ballroom C
Co-hosted by the Council on Science and Public Health and the AMA Advocacy Resource Center

In the United States, more than 32,000 persons die as a result firearm-related violence, suicides, and accidents each year, making firearm-related morbidity and mortality a major public health problem, whose solution requires a multidisciplinary and inter-professional collaboration. Many physicians have first-hand experience with the effects of firearm-related injuries and deaths and the impact of such events on the lives of their patients. However, to reduce firearm-related injuries and deaths, it is essential to address culture, firearm safety, and regulations that maximize safety and prevention while being consistent with the Second Amendment.

Participants will be able to describe the trends in morbidity and mortality associated with gun violence in the U.S., identify evidenced-based strategies available to reduce firearm morbidity and mortality, and define the physician's unique role in promoting gun safety and preventing gun violence. Featured speakers include Marian "Emmy" Betz, MD, MPH, MPH, associate professor, emergency medicine, University of Colorado School of Medicine; Garen Wintemute, MD, MPH, professor, emergency medicine, University of California-Davis School of Medicine; and Megan Ranney, MD, MPH, associate professor, emergency medicine, Warren Alpert Medical School, Brown University. The session will be moderated by David Welsh, MD, member of the Council on Science and Public Health.

***Transforming Clinical Practice: A step-wise approach (*1 AMA PRA Category 1 Credit™*)**
9–9:59 a.m. Monday, June 11, Crystal Ballroom A
Hosted by AMA's Professional Satisfaction and Practice Sustainability Strategy Group

The Transforming Clinical Practice initiative (TCPi) is a Centers for Medicare & Medicaid Services (CMS) funded four year program that supports 140,000 clinicians as they reinvent their clinical practices as they move towards providing value based care (VBC). AMA is supporting TCPi participants by sharing STEPS Forward modules as well as MACRA/QPP, IHO, Opioid and resources. AMA is committed sharing its TCPI experience and resources with all AMA audiences.

In this interactive session, speakers will describe the TCPi, AMA's efforts and tools to help attendees assess their practice capabilities and identify pain points and to provide information/resources they can use in their practices. Hear from physicians/practices on the front-lines of transformation who will share their performance stories and offer valuable and practical tips for moving to VBC.

Featured speakers include:
- Kathleen Blake, MD, VP Healthcare Quality, American Medical Association
- Kerri Lanum, MS, Quality Improvement Advisor, Great Lakes Practice Transformation Network
- Deena Layton, RN, MSN, Physician Practice Quality Coordinator, Riverside Medical Center
- Thomas Eppes, Jr., MD, Central Virginia Family Physicians – Privia Medical Group
- Michael Hanak, MD, FAAFP, Assistant Professor, Department of Family Medicine, Rush Medical College

Social Media Ambassadorship
9–9:59 a.m. Monday, June 11, Regency Ballroom D
Co-hosted by AMA's Social Media and Physician Engagement Groups

Leveraging "brand ambassadors" is more important now than ever. Ambassadors lend authenticity to an organization, bringing real people, voices, and stories to the forefront. Learn everything you need to know to be a skilled AMA ambassador on social media, including finding your voice, how to hit the right notes at the right moments, and ways you can tap into your own personal strengths and share your story. All levels of experience on social media are welcome!

***Litigation Center open meeting (*2.0 AMA PRA Category 1 Credits™*)**
9:15–11:15 a.m. Monday, June 11, Regency Ballroom A
Hosted by the Litigation Center of the American Medical Association and State Medical Societies

This open meeting of the Litigation Center will discuss freedom of speech for physicians. Find out whether the AMA, even when it disapproves of what is said, will defend the right to say it.

***CEJA open forum (*1.5 AMA PRA Category 1 Credits™*)**
9:30–11 a.m. Monday, June 11, Columbus C-D
Hosted by the Council on Ethical and Judicial Affairs

The Council on Ethical and Judicial Affairs will devote it's A-18 Open Forum to facilitated small-group discussions relating to continuity of care in today's complex health care environment. The session will feature a brief introduction by faculty, small-group discussions facilitated by members of the Council, and a concluding plenary session for groups to share their insights and suggestions.

Please note that the program will begin promptly at 9:30. Given the format of small-group discussion, attendees are asked to be present for the entire 90-minute session. Space is limited and will be available on a first-come, first-served basis.

The full agenda for the Open Forum can be found at ama-assn.org/go/ceja on AMA's website.

***Cost-sharing and preventive interventions (*1 AMA PRA Category 1 Credit*™)**
10–11 a.m. Monday, June 11, Crystal Ballroom A
Co-hosted by the Council on Medical Service and Council on Science and Public Health

Evidence-based preventive services can save lives and improve health by identifying illnesses earlier. Coverage of preventive services was expanded under the Affordable Care Act (ACA) to include coverage, without cost sharing, of services rated as `A' (strongly recommended) or `B' (recommended) by the US Preventive Services Task Force (USPSTF). The ACA's coverage of preventive services increased access to preventive care.

Valuable preventive interventions are often outside the scope of the ACA "zero dollar" coverage, and out-of-pocket costs can be a barrier to the use of such preventive interventions. Patient cost-sharing typically does not distinguish between high- and low-value items and services. A more precise benefit design can enhance patient-centered outcomes, while reducing the harm associated with high cost-sharing. Value-Based Insurance Design (VBID), consistent with AMA policy, applies the principle of "clinical nuance," to align patient cost-sharing with the value of the care to a specific patient.

In this session, you will learn about the methods and processes used by the USPSTF in making evidenced-based recommendations for preventive services and the ways insurance design can be used to align incentives. Attendees will have the opportunity to participate in a critical discussion about improving the alignment of cost-sharing for high-value services.

Featured speakers include A. Mark Fendrick, MD, Professor, Division of General Medicine, Department of Internal Medicine and Department of Health Management and Policy, and Director of the V-BID Center at the University of Michigan and Alex H. Krist, MD, MPH, Vice Chair of the USPSTF, Associate Professor of Family Medicine and Population Health at Virginia Commonwealth University. The session will be moderated by Robert A. Gilchick, MD, MPH, Chair, Council on Science and Public Health.

***Three Ways the AMA's Accelerating Change in Medical Education Consortium is Transforming Physician Training (*1 AMA PRA Category 1 Credit*™)**
10–11 a.m. Monday, June 11, Regency Ballroom D
Hosted by the AMA Accelerating Change in Medical Education Consortium

Five years ago the AMA awarded 11 medical schools $1 million each for projects that would transform how physicians were trained and brought these schools together to form the Accelerating Change in Medical Education Consortium. Three years ago, another 21 medical schools were brought into the consortium with $75,000 grants. This session will outline three of the notable innovations emerging from the consortium: health systems science, an electronic health record designed for educational settings, and medical student coaching. Faculty will present how these innovations are impacting medical education and how they may affect physicians in practice. Complimentary copies of "Coaching in Medical Education: A Faculty Handbook," written and produced by consortium schools, will be available at this session.

†Ready or not, here we come: Transitioning to practice in a modern healthcare system (*1 AMA PRA Category 1 Credit*™)
10–11 a.m. Monday, June 11, Regency Ballroom B
Hosted by the Surgical Caucus of the AMA

This program will describe the transition to practice commonly experienced by surgical residents and how the profession can enhance this process, and discuss preparedness of surgical residents completing training within current program requirements.

†The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
The American College of Surgeons designates this live activity for a maximum of *1 AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Section and special group events

A number of section-sponsored events will take place during the 2018 Annual Meeting. All Annual Meeting participants are welcome to attend the AMA section and special group meetings or events. Visit ama-assn.org/about/member-sections-group for information beyond the events listed here.

AMA Organized Medical Staff Section (AMA-OMSS) assembly meeting
2–3 p.m. Thursday, June 7, Crystal Ballroom B

AMA Organized Medical Staff Section (AMA-OMSS) reception
5:30 p.m. Thursday, June 7, Crystal Ballroom B

AMA Doctors Back to School™—Improving workforce diversity
7:15–11 a.m. Friday, June 8. Roundtrip bus transportation to a local high school departs from the West Tower entrance of the Hyatt Regency Chicago.
Hosted by the AMA Minority Affairs Section (AMA-MAS)

AMA Young Physicians Section (AMA-YPS) assembly meeting
8:45 a.m.–5 p.m. Friday, June 8, Crystal Ballroom C

AMA Organized Medical Staff Section (AMA-OMSS) assembly meeting
3–4:40 p.m. Friday, June 8, Crystal Ballroom B

AMA International Medical Graduates Section (AMA-IMGS) and AMA Minority Affairs Section (AMA-MAS) candidates' forum
3–5:10 p.m. Friday, June 8, Columbus G

AMA Advisory Committee on Lesbian, Gay, Bisexual, Transgender, and Queer Issues (AMA-LGBTQ) and Allies caucus and reception
5–7:30 p.m. Friday, June 8, Plaza B

AMA Minority Affairs Section (AMA-MAS) reception and business meeting
5:30–7 p.m. Friday, June 8, Columbus K-L

AMA Senior Physicians Section (AMA-SPS) luncheon and business meeting
11:30 a.m.–Noon Saturday, June 9, Columbus K-L

LGBTQ Section Council meeting
12:15–1:45 p.m. Saturday, June 9, Hong Kong

AMA International Medical Graduates Section (AMA-IMGS) congress and reception
5:30–7:30 p.m. Saturday, June 9, Columbus G

AMA Women Physicians Section (AMA-WPS) business meeting
5:30–7:30 p.m. Saturday, June 9, Columbus E-F

12th Annual Desserts from Around the World reception
9:30–11 p.m. Saturday, June 9, Crystal Ballroom A-B
Hosted by the AMA International Medical Graduates Section (AMA-IMGS)

AMA Young Physicians Section (AMA-YPS) caucus
6–7 p.m. Sunday, June 10, San Francisco

AMA International Medical Graduates Section (AMA-IMGS) and AMA Minority Affairs Section (AMA-MAS) delegates' caucus
8:30–9:30 a.m. Monday, June 11, Roosevelt 3A

AMA Medical Student Section (AMA-MSS), AMA Resident and Fellow Section (AMA-RFS), and AMA Young Physicians Section (AMA-YPS) joint caucus
9:30–11 a.m. Monday, June 11, Crystal Ballroom B-C

Busharat Ahmad, MD, leadership development program
10:45–11:45 a.m. Monday, June 11, Columbus E-F

AMA Women Physicians Section (AMA-WPS) Associates' luncheon and business session
11:30 a.m.–1 p.m. Monday, June 11, Ogden

Exhibits

Visit the AMA Member Center Booth for access to 5 new activities!
1. Update your AMA account to customize your news subscriptions
2. Take a selfie pic and post on our Instagram launch
3. Rest & recharge your devices
4. Learn how to spread the word about the AMA to your peers
5. Share your story for #MembersMoveMedicine

Exhibit Dates & Times:

Friday, June 8	2 – 6 p.m.
Saturday, June 9	10 a.m. – 6 p.m.
Sunday, June 10	7:30 – 11:30 a.m.
Monday, June 11	10 a.m. – 6 p.m.
Tuesday, June 12	7:30 a.m. – noon

AMA Foundation booth
Please visit the AMA Foundation booth in Columbus Hall to learn more about how the Foundation is working directly with free clinics across the country to improve access to quality health care in underserved communities through the *Community Health Grants Program*. Also, make sure to ask about how *Physicians of Tomorrow Scholarships* are cultivating the next generation of physician leaders. Interested in serving as a mentor to one of these inspiring students? Ask one of the program team members how you can get involved.

Support these outstanding programs, students and more by making a gift online, via the official AMA Meeting App, or at our booth. For additional information, please call 312.464.4200.

Special Events

AMA Foundation Donor Reception
6:30–7:30 p.m. Friday, June 8, Crystal Ballroom C

"When I was notified by both my school and the AMA Foundation I received this scholarship, I was ecstatic. With this scholarship, the AMA and the Foundation have made an investment in my potential."
- Rachel Bervell, AMA Foundation 2017 Underrepresented in Medicine Scholarship Recipient

The AMA Foundation's Annual Donor Reception recognizes and thanks those generous supporters who made a new gift or pledge in 2017 or 2018. The generosity from donors made it possible for the AMA Foundation to award over $300,000 to free community-based health programs and provide scholarships to 26 outstanding medical students such as Rachel.

Join the Foundation to celebrate you! If you've not already done so, make your annual gift today, and join your friends at this special reception.

If you received an invitation by mail, please RSVP by Friday, June 1. If you did not receive an invitation but wish to attend, email amafoundation@ama-assn.org or call 312.464.4200 to make a donation and RSVP for the reception.

New delegate orientation
The Specialty and Service Society (SSS) invites new delegation members to participate in a new delegate orientation at 8 p.m. Friday, June 8 in Columbus E-F. The adoption of the new delegate allocation system for the specialty societies resulted in over 50 new specialty society delegates attending the House of Delegates meeting this June. The SSS along with AMA leadership and the specialty section council leadership recognize that an informal gathering to give an overview of the AMA policy making process and all the activities that surround the workings of the House of Delegates would be very useful to new attendees. A portion of the session will be dedicated to networking/relationship building as that is also important in our policy development process. State and specialty delegates and alternate delegates as well as new staff are welcome to attend. Please rsvp to terri.marchiori@ama-assn.org.

Ron Davis Memorial 5K run/walk
The 8th Annual Ron Davis Memorial 5K run/walk will take place at 6 a.m. Saturday, June 9. Interested parties should meet near the motor entrance on the Gold Level in the East Tower of the Hyatt Regency Chicago. This is a self-guided event along the shore of Lake Michigan.

AMA Alliance welcome table
The AMA Alliance would like to invite any spouses of delegates or alternate delegates to visit their Welcome Table in the registration area to receive a gift bag and chance at a drawing for a special prize. The Welcome Table will be open all day Saturday, June 9.

Catholic Mass
Father Dan Costello will again join us to celebrate Catholic Mass at 6:30 p.m. Saturday, June 9 in Columbus I-J.

US Surgeon General to address HOD
US Surgeon General Jerome M. Adams, MD, MPH, will address the House of Delegate at 2 p.m. Monday June 11. Dr Adams, a longtime AMA member, is the 20th Surgeon General of the United States and was sworn into office this past September. He earned his master of public health degree at the University of California at Berkeley and his medical degree from Indiana University School of Medicine, is a board-certified anesthesiologist, and served as Indiana State Health Commissioner from 2014 to 2017.

As Indiana Health Commissioner, Dr. Adams presided over efforts to deal with the state's unprecedented HIV outbreak, working directly with the Centers for Disease Control and Prevention as well as with state and local health officials and community leaders. Dr. Adams' motto as Surgeon General is "better health through better partnerships," and as Surgeon General, he is committed to maintaining strong relationships with the public health community and forging new partnerships with non-traditional partners, including business and law enforcement. He has pledged to lead with science, facilitate locally led solutions to the nation's most difficult health problems, and deliver higher quality healthcare at lower cost through patient and community engagement and better prevention.

AMPAC's Capitol Club luncheon event
The American Medical Association Political Action Committee (AMPAC) is the bipartisan political arm of the AMA that helps elect medicine-friendly candidates running for federal office. AMPAC needs your support in order to have an impact on the AMA's continuing advocacy efforts in Washington, DC.

AMPAC will be hosting a private Capitol Club luncheon for all 2018 members from noon to 1:30 p.m. Tuesday, June 12. AMPAC's special guest is David Axelrod, a veteran of politics and the former chief strategist and advisor to President Barack Obama. He also serves as CNN's Senior Political Commentator and is the Director of the University of Chicago's non-partisan Institute of Politics. He will share his thoughts on politics in America today including his take on the 2018 midterm elections. Be sure not to miss this special event.

If you are already a 2018 AMPAC Capitol Club member, please stop by the AMPAC booth to pick up your ticket to the luncheon. If you are interested in becoming an AMPAC member or would like more information on the luncheon, please stop by AMPAC's booth outside the HOD meeting room. The AMPAC booth will be open for business on Saturday, June 9 through Tuesday, June 12.

NOTES:

The following list is provided for your convenience.
All items mentioned in the *Speakers' Letter* are included.
(Items listed in bold are official AMA-HOD sessions, reference committees or programs.)
All events are at the Hyatt Regency Chicago unless indicated by italics.
Activities offering continuing medical education credit are preceded by an asterisk (*) or dagger (†)

Time	Event	Location†
	Thursday, June 7	
7 a.m.–7 p.m.	Childcare availability	Reservations required
2-3 p.m.	AMA-OMSS assembly meeting	Crystal Ballroom B
5 p.m.	Deadline for receipt of not-for-official-business items	AMA staff area
5:30 p.m.	AMA-OMSS reception	Crystal Ballroom B
	Friday, June 8	
7 a.m.–6 p.m.	AMA-HOD registration	Grand Foyer
7 a.m.–7 p.m.	Childcare availability	Reservations required
7:15–11 a.m.	*AMA Doctors Back to School™*	*Meet at West Tower entrance*
8:45 a.m.–5 p.m.	AMA-YPS assembly meeting	Crystal Ballroom C
9 a.m.–noon	*Value-based care: Understanding models of risk	Crystal Ballroom A
9:30–10:30 a.m.	*Teamwork, communication, and patient safety: Elements of medical staff leadership in patient care	Crystal Ballroom B
10–11 a.m.	Exploring the cutting edge of gene therapy in medicine	Acapulco
10:45–11:45 a.m.	*Blockchain in health care: Hype or here to stay?	Crystal Ballroom B
11 a.m.–noon	A day in the life of me: Tackling prejudice against providers	Acapulco
1:20–2 p.m.	How to negotiate your employment contract	Columbus I–J
1:30–2:30 p.m.	After the smoke clears: Provider well-being after mass casualty incidents	Acapulco
1:30–3 p.m.	*Understanding CMS's new BPCI Advanced Model	Crystal Ballroom A
2–5 p.m.	OSMAP general session	Grand Ballroom A
3–4:40 p.m.	AMA-OMSS assembly meeting	Crystal Ballroom B
3–5:10 p.m.	AMA-IMGS and AMA-MAS candidates' forum	Columbus G
3–5:30 p.m.	*Stakeholders' forum: Educational implications of incorporating precision medicine into a population health model	Columbus E–F
5 p.m.	OSMAP reception	Grand Ballroom B
5–7:30 p.m.	AMA-LGBTQ Advisory Committee and Allies caucus and reception	Plaza B
5:30–7 p.m.	AMA-MAS reception and business meeting	Columbus K–L
6:30–7:30 p.m.	AMA Foundation Donor Reception	Crystal Ballroom C
8 p.m.	New delegate orientation	Columbus E–F
	Saturday, June 9	
6 a.m.	Ron Davis Memorial run/walk	Motor entrance, east tower
6:45–9:30 a.m.	Surgical Caucus Handbook review	Comiskey Room
7 a.m.–6 p.m.	AMA-HOD registration	Grand Foyer
7 a.m.–7 p.m.	Childcare availability	Reservations required
8 a.m.–5 p.m.	AMA Alliance welcome table	AMA registration area
8:30–9:30 a.m.	*Improving health outcomes for vulnerable patient populations	Crystal Ballroom B
9:45–10:45 a.m.	*#MeToo: Sexual harassment and discrimination in medicine	Crystal Ballroom B
10:45 a.m.–noon	*From disruption to reform: Learn to spark change and move medicine forward	Columbus C–D
11 a.m.–noon	*Health care change agents: Traditional and non-traditional players fuel the fire	Crystal Ballroom C
11 a.m.–noon	*Small changes, big results: Innovations in patient-centered technology	Regency Ballroom A–C
11:30 a.m.–noon	AMA-SPS luncheon and business meeting	Columbus K–L
Noon–1:30 p.m.	*How to successfully transition out of medicine and into retirement	Columbus K–L
12:15–1:45 p.m.	LGBTQ Section Council meeting	Hong Kong
2–6 p.m.	**HOD opening session; nominations; president-elect debate**	**Grand Ballroom**
5–6 p.m.	Academic Medicine caucus	Water Tower Room
5:30–7:30 p.m.	AMA-IMGS congress and reception	Columbus G
5:30–7:30 p.m.	AMA-WPS business meeting	Columbus E–F
6:30 p.m.	Catholic Mass	Columbus I–J
9:30–11 p.m.	12th annual desserts from around the world reception	Crystal Ballroom A–B

Note: All events are at the Hyatt Regency Chicago unless otherwise indicated.
Items preceded by an asterisk (*) or dagger (†) are designated for *AMA PRA Category 1 Credit™*.

Time	Event	Location†
	Sunday, June 10	
7 a.m.–6 p.m.	AMA-HOD registration	Grand Foyer
7 a.m.–7 p.m.	Childcare availability	Reservations required
8–8:30 a.m.	**HOD second session**	**Grand Ballroom**
8:30 a.m.–noon	**Reference Committee on Amendments to Constitution and Bylaws**	**Crystal Ballroom**
8:30 a.m.–noon	**Reference Committee B**	**Regency Ballroom B**
8:30 a.m.–noon	**Reference Committee C**	**Regency Ballroom C**
8:30 a.m.–noon	**Reference Committee D**	**Regency Ballroom D**
8:30 a.m.–noon	**Reference Committee G**	**Regency Ballroom A**
1:30–5 p.m.	**Reference Committee A**	**Regency Ballroom A**
1:30–5 p.m.	**Reference Committee E**	**Regency Ballroom D**
1:30–5 p.m.	**Reference Committee F**	**Grand Ballroom**
5–6 p.m.	Rural Medicine caucus	Columbus H
6–7 p.m.	AMA-YPS caucus	San Francisco
	Monday, June 11	
7 a.m.–6 p.m.	AMA-HOD registration	Grand Foyer
7 a.m.–7 p.m.	Childcare availability	Reservations required
8–8:59 a.m.	AMA Ambassador Program: Why you should join	Regency Ballroom D
8–8:59 a.m.	*Value-based contracting: The latest tips and strategies from the frontlines	Crystal Ballroom A
8–9:29 a.m.	*Preventing gun violence: What physicians can do now	Regency Ballroom C
8:30–9:30 a.m.	AMA-IMGS and AMA-MAS delegate caucus	Roosevelt 3A
8:30–10 a.m.	Academic Medicine caucus	Water Tower Room
9–9:59 a.m.	Social Media Ambassadorship	Regency Ballroom D
9–9:59 a.m.	*Transforming Clinical Practice: A step-wise approach	Crystal Ballroom A
9:15–11:15 a.m.	Litigation Center	Regency Ballroom A
9:30–11 a.m.	CEJA open forum	Columbus C–D
9:30–11 a.m.	AMA-MSS, AMA-RFS and AMA-YPS joint caucus	Crystal Ballroom B–C
10–11 a.m.	† Ready or not, here we come: Transitioning to practice in a modern healthcare system	Regency Ballroom B
10–11 a.m.	*Three Ways the AMA's Accelerating Change in Medical Education Consortium is Transforming Physician Training	Regency Ballroom D
10–11 a.m.	*Cost-sharing and preventive interventions	Crystal Ballroom A
10–11:30 a.m.	Private Practice Physician Caucus	Columbus I–J
10:45–11:45 a.m.	Busharat Ahmad, MD, leadership development program	Columbus E–F
11 a.m.–1:30 p.m.	AMA-WPS Associates' luncheon and business session	Ogden
2–6 p.m.	**HOD business session**	**Grand Ballroom**
	Tuesday, June 12	
7 a.m.–6 p.m.	AMA-HOD registration	Grand Foyer
7 a.m.–7 p.m.	Childcare availability	Reservations required
7:30–8:45 a.m.	Elections	Columbus K–L
9 a.m.–3 p.m.	**HOD business session**	**Grand Ballroom**
Noon–1:30 p.m.	AMPAC's Capitol Club luncheon	TBD
5 p.m.	Inaugural, Barbara L. McAneny, MD	Crystal Ballroom
6:30 p.m.	Inaugural reception	Grand Ballroom Foyer
7 p.m.	Inaugural dinner dance	Grand Ballroom
	Wednesday, June 13	
7 a.m.–noon	AMA-HOD registration	Grand Foyer
7 a.m.–noon	Childcare availability	Reservations required
9 a.m.–noon	**HOD business session**	**Grand Ballroom**

AMA International Medical Graduates

2018 Annual Meeting

June 8–11
Hyatt Regency Chicago

Join us for the 21st American Medical Association International Medical Graduates (IMG) Section Annual Meeting. We encourage you to invite a colleague or friend to attend and share in the following information sessions.

AMA-IMG Section and AMA Minority Affairs Section (MAS) candidates forum

3–5:10 p.m., Friday, June 8
Meet the candidates who are running for an AMA Board of Trustees position. This candidates forum will be cosponsored by the AMA-MAS.

Cosponsored educational sessions by the AMA sections and special group

8 a.m.–noon, Saturday, June 9
Join us for a wide variety of interesting educational sessions on Saturday morning.

AMA-IMG Section reception and congress

5:30–7:30 p.m., Saturday, June 9
Plan to attend the 21st AMA-IMG Section Annual Meeting where you will hear an ECFMG update from William Pinsky, MD, CEO/president of ECFMG, and meet William F. Owen, MD, from the Ross University School of Medicine. Dr. Owen will discuss the Ross Caribbean Medical School Curriculum and provide facts about the school's students. Additional discussions will include organizational reports and resolutions being considered at the 2018 AMA Annual Meeting. We also invite you to share your comments on resolutions being considered for the 2018 Annual Meeting.

12th annual "Desserts from around the world" reception

9:30–11 p.m., Saturday, June 9
Crystal Ballroom
Each year this event gets bigger and tastier! Join us in trying new and exciting ethnic desserts. You are also welcome to be a sponsor for this event. For more information, contact img@ama-assn.org.

Reference committee hearings

8:30 a.m.–5 p.m., Sunday, June 10
Participate and hear reference committee deliberations on AMA House of Delegates reports and resolutions.

AMA-IMG Section and AMA-MAS delegates caucus

8:30–9:30 a.m., Monday, June 11
Meet your respective section delegates and discuss the strategies for deliberations on various reference committee reports and resolutions.

Busharat Ahmad, MD, Leadership Development Program

10:45–11:45 a.m., Monday, June 11
Learn how to improve your leadership skills and become an effective leader in your organization.

Register for the program here. Email or call the AMA-IMG Section at (312) 464-5397 if you have questions.

Register today!

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Tasty desserts with an international flair and live entertainment!

Hosted by the AMA International Medical Graduates (IMG) Section

9:30 p.m.
Saturday, June 9
Crystal Ballroom
Hyatt Regency Chicago

Email **img@ama-assn.org** with questions.

18-221370:BC:PDF:4/17:ST

You're invited to participate in an AMA-IMG Section event:

Busharat Ahmad, MD, leadership development program

Climbing the ladder of leadership
10:45–11:45 a.m.
Monday, June 11
Hyatt Regency Chicago
Chicago

The American Medical Association International Medical Graduates (IMG) Section invites you to participate in a special leadership development program at the AMA Annual Meeting.

Commemorating Busharat "Bush" Ahmad, MD, a strong advocate for IMGs who was instrumental in the formation of the AMA-IMG Section, this program consistently brings dynamic speakers to the AMA's annual and interim meetings. It is designed to develop individuals who are aspiring to be dynamic leaders in the health care profession.

Featured speaker: Ardis Dee Hoven, MD
This year's featured speaker is Ardis Dee Hoven, MD, an internal medicine and infectious disease specialist from Lexington, Ky., who is a past president of the AMA. Dr. Hoven is currently chair of the Council of the World Medical Association; she was first elected in 2015, reelected in 2017 and will complete her service in 2019.

In 2013, Dr. Hoven was named one of *Modern Healthcare Magazine's* Top 25 Women in Healthcare, in addition to the 100 Most Influential People in Healthcare (#54).

All 2018 AMA Annual Meeting attendees are welcome to attend this event.
For more information, email **img@ama-assn.org** or call **(312) 464-5397**.

Women in medicine: Celebrating our legacy, embracing our future

The American Medical Association Women Physicians Section (WPS) is proud to celebrate the AMA's Women in Medicine Month this coming September. This year's theme is "Women in medicine: Celebrating our legacy, embracing our future," capturing the AMA-WPS and its long history of championing women as leaders.

SEPT. 6 2018

AMA-WPS Women in Medicine Day

Join the celebration

Explore the rich history of women in medicine featuring remarkable accomplishments that affect us both as physicians and as women.

ama-assn.org/women-medicine-month

Meet the honorees of this year's AMA-WPS Inspirational Physicians Recognition Program who have offered their time, wisdom and support to others throughout their professional journeys.

ama-assn.org/inspirational-physicians-recognition

Visit the AMA-WPS website on Sept. 12 when we will announce the 2018 research grant winners of the Joan F. Giambalvo Fund for the Advancement of Women.

ama-assn.org/giambalvo-fund

Follow the AMA on Facebook and Twitter to see inspiring stories about women in medicine throughout the month. **#WIMmonth**

Visit **ama-assn.org/women-physicians-section** to learn more about AMA-WPS leadership opportunities and advocacy for women's health issues.

Not an AMA member? Gain access to the AMA's benefits for women in medicine by joining today: **commerce.ama-assn.org/membership**.

TBG 230615:2000:5/18:DF

AMA Senior Physicians Section

2018 Annual Meeting

CME AVAILABLE!

Saturday, June 9
Hyatt Regency Chicago | Columbus K/L

The American Medical Association Senior Physicians Section (SPS) invites you to this joint educational program with the AMA Academic Physicians Section (APS) during the 2018 AMA Annual Meeting. We hope you can join us and enjoy the fellowship of your senior physician colleagues.

How to successfully transition out of medicine and into retirement

Noon–1:30 p.m.
Approved for 1.5 *AMA PRA Category 1 Credits*™*
Moderator: Richard Allen, MD, chair-elect, AMA-SPS Governing Council
Speaker: Luis T. Sanchez, MD, chair, Committee on Senior Physicians, Massachusetts Medical Society
Panelist: Cynda Ann Johnson, MD, MBA, member-at-large, AMA-APS Governing Council

For many physicians, retirement is welcomed after a lifetime of work and responsibilities. However, some physicians worry about retiring for fear of losing their primary identity or purpose. Successful planning can help ease these worries and is critical to a full, active lifestyle.

This session will focus on a planning process that supports a gradual transition away from medical practice while recognizing the value of experienced late-career physicians.

It will also explore how physicians can actively maintain their involvement in medicine throughout retirement. The AMA-APS will discuss teaching and volunteer opportunities offered in medical schools and share strategies for how senior physicians can pass their knowledge along to the next generation.

Objectives

- Describe the evidence-based findings on why aging can be particularly difficult for physicians
- Recognize the importance of self-awareness and well-being in maintaining your health
- List three strategies you can use to facilitate a smooth transition to retirement
- Identify new opportunities to stay active and involved in medicine

AMA-SPS assembly meeting

11:30 a.m.–noon
Saturday, June 9
Please join us for the AMA-SPS assembly meeting where we will discuss AMA House of Delegates' business items and future AMA-SPS activities.
A light lunch will be offered at 11:30 a.m. (first come, first served).

Spread the word! Any physician 65 years of age and above is welcome to attend.

Visit ama-assn.org/senior-physicians-section to learn more.

* The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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