DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2017 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-17)

Report of Reference Committee C

Kenneth M. Certa, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 3 – Obesity Education
2. Resolution 304 – Support of Equal Standards for Foreign Medical Schools Seeking Title IV Funding
3. Resolution 313 – Study of Declining Native American Medical Student Enrollment
4. Resolution 319 – Public Access to Initial Board Certification Status of Time-Limited ABMS Diplomates
5. Resolution 320 – Cultural Competence in Standardized Patient Programs Within Medical Education
6. Resolution 323 – Exceptions to Medicare GME Cap-Setting Deadlines for Residency Programs in Medically Underserved/Economically Depressed Areas

RECOMMENDED FOR ADOPTION AS AMENDED

7. Council on Medical Education Report 1 – Council on Medical Education Sunset Review of 2007 House Policies
8. Council on Medical Education Report 2 – Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 315-A-16)
9. Council on Medical Education Report 7 – Expansion of Public Service Loan Forgiveness
10. Council on Medical Education Report 9 – Feasibility and Appropriateness of Transferring Jurisdiction over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools
11. Resolution 301 – Mental Health Disclosures on Physician Licensing Applications
12. Resolution 302 – Comprehensive Review of CME Process
13. Resolution 303 – Addressing Medical Student Mental Health Through Data Collection and Screening
14. Resolution 305 – Reduction of Caregiver Burnout
15. Resolution 306 – U.S. International Medical Graduates in Physician Workforce
16. Resolution 308 – Immigration Reform Impacts on International Medical Graduate Training and Patient Access

Resolution 311 – Support of International Medical Students and Graduates

Resolution 312 – Supporting International Medical Graduates and Students

Resolution 317 – Immigration
Resolution 321 – Continued Support of H-1B Visa Programs for International Medical Graduates
Resolution 325 – Ensure an Effective H-1B Visa Program to Protect Patient Access to Care
Resolution 326 – Supporting International Medical Graduates and Students

17. Resolution 309 – Future of the USMLE: Examining Multi-Step Structure and Score Usage
18. Resolution 310 – Breast Pump Accommodations During Medical Licensing Exams
19. Resolution 314 – Educating a Diverse Physician Workforce
20. Resolution 315 – Inclusion of Developmental Disabilities Curriculum in Undergraduate, Graduate and Continuing Medical Education of Physicians
21. Resolution 316 – Action Steps Regarding Maintenance of Certification
22. Resolution 324 – Improve HRSA Projections of the Physician Workforce

RECOMMENDED FOR REFERRAL

23. Council on Medical Education Report 6 – Standardizing the Allopathic Residency Match System and Timeline (Resolution 310-A-16)
24. Resolution 318 – Oppose Direct to Consumer Advertising of the ABMS MOC Product

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

25. Resolution 307 – Formal Business and Practice Management Training During Medical Education
26. Resolution 322 – Ending Maintenance of Certification Examinations

(1) COUNCIL ON MEDICAL EDUCATION REPORT 3 - OBESITY EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 3 adopted and the remainder of the report filed.

Council on Medical Education Report 3 asks 1) That our American Medical Association (AMA) make this report available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians; and 2) That AMA Policy D-440.980 (5), "Recognizing and Taking Action in Response to the Obesity Crisis," be rescinded, as having been fulfilled by this report.

Your Reference Committee heard unanimous support for this report's recommendations and received additional guidance on resources to add to the report—i.e., the American Association of Clinical Endocrinologists' Obesity Resource Center, as well as the Provider Competencies for the Prevention and Management of Obesity from the Provider Training and Education Workgroup of the Integrated Clinical and Social Systems for the Prevention and Management of Obesity Innovation Collaborative. It was also suggested that the report include hyperlinks to the organizations/resources listed therein. Therefore, your Reference Committee recommends that Council on Medical Education Report 3 be adopted.

(2) RESOLUTION 304 - SUPPORT OF EQUAL STANDARDS FOR FOREIGN MEDICAL SCHOOLS SEEKING TITLE IV FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 304 be adopted.

HOD ACTION: Resolution 304 adopted.

Resolution 304 asks that our AMA support the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.

Your Reference Committee heard uniformly positive virtual and live testimony in favor of adoption of Resolution 304. Currently, a small number of foreign medical schools are exempt from federal eligibility requirements for Title IV funding, due to a grandfathering clause from 1992. These requirements stipulate that schools enroll at least 60% non-U.S. citizens or permanent residents, and that 75% of students pass the United States

Medical Licensing Examination. Setting consistent eligibility requirements for all offshore medical schools would increase accountability among these schools for this important federal funding resource and reduce the possibility of any cavalier misuse of such funds. It would also ensure that U.S. students attending such schools are able to receive a quality education that prepares them to practice medicine in the United States and lessen the odds for these students to become burdened with a large loan debt and be unable to enter a residency program and become a practicing physician in the U.S. Therefore, your Reference Committee recommends that Resolution 304 be adopted.

(3) RESOLUTION 313 - STUDY OF DECLINING NATIVE AMERICAN MEDICAL STUDENT ENROLLMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 313 be adopted.

HOD ACTION: Resolution 313 adopted.

Resolution 313 asks that our AMA 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.

Your Reference Committee heard limited but supportive testimony on this item and on the need for increased diversity of the physician workforce, to support access to patient care among underserved populations. Testimony from the American Academy of Pediatrics noted that organization's development of a task force on diversity and inclusion, which may be able to assist in information gathering for the proposed AMA study. Existing AMA policy on diversity dovetails with the intent of this resolution, and the noted decline in the number of Native Americans entering medical school is worrisome and may hold future negative ramifications for access to care. Accordingly, your Reference Committee recommends that Resolution 313 be adopted.

(4) RESOLUTION 319 - PUBLIC ACCESS TO INITIAL BOARD CERTIFICATION STATUS OF TIME-LIMITED ABMS DIPLOMATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 319 be adopted.

HOD ACTION: Resolution 319 adopted.

Resolution 319 asks that our AMA amend the AMA Principles of Maintenance of Certification (MOC), AMA Policy H-275.924, "Maintenance of Certification," by addition as follows:

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. (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of inclusion of initial certification as well as the status of time-limited diplomates in all ABMS and ABMS member board websites and physician certification databases. It was noted that the preservation of information of such an achievement is worthy of permanent documentation. Therefore, your Reference Committee recommends that Resolution 319 be adopted.

(5) RESOLUTION 320 - CULTURAL COMPETENCE IN STANDARDIZED PATIENT PROGRAMS WITHIN MEDICAL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 320 be adopted.

HOD ACTION: Resolution 320 adopted.

Resolution 320 asks that our AMA amend existing AMA Policy H-295.897, "Enhancing the Cultural Competence of Physicians" by addition as follows:

7. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.

Your Reference Committee heard overwhelmingly supportive testimony on the need for medical students to encounter diverse standardized patients so that they are prepared to address health disparities and provide culturally competent care to an increasingly diverse patient population. Therefore, your Reference Committee recommends that Resolution 320 be adopted.

(6) RESOLUTION 323 - EXCEPTIONS TO MEDICARE GME CAP-SETTING DEADLINES FOR RESIDENCY PROGRAMS IN MEDICALLY UNDERSERVED/ECONOMICALLY DEPRESSED AREAS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 323 be adopted.

HOD ACTION: Resolution 323 adopted.

Resolution 323 asks that our AMA advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas.

Your Reference Committee heard online and live testimony that supported adoption of Resolution 323. It was noted that all available and feasible avenues should be taken to help ease the shortage of physicians, especially in medically underserved and economically depressed areas. While existing AMA policy supports preserving, stabilizing and expanding funding for graduate medical education in general, this item urges support for a specific mechanism for expanding GME. The current five-year deadline for establishing a program before the funding-cap is set, as noted in virtual testimony, "is not feasible in certain underserved areas, and does not allow medical school programs to establish sufficiently robust programs before the cap goes into effect." Therefore, your Reference Committee recommends that Resolution 323 be adopted.

(7) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2007 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 1 be amended by addition, to read as follows:

Council on Medical Education Report 1 recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of H-295.908, Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment, which should be retained, and the remainder of this report be filed. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

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

Council on Medical Education Report 1 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.

Your Reference Committee heard testimony in general support of this item. It was noted in testimony, however, that H-295.908, Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment, should be retained, to protect medical students in the event of an unanticipated medical school closure or enrollment reduction. Your Reference Committee agrees, and urges that this policy be retained. Additional testimony was heard concerning H-150.996, Nutrition Courses in Medicine, urging that this item be retained and not revised, as proposed in the report. Your Reference Committee, however, believes the proposed edits (as shown on page 3 of the appendix to the report) are appropriate, in that AMA Policy H-150.995, Basic Courses in Nutrition, renders this policy superfluous. That policy reads, "Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels." Therefore, your Reference Committee recommends that Council on Medical Education Report 1 be adopted as amended.

(8) COUNCIL ON MEDICAL EDUCATION REPORT 2 - UPDATE ON MAINTENANCE OF CERTIFICATION AND OSTEOPATHIC CONTINUOUS CERTIFICATION (RESOLUTION 315-A-16)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 2 be amended by addition and deletion, to read as follows:

1. That ~~the Council on Medical Education collaborate with the Council on Legislation and/or the Council on Medical Service to determine MOC alignment with legislative activities and quality, patient safety and value qualifiers, such as the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA)~~our American Medical Association (AMA) advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 2 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 2 provides an update on MOC and OCC, and asks 1) That the Council on Medical Education collaborate with the Council on Legislation

and/or the Council on Medical Service to determine MOC alignment with legislative activities and quality, patient safety and value qualifiers, such as the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act (MACRA); 2) That our AMA rescind Policy D-275.954 (28), "Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC)," since that has been accomplished through this report.

Your Reference Committee heard testimony in support for the Council's annual report to the House of Delegates. During the testimony, several specialty societies acknowledged that the Council's efforts with the American Board of Medical Specialties and the ABMS member boards are resulting in improvements to the Maintenance of Certification (MOC) process. There was also some discussion of the work underway to develop a society maintenance pathway for some internal medicine specialty groups. It was also noted that AMA advocacy has focused on educating state medical associations about activity around the country, as well as the risks and benefits of legislating the use of MOC. The first recommendation in the report was amended to address concerns that the recommendation may be misinterpreted to imply a role for MOC at the federal level or a nexus between MOC and federal programs, such as the Quality Payment Program. In addition, the Council on Medical Education clarified that only Part 28, of Policy D-275.954, "Maintenance of Certification (MOC) and Osteopathic Continuous Certification," was rescinded, since this has been accomplished through this report. Part 28 read, "Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways." Your Reference Committee concurs that Part 28 has been accomplished and can be rescinded. Therefore, your Reference Committee recommends that Council on Medical Education Report 2 be adopted as amended.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 7 - EXPANSION OF PUBLIC SERVICE LOAN FORGIVENESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Education Report 7 be amended by deletion, to read as follows:

That our AMA reaffirm Policy D-305.993 (1-9), which asks that the AMA advocate against a cap on federal loan forgiveness programs ~~but also advocate that any cap on loan forgiveness under the PSLF program be at least equal to the principal amount borrowed~~. (Reaffirm HOD policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 6 in Council on Medical Education

Report 7 be amended by addition and deletion, to read as follows:

That our AMA encourage medical school financial advisors to promote to medical students ~~the Students to Service Loan Repayment Program of the National Health Service Corps (NHSC)~~ 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. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 7 in Council on Medical Education Report 7 be amended by addition and deletion, to read as follows:

That our AMA strongly advocate that the terms of ~~any restrictive changes to~~ the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes ~~take effect after all individuals currently within their PSLF eligibility period are "aged out" of the PSLF program under the conditions in place when they began their eligibility~~. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 7 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 7 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 7 asks 1) That our AMA encourage 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; 2) That our AMA rescind Policy D-305.993 (10), as having been fulfilled by this report; 3) That our AMA reaffirm Policy D-305.993 (1-9), which asks that the AMA advocate against a cap on federal loan forgiveness programs but also advocate that any cap on loan forgiveness under the PSLF program be at least equal to the principal amount borrowed; 4) That our AMA advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; 5) That

our AMA encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; 6) That our AMA encourage medical school financial advisors to promote to medical students the Students to Service Loan Repayment Program of the National Health Service Corps (NHSC) 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; and 7) That our AMA strongly advocate that any restrictive changes to the PSLF take effect after all individuals currently within their PSLF eligibility period are "aged out" of the PSLF program under the conditions in place when they began their eligibility.

Your Reference Committee heard testimony in support of this report, especially regarding the need for transparency in the loan repayment process. Additional testimony highlighted the added financial barriers faced by larger proportions of underrepresented in medicine (URM) students, and linked loan repayment programs with enhanced opportunities for these individuals to pursue clinical training. Testimony also revealed that service-based loan repayment options encourage practice in areas that otherwise experience difficulty attracting and retaining physicians, and therefore increase patient access to care. Others noted that these types of repayment options are more important in today's learning environment, when young physicians are graduating later in life with extremely high levels of debt, versus a previous era of medicine in which economic well-being was more assured. For these reasons, your Reference Committee recommends that CME Report 7 be adopted as amended.

(10) COUNCIL ON MEDICAL EDUCATION REPORT 9 - FEASIBILITY AND APPROPRIATENESS OF TRANSFERRING JURISDICTION OVER REQUIRED CLINICAL SKILLS EXAMINATIONS TO LCME-ACCREDITED AND COCA-ACCREDITED MEDICAL SCHOOLS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 9 be <u>amended by substitution</u>, to read as follows:

<u>Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.</u>

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Education Report 9 be <u>amended by substitution</u>, to read as follows:

<u>Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.</u>

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 9 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 9 asks 1) That our AMA rescind Policy D-295.988 (2), "Clinical Skills Assessment During Medical School D-295.988," due to inadequate stakeholder support for transferring jurisdiction of clinical skills examinations to medical schools, unless and until a viable alternative can be identified; 2) That AMA Policy D-295.988 (3) be amended by addition and deletion to read as follows:
"3. Our AMA will work to: (a) ensure ~~rapid yet~~ carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through ~~immediate~~ steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; and (d) ~~engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e)~~ include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency."
3) That our AMA encourage development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination; and 4) That our AMA, through the Council on Medical Education, continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.

Your Reference Committee heard overwhelmingly supportive testimony for continued engagement with stakeholders regarding clinical skills assessment. Concerns were voiced regarding the predictive value of the exam and the financial barriers that arise from limited numbers of testing sites, and these types of questions will be explored through ongoing discussion with involved parties. However, speakers also acknowledged the importance of accountability to the public and the value of standardized, validated assessment. Currently, the FSMB and its member state medical boards do not support school-based examinations as an acceptable substitute for a national examination to assess clinical skills competency, and medical school support for the proposal to transfer jurisdiction has been mixed. However, the FSMB and NBME are establishing a USMLE advisory panel consisting of U.S. and international medical students, residents, and fellows, with the goal of providing direct feedback to and improving communication from the USMLE program. Therefore, your Reference

Committee recommends that Council on Medical Education Report 9 be adopted as amended.

(11) RESOLUTION 301 - MENTAL HEALTH DISCLOSURES ON PHYSICIAN LICENSING APPLICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 301 be amended by addition, to read as follows:

RESOLVED, That our AMA encourage state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 301 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA 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~~ adopt policy that, if an applicant has disclosed a history of physical or behavioral health treatment, a treating physician submit to the board documentation that the applicant's current state of health does not interfere with the applicant's ability to practice medicine ~~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); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 301 be adopted as amended.

HOD ACTION: Recommendation B referred, and the remainder of Resolution 301 adopted as amended.

Resolution 301 asks 1) That our AMA encourage state medical boards to consider physical and mental conditions similarly; 2) That our AMA encourage state medical boards to recognize that the presence of a mental health condition does not equate with an impaired ability to practice medicine; 3) That our AMA 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.~~ ; and 4) That our AMA encourage 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.

Your Reference Committee heard supportive testimony on this item from a wide variety of stakeholders, reflecting a growing concern among the profession and the public related to physician and medical student depression, burnout, and suicide. Our AMA has expressed strong support of physical and mental health care services for medical students and physicians. CME Report 1-I-16 addressed the 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. Policy H-295.858 (2) 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." Additionally, Policy H-275.945, Self-Incriminating Questions on Applications for Licensure and Specialty Boards, directs our AMA to 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, seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards, and 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. Policy H-345.973, Mental Health Services for Medical Students and Resident and Fellow Physicians, directs our AMA to promote the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Finally, Policy H-275.970, Licensure Confidentiality, directs the AMA 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; to encourage boards to include in application forms only requests for information that can reasonably be related to medical practice; 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; 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 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. Despite this existing policy, testimony reflected additional concern 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, your Reference Committee recommends that Resolution 301 be adopted as amended.

(12) RESOLUTION 302 - COMPREHENSIVE REVIEW OF CME PROCESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 302 be <u>amended by addition</u>, to read as follows:

RESOLVED, That our American Medical Association<u>, in collaboration with the Accreditation Council for Continuing Medical Education,</u> do a comprehensive review of the

continuing medical education (CME) process on a national level, with the goal of decreasing costs and simplifying the process of providing CME.
RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 302 be adopted as amended.

HOD ACTION: Resolution 302 adopted as amended.

Resolution 302 asks that our AMA do a comprehensive review of the continuing medical education (CME) process on a national level, with the goal of decreasing costs and simplifying the process of providing CME.

Your Reference Committee heard positive testimony on this item. The Council on Medical Education has engaged in similar efforts in the past, and continues to work closely with the Accreditation Council for Continuing Medical Education (ACCME). As noted in the testimony, the Council has a sub-committee that focuses on continuing medical education (CME) and has two AMA nominated Directors who sit on the Board of Directors of ACCME. The AMA and ACCME have a Bridge Committee, which is simplifying and better aligning the glossary and processes regarding CME on a national level and across all disciplines. The role of the AMA in CME has been to define what constitutes a CME activity and how to award credit for it (*AMA PRA Category 1 Credit*™). Therefore, your Reference Committee recommends that Resolution 302 be adopted as amended.

(13) RESOLUTION 303 - ADDRESSING MEDICAL STUDENT MENTAL HEALTH THROUGH DATA COLLECTION AND SCREENING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 303 be amended by addition of new third Resolve, to read as follows:

RESOLVED, That our AMA 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. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 303 be adopted as amended.

HOD ACTION: Resolution 303 adopted as amended.

Resolution 303 asks 1) That our AMA encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; and 2) That our AMA encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students.
Your Reference Committee heard overwhelmingly supportive testimony of Resolution 303. Medical students are at high risk for depression and suicidal thinking, but face significant barriers to accessing care. Other nations (such as Australia) have successfully conducted national mental health surveys of physicians/medical students, but there is a dearth of equivalent data in the United States. Anonymous screening of medical students for depression and suicidal ideation can promote awareness and reduce stigma, and collecting data on this population can aid in the identification and development of more effective interventions. Therefore, your Reference Committee recommends that Resolution 303 be adopted as amended.

(14) RESOLUTION 305 - REDUCTION OF CAREGIVER BURNOUT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association encourage partner organizations to develop resources to better prepare and support lay caregivers ~~in performing medical/nursing tasks~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA identify and disseminate resources ~~create an online educational module~~ to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 adopted as amended.

Resolution 305 asks 1) That our AMA encourage partner organizations to develop resources to better prepare caregivers in performing medical/nursing tasks; and 2) That

our AMA create an online educational module to promote physician understanding of caregiver burnout and develop strategies to support caregivers and their patients.

Your Reference Committee heard significant testimony on the important and timely issue of lay caregiver burnout, which is increasing as hospital stays shorten and baby boomers age. The word "lay" was added to clarify the focus on the numerous friends and family members who provide care in a non-professional, non-medical capacity. Testimony also suggested that it would be better to partner with organizations, such as the AARP, that are already working in this area, rather than the AMA creating its own educational modules. Your Reference Committee agrees, and recommends that Resolution 305 be adopted as amended.

(15) RESOLUTION 306 - U.S. INTERNATIONAL MEDICAL GRADUATES IN PHYSICIAN WORKFORCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 306 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~work with~~ encourage the Educational Commission ~~on~~ for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident~~cy~~ Matching Program (NRMP) and are therefore unable to get a residency or practice medicine. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 adopted as amended.

Resolution 306 asks that our AMA work with the Educational Commission on Foreign Medical Graduates (ECFMG) to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Residency Matching Program (NRMP) and are therefore unable to get a residency or practice medicine.

Your Reference Committee heard limited but supportive testimony for Resolution 306. The Council on Medical Education noted that the Educational Commission for Foreign Medical Graduates is better suited to study this issue, and recommended the change in verbiage as noted above; the authors of the resolution agreed, considering this a friendly amendment. Better information on this growing issue will help U.S. citizens and their health professions advisors make better, more informed choices about their future prospects as a physician. Additional editorial changes are proffered to ensure accuracy

in the names of the ECFMG and NRMP. Therefore, your Reference Committee recommends that Resolution 306 be adopted as amended.

(16) RESOLUTION 308 - IMMIGRATION REFORM IMPACTS ON INTERNATIONAL MEDICAL GRADUATE TRAINING AND PATIENT ACCESS
RESOLUTION 311 - SUPPORT OF INTERNATIONAL MEDICAL STUDENTS AND GRADUATES
RESOLUTION 312 - SUPPORTING INTERNATIONAL MEDICAL GRADUATES AND STUDENTS
RESOLUTION 317 – IMMIGRATION
RESOLUTION 321 - CONTINUED SUPPORT OF H-1B VISA PROGRAMS FOR INTERNATIONAL MEDICAL GRADUATES
RESOLUTION 325 - ENSURE AN EFFECTIVE H-1B VISA PROGRAM TO PROTECT PATIENT ACCESS TO CARE
RESOLUTION 326 - SUPPORTING INTERNATIONAL MEDICAL GRADUATES AND STUDENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 308, 311, 312, 317, 321, 325, and 326.

HOD ACTION: The following resolution adopted in lieu of Resolutions 308, 311, 312, 317, 321, 325, and 326.

IMPACT OF IMMIGRATION BARRIERS ON THE NATION'S HEALTH

RESOLVED, That our American Medical Association (AMA) recognize the valuable contributions and affirm 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 (New HOD Policy); and be it further

RESOLVED, That our AMA 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 (New HOD Policy); and be it further

RESOLVED, That our AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice (New HOD Policy); and be it further

RESOLVED, That our AMA 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. (Directive to Take Action); and be it further

RESOLVED, That our AMA update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce. (Directive to Take Action)

Resolution 308 asks 1) That our AMA advocate for the timely processing of visas for physicians to fill residency and fellowship training spots; 2) That our AMA study the current impact of immigration reform efforts on residency and fellowship training programs, physician supply, and timely access of patients to healthcare throughout the US ; and 3) That our AMA report back to the House of Delegates by the 2017 Interim Meeting such study findings, including appropriate proposals to advocate on behalf of international medical graduate physicians and their patients.

Resolution 311 asks 1) That our AMA recognize the unique contributions and affirm 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; and 2) That our AMA oppose changes to immigration policies for international and foreign-born medical graduates and students that use country of origin to restrict visa procurement and ability to travel outside of the U.S. and return with a visa.

Resolution 312 asks 1) That our AMA 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; and 2) That our AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

Resolution 317 asks that our AMA lobby the US Congress and other appropriate US government officials to exempt physicians from any current or future ban or suspension impacting immigration or the issuance of a J1 Visa or H1-B Visa.

Resolution 321 asks that our AMA urge the Trump Administration to immediately reinstate premium processing of H-1B visas for physicians to prevent any negative impact on patient care in underserved communities.

Resolution 325 asks that our AMA proactively work with appropriate officials to secure an exemption of medical professionals from the suspension of and any future modifications to the H-1B visa program, in order to allow for efficient entry of international physicians into the United States.

Resolution 326 asks that our AMA 1) oppose laws and regulations that would broadly deny entry or re-entry to the United States by persons based on their country of origin and/or religion who currently have legal visas, including permanent resident status (green card) and student visas, and oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

Your Reference Committee heard universal support for these timely and salient resolutions, which seek to address and rectify the multiple implications of restricting US travel for foreign-born physicians, trainees, and researchers. In addition, these travel restrictions are predicted to impact patient access to care, especially in areas of need. These same implications hold true for other foreign-born clinicians and trainees employed in this country, and, by extension, physicians' and other clinicians' family members.

Restricting travel on the basis of country of origin or religion goes against the principles and policy of our AMA, which has worked to enhance physician diversity and to address the quality of care received and experienced by diverse patients and populations. Policy D-255.991, Visa Complications for IMGs in GME, directs our AMA to work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position. It also calls on our AMA to study, in collaboration with the ECFMG and the ACGME, the frequency of such J-1 Visa reentry denials and their impact on patient care and residency training, and, with other stakeholders, to advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Many communities, including rural and low-income areas, face challenges attracting physicians to meet their health care needs. IMGs often fill these openings. To date, one out of every four physicians practicing in the United States is an IMG. In certain specialties, that number is even higher. These physicians are licensed by the same stringent requirements applied to U.S. medical school graduates. They are more likely to practice in underserved and poor communities, and to fill training positions in primary care and other specialties that face significant workforce shortages. Existing AMA policy, Policy D-255.985, Conrad 30 - J-1 Visa Waivers, directs our AMA to advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with

the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.

Additional concerns have been voiced by the biomedical research community. Restriction of travel will negatively impact the free flow of ideas and the cooperation that have historically led to advancements in the delivery of care.

For these reasons, your Reference Committee recommends adoption of the proposed resolution in lieu of these seven items.

(17) RESOLUTION 309 - FUTURE OF THE USMLE: EXAMINING MULTI-STEP STRUCTURE AND SCORE USAGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 309 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with the appropriate stakeholders to study ~~investigate~~ the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 309 be amended by addition, to read as follows:

RESOLVED, That our AMA work with the appropriate stakeholders to study alternate means of scoring USMLE exams in order to avoid the inappropriate use of USMLE scores for screening residency applicants. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 309 be adopted as amended.

HOD ACTION: Resolution 309 adopted as amended.

Resolution 309 asks 1) That our AMA work with the appropriate stakeholders to investigate the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies; and 2) That our AMA work with the appropriate stakeholders to study alternate means of scoring USMLE exams.

Your Reference Committee heard almost entirely supportive testimony for this resolution. A comprehensive study regarding the possibility of combining the USMLE Step 1 and Step 2 exams was completed roughly 10 years ago, and this study also addressed changing the approach to score reporting. However, innovative UME models, such as those found in the AMA's Accelerating Change in Medical Education consortium, have altered the medical education landscape to the point that a fresh look may be warranted. This resolution calls for appropriate stakeholders to be involved in such a discussion, and a number of different parties, including state licensing boards, program directors, and trainees, will need to be heard. In addition, consistent with existing AMA policy, the Council on Medical Education cautioned against the inappropriate use of USMLE scores when screening residency program applicants. Therefore, your Reference Committee recommends that Resolution 309 be adopted as amended.

(18) RESOLUTION 310 - BREAST PUMP ACCOMMODATIONS DURING MEDICAL LICENSING EXAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-295.861 be amended by addition and deletion, to read as follows:

Our AMA 1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give ~~lactating mothers~~ breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and 2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-295.861 be adopted as amended in lieu of Resolution 310.

HOD ACTION: Policy H-295.861 adopted as amended in lieu of Resolution 310.

Resolution 310 asks 1) That our AMA encourage that the accommodation of breastfeeding individuals in all medical licensing exams in all specialties be allowed if the individual can provide a note from their physician; and 2) That our AMA encourage that accommodations include necessary time per exam day in addition to the standard pool of scheduled break time found in the specific exam as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump.

Your Reference Committee heard powerful testimony in support of this resolution, which is in line with AMA policies supporting breastfeeding. Testimony from the Medical Student Section noted that existing AMA policy was similar to the intent of Resolve 1; therefore, your Reference Committee recommends the proposed changes, as shown, to reflect Resolve 1 in and incorporate Resolve 2 into that policy.

H-295.861, Accommodating Lactating Mothers Taking Medical Examinations
Our AMA urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give lactating mothers additional break time and a suitable environment during examinations to express milk.

(19) RESOLUTION 314 - EDUCATING A DIVERSE PHYSICIAN WORKFORCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 314 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA provide on-line educational materials for its membership that address ~~cultural, racial and religious issues in patient care~~ diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 314 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA create and support programs that introduce elementary through high school students, especially those from ~~under-represented minority~~ groups that are underrepresented in medicine (URM), to healthcare careers (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fifth Resolve of Resolution 314 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA recommend that medical school admissions committees use holistic ~~evaluation~~ assessments of admission applicants~~,~~ ~~taking~~ that take into account the diversity of preparation and the variety of talents that applicants bring to their education (New HOD Policy); and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the sixth Resolve of Resolution 314 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to ~~race and ethnicity~~ URM status collected from Electronic Residency Application Service (ERAS) applications through the National Residen~~t~~cy Matching Program (NRMP) (New HOD Policy); and be it further

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 314 be adopted as amended.

HOD ACTION: Resolution 314 adopted as amended.

Resolution 314 asks 1) That our AMA develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population; 2) That our AMA provide on-line educational materials for its membership that address cultural, racial and religious issues in patient care; 3) That our AMA create and support programs that introduce elementary through high school students, especially those from under-represented minority groups, to healthcare careers; 4) That our AMA 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; 5) That our AMA recommend that medical school admissions committees use holistic evaluation of admission applicants, taking into account the diversity of preparation and the variety of talents that applicants bring to their education; 6) That our AMA advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to race and ethnicity collected from Electronic Residency Application Service (ERAS) applications through the National Residency Matching Program (NRMP); and 7) That our AMA continue the research, advocacy,

collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

Your Reference Committee heard testimony in favor of this resolution, in light of the mismatch between the physician and patient populations and the need to increase the number of physicians from groups that are underrepresented in medicine (URM). It was noted that the AMA has existing policy and initiatives that relate to this issue. For example, the intent of the highly successful Doctors Back to School program is reflected in the third Resolve. Testimony reflected, however, that this resolution offers a concrete plan of action versus policy that is more philosophical in nature. As noted in online testimony, this item "outlines actionable items for the AMA to enact to increase diversity by supporting current and future physicians." Additional testimony from the Gay and Lesbian Medical Association urged a more expansive approach to diversity, to go beyond race/ethnicity. In addition, testimony noted the need to use the more precise term "underrepresented in medicine" versus "underrepresented minority," in that not all minority populations are underrepresented in medicine. These changes are reflected in your Reference Committee's proposed recommendations, for which we urge adoption with the amendments shown.

(20) RESOLUTION 315 - INCLUSION OF DEVELOPMENTAL DISABILITIES CURRICULUM IN UNDERGRADUATE, GRADUATE AND CONTINUING MEDICAL EDUCATION OF PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 315 be amended by addition, to read as follows:

RESOLVED, That our AMA encourage 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 (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the fifth Resolve of Resolution 315 be amended by addition, to read as follows:

RESOLVED, That our AMA encourage 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 (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the sixth Resolve of Resolution 315 be amended by addition, to read as follows:

RESOLVED, That our AMA encourage 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. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 315 be adopted as amended.

HOD ACTION: Resolution 315 adopted as amended.

Resolution 315 asks 1) That our AMA reaffirm AMA Policies H-90.968, "Medical Care of Persons with Developmental Disabilities," and H-90.969, "Early Intervention for Individuals with Developmental Delay"; 2) That our AMA recognize the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community; 3) That our AMA support 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; 4) That our AMA encourage allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities; 5) That our AMA encourage graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities; and 6) That our AMA encourage continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.

Your Reference Committee heard unanimous testimony in support of this item, which recognizes the importance of managing persons with developmental disabilities as part of overall patient care. This patient population has unique health challenges and can be particularly at risk for health-care disparities. It was recommended that the Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, Accreditation Council for Continuing Medical Education, and specialty boards also be encouraged to address this issue in medical schools, residency, and CME programs. Therefore, your Reference Committee recommends that Resolution 315 be adopted as amended.

(21) RESOLUTION 316 - ACTION STEPS REGARDING MAINTENANCE OF CERTIFICATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 316 be amended by deletion, to read as follows:

RESOLVED, That our AMA recognize that lifelong learning for a ~~medical~~ physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) ~~course~~ appropriate to that physician's medical practice as determined by the relevant specialty society (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy D-275.954 (34) be reaffirmed in lieu of the third Resolve in Resolution 316.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 316 be referred.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fifth Resolve of Resolution 316 be referred.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 316 be adopted as amended.

HOD ACTION: Resolution 316 adopted as amended.

Resolution 316 asks 1) That our AMA affirm that lifelong learning is a fundamental obligation of our profession; 2) That our AMA recognize that lifelong learning for a medical physician is best achieved by ongoing participation in a program of high quality continuing medical education (CME) course appropriate to that physician's medical practice as determined by the relevant specialty society; 3) That our AMA develop model state legislation that would bar hospitals, health care insurers, and the state medical licensing board from using non-participation in the ABMS sponsored MOC process using lifelong, interval, high stakes testing as a exclusionary criteria for credentialing; 4) That our AMA 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; 5) That our AMA 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.

Your Reference Committee heard mixed testimony on this item. There was overwhelming support for the first and second resolves, which are consistent with existing HOD policy that recognizes the need for lifelong learning. Current HOD policy defines a physician as "an individual who has received a 'Doctor of Medicine' or a 'Doctor of Osteopathic Medicine' degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine." Therefore, the qualifier "medical" has been stricken from the second Resolve. In accordance with existing policy, our AMA has already developed model state legislation that would bar hospitals, health care insurers, and state medical boards from requiring participation in MOC processes as a condition of credentialing, privileging, insurance panel participation, licensure, or licensure renewal. This model legislation, which was released in 2016, is on file with the AMA Advocacy Resource Center and available upon request. Our 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. Your Reference Committee therefore recommends that Resolution 316 be adopted as amended.

(22) RESOLUTION 324 - IMPROVE HRSA PROJECTIONS OF THE PHYSICIAN WORKFORCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 324 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~work with~~ encourage the Health Resources & Service Administration ~~and~~ to collaborate with specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 324 be adopted as amended.

HOD ACTION: Resolution 324 adopted as amended.

Resolution 324 asks that our AMA work with the Health Resources & Service Administration and specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.

Your Reference Committee heard limited but positive testimony in support of adoption of this item. The Council on Medical Education proffered a friendly amendment to ensure a more effective and efficient approach to this important work, to ensure collaboration between the Health Resources and Services Administration and the relevant specialty societies. Therefore, your Reference Committee recommends that Resolution 324 be adopted as amended.

(23) COUNCIL ON MEDICAL EDUCATION REPORT 6 - STANDARDIZING THE ALLOPATHIC RESIDENCY MATCH SYSTEM AND TIMELINE (RESOLUTION 310-A-16)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 6 be referred.

HOD ACTION: Original Recommendation 1 of Council on Medical Education Report 6 adopted; Recommendations 2 and 3 referred.

Council on Medical Education Report 6 asks 1) That our AMA support the movement toward a unified and standardized residency application and match system for all non-military residencies; 2) That our AMA encourage the Association of University Professors of Ophthalmology, the American Urological Association, and other appropriate stakeholders to move ophthalmology and urology to the National Resident Matching Program; and 3) That our AMA encourage the National Resident Matching Program to develop a process by which sequential matches could occur for those specialties that require a preliminary year of training, allowing a match to the GY2 position, followed later in the year by a match to a GY1 position, thus reducing application and travel costs for applicants.

Your Reference Committee heard almost evenly mixed testimony on this report. Representatives of the affected disciplines (ophthalmology and urology) argued that the current match system works well and provides savings in travel costs and minimizes inconvenience. Related to Recommendation 3, as well, it was noted that it is impossible to guarantee that the National Resident Matching Program's complex match algorithm

could accommodate a sequential match. In addition, those who are unsuccessful in the ophthalmology or urology match can pursue a position in the NRMP match. Others argued in favor of adoption, to level the playing field for all medical students; simplify couples' matching (particularly for couples who are in separate matches); and heighten the opportunity for students to be exposed (during their fourth year rotations) to fields that they might have otherwise enjoyed. Therefore, your Reference Committee recommends that Council on Medical Education Report 6 be referred.

(24) RESOLUTION 318 - OPPOSE DIRECT TO CONSUMER ADVERTISING OF THE ABMS MOC PRODUCT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 318 be referred.

HOD ACTION: Resolution 318 referred.

Resolution 318 asks 1) That our AMA 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) That our AMA 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.

Your Reference Committee heard mixed testimony on this issue. Although our 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 is making a statement to inform the public about the certification status of physicians. There is no precedent in AMA policy which supports this issue, and the AMA has no purview over how the ABMS communicates information about its certification process. Therefore, your Reference Committee recommends that Resolution 318 be referred for further study.

(25) RESOLUTION 307 - FORMAL BUSINESS AND PRACTICE MANAGEMENT TRAINING DURING MEDICAL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-295.316, H-405.990 (Part 3), H-295.864, and H-295.924 be reaffirmed in lieu of Resolution 307.

HOD ACTION: Policies D-295.316, H-405.990 (Part 3), H-295.864, and H-295.924 be reaffirmed in lieu of Resolution 307.

Resolution 307 asks 1) That our AMA encourage the Liaison Committee for Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), Association of American Medical Colleges (AAMC) and other entities responsible for medical education to advocate for and support the creation of a more standardized process and approach for training and education in business and practice management skills for medical practitioners across the continuum of medical school, residency, fellowship and independent practice; and 2) That our AMA encourage LCME, ACGME, AAMC and other entities responsible for the education of future physicians, to provide educational resources and programs on business administration and practice management in their medical education curriculum.

Your Reference Committee heard testimony highlighting the importance of business and practice management training, and a number of individuals commented that while medicine is indeed a calling, it is also a business in today's increasingly corporate practice atmosphere. However, testimony also opposed the resolution because of how its implied curricular mandate would affect an already crowded curriculum. The AMA has long recognized and acknowledged the importance of physician skills in business and practice management as well as the lack of options for physicians to obtain such skills. Existing policy already directs the AMA to encourage the LCME, ACGME, AAMC, and other relevant organizations to advocate for and support the creation of a more standardized process and approach for training and education in business and practice management skills as well as to provide educational resources and programs on business administration and practice management in medical education.

AMA Policy D-295.316 addresses the creation of leadership and management training opportunities. Part 2 states that our AMA will work with key stakeholders to advocate for collaborative programs between medical schools and related schools of business and management to better prepare physicians for administrative and leadership responsibilities in medical management. Part 3 states that our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills, and management techniques integral to leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership capabilities.

Policy H-405.990 (Part 3) The AMA advocates for continued efforts to collect and disseminate relevant and useful data pertaining to physician managers. Policies H-295.864 and H-295.924 also support the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing the future physician leaders.

In addition, the AMA has several resources addressing the intent of the resolution. The AMA's Introduction to the Practice of Medicine, an interactive, web-based and tablet-compatible educational series, is offered by a large number of teaching institutions nationwide and helps resident/fellow physicians achieve the six general competencies, including systems-based practice and practice-based learning. This resource is being recast as the GME Competency Education Program, and will include modules such as understanding the litigation process, coding and documentation, choosing the right type of practice, CPT coding, fraud and abuse violations, personal finance, and physician employment contracts. Similarly, the AMA's Succeeding from Medical School to Practice online program includes education on business and economics issues. The AMA is developing educational programming for medical students, residents/fellows, and practicing physicians on these topics as part of its online tutorial series, STEPSForward™. The AMA is working to develop physician leadership programs for the AMA's Education Center to assist physicians in both rethinking and transforming their traditional roles, and in preparing for leadership opportunities from which they can help shape the health care system to produce better outcomes for physicians and their patients. This education will benefit physicians no matter where they are in their career or in which type of setting they practice. Also, the AMA's new Health Systems Science textbook focuses on value in health care, patient safety, quality improvement, teamwork and team science, leadership, clinical informatics, population health, socio-ecological determinants of health, health care policy, and health care economics. Finally, members of the AMA's Accelerating Change in Medical Education consortium's Leadership and Change Management Interest Group are actively working on a compilation of existing leadership curricula at the undergraduate medical education level. Therefore, your Reference Committee recommends that the policies noted above be reaffirmed in lieu of Resolution 307.

Management and Leadership for Physicians D-295.316

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs between medical schools and related schools of business and management to better prepare physicians for administrative and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership capabilities.

Physician Managers H-405.990 (3)

The AMA advocates . . . (3) continued efforts to collect and disseminate relevant and useful data pertaining to physician managers.

Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864
Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.

Future Directions for Socioeconomic Education H-295.924
The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum;
(2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and
(3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum.

(26) RESOLUTION 322 - ENDING MAINTENANCE OF CERTIFICATION EXAMINATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policies H-275.924 and D-275.954 be reaffirmed in lieu of Resolution 322.

HOD ACTION: Policies H-275.924 and D-275.954 reaffirmed in lieu of Resolution 322.

Resolution 322 asks 1) That our AMA oppose the requirement of Maintenance of Certification (MOC) as currently constituted in privileging and credentialing providers by health systems, hospitals, and payers; 2) That our AMA call on the American Board of

Medical Specialties to pursue ongoing meaningful continuing medical education as a pathway to MOC without the requirement for re-examination; and 3) That our AMA reaffirm Policies H-275.924 and D-275.954, and report back at the 2017 Interim Meeting with an update on progress made to toward these policies.

Your Reference Committee heard testimony largely in support of this item. The first Resolve, which opposes the requirement of Maintenance of Certification (MOC) as currently constituted in privileging and credentialing providers by health systems, hospitals, and payers, is covered by existing policy, H-275.924 (15). The second Resolve, which calls for the American Board of Medical Specialties to pursue ongoing meaningful continuing medical education as a pathway to MOC without the requirement for re-examination is already HOD policy D-275.954 (5)(30)(32). As was heard in testimony, most of the ABMS member boards have already moved away from the high-stakes examinations in favor of formats that their diplomates value. The third Resolve is covered by existing Policy D-275.954, which requires preparation of a yearly report to the House of Delegates regarding the MOC and OCC process. Therefore, your Reference Committee recommends that Policies H-275.924 and D-275.954 be reaffirmed in lieu of Resolution 322.

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 not be cost prohibitive or present barriers 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.

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. Examine the activities that medical specialty organizations have underway to review alternative pathways for board recertification; and determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board recertification are equivalent to established pathways.
29. 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.
30. 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.
31. 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.
32. 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.

33. 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.
34. 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.
35. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

Madam Speaker, this concludes the report of Reference Committee C. I would like to thank committee members Barbara A. Hummel, MD; Jerome Jeevarajan; Noah Kohn, MD; Anne Langguth, MD; Karl Napekoski, MD; and Janet West, MD; and all those who testified before the committee, as well as our AMA staff, including Catherine Welcher; Carrie Radabaugh; Fred Lenhoff; Alejandro Aparicio, MD; and Richard Hawkins, MD.

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