OMSS Governing Council Report A – HOD Handbook Review – June 2021 Special Meeting

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Item #	Ref Com	Title and Sponsor(s)	Proposed Policy	Governing Council Recommendation
1	CCB	CEJA Report 3 – Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues"	The Council on Ethical and Judicial Affairs Recommends that Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues," be retitled as "Physician Responsibilities to Colleagues with Illness, Disability or Impairment" and amended by substitution as follows; and the remainder of this report be filed: Providing safe, high quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession. While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly. As individuals, physicians should: a. Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment. b. Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence. c. Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions. d. Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice. e. Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.	Support intent

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			Collectively, physicians should nurture a respectful, supportive professional culture by: f. Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety. g. Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers. h. Eliminating stigma within the profession regarding illness and disability. i. Advocating for supportive services and accommodations to enable physicians who require assistance to provide safe, effective care. j. Advocating for respectful and supportive, evidence-based peer review policies and practices that will ensure patient safety and practice competency.	
2	CCB	Res. 001 – Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD) (New York)	RESOLVED, That our American Medical Association affirm that no physician or medical student should be presumed to be impaired by substance or illness solely because they are diagnosed with a substance use disorder (New HOD Policy); and be it further RESOLVED, That our AMA affirm that no physician or medical student should be presumed impaired because they and their treating physician have chosen medication for opioid use disorder (MOUD) to address the substance use disorder, including methadone and buprenorphine (New HOD Policy); and be it further RESOLVED, That our AMA strongly encourage the leadership of physician health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers to help end stigma and discrimination against physicians and medical students with substance use disorders and allow and encourage the usage of medication for opioid use disorder (MOUD), including methadone or buprenorphine, when clinically appropriate and as determined by the physician or medical student (as patient) and their treating physician, without penalty (such as restriction of privileges, licensure, ability to prescribe medications or other treatments, or other limits on their ability to practice medicine), solely because the physician's or medical student's treatment plan includes MOUD (Directive to Take Action); and be it further RESOLVED, That our AMA survey physician health programs and state medical boards and report back about whether they allow participants/licensees to use MOUD without punishment, or exclusion from practicing medicine or having to face other adverse consequences. (Directive to Take Action)	Support intent

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3	CCB	Res. 003 – Healthcare Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions (American Academy of Pediatrics)	RESOLVED, That our American Medical Association adopt the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine: GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces. An effective healthcare anti-discrimination policy should: • Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting. • Ensure the policy is prominently displayed and easily accessible. • Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions. • Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system. • Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions. • Create anti-discrimination policies that: o Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.). o Define expected and prohibited behavior. o Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions. o Ensure privacy and confidentiality to the reporter. o Provide a confidential method for documenting and reporting incidents. o Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action. • These policies should include: o Taking every complaint seriously. o Acting upon every complaint immediately.	Seek referral

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			○ Developing appropriate resources to resolve complaints. ○ Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting. ○ Communicating decisions and actions taken by the organization following a complaint to all affected parties. ○ Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives. In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions. Tactics to help create this type of organizational culture include: • Surveying staff, trainees and medical students, anonymously and confidentially to assess: ○ Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions. ○ Ideas about the impact of this behavior on themselves and patients. • Integrating lessons learned from surveys into programs and policies. • Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions. • Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions. • Providing designated support person to confidentially accompany the person reporting an event through the process. (New HOD Policy)	
4	CCB	Res 007 – Nonconsensual Audio/Video Recording at Medical Encounters	RESOLVED, That our American Medical Association encourage that any audio or video recording made during a medical encounter should require both physician and patient notification and consent. (New HOD Policy)	Support intent

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		(Virginia, New Jersey, District of Columbia, Louisiana, American Association of Clinical Urologists, American Urological Association, Maryland)		
5	CCB	Res. 009 – Supporting Woman and Underrepresented Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties (Illinois)	RESOLVED, That our American Medical Association advocate for increased research on changes in specialty interests throughout medical education, including both undergraduate and graduate medical education, specifically in competitive specialties, with a focus on student demographics; (Directive to Take Action) and be it further RESOLVED, That our AMA amend the following policy to in order to support increasing representation and the recruitment of students who identify with groups classically not represented in competitive fields: H-200.951 Strategies for Enhancing Diversity in the Physician Workforce Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. Our AMA will both support and takeactive measures to support medical students who identify with groups underrepresented in competitive specialties, such as women and minority students, in order to take concrete steps to enhance diversity in the physician workforce. (Modify Current HOD Policy); and be it further RESOLVED, That our AMA maintain allocated yearly funding for AMA-MSS national meeting attendance and maintain concrete and standing mechanisms for increasing participation for medical students within our AMA-MSS from medical schools with classically low national meeting attendance, which will be defined as less than five students per national AMA-MSS meeting over a period of five consecutive years, having one or more of the following characteristics: 1. Identify with group(s) underrepresented and disadvantaged in medicine 2. Are from medically underserved areas 3. Are first generation college graduates	Monitor

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			as a mechanism to create more exposure to leadership and networking opportunities for these students. (Directive to Take Action)	
6	A	CMS Report 02 – Continuity of Care for Patients Discharged from Hospital Settings	The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of amended Resolution 212-A-19, and the remainder of the report be filed. 1. That our American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. (New HOD Policy) 2. That our AMA support medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge. (New HOD Policy) 3. That our AMA support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients. (New HOD Policy) 4. That our AMA advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors. (New HOD Policy) 5. That our AMA advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTBP) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy) 6. That our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTBP tools. (New HOD Policy) 7. That our AMA reaffirm Policy H-125.979, which directs the AMA to work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers. (Reaffirm HOD Policy)	Support intent

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7	A	CMS Report 07 – Addressing Equity in Telehealth	The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020, and that the remainder of the report be filed. 1. That our American Medical Association (AMA) reaffirm Policy D-480.963, which advocates for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-478.980, which advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. (Reaffirm HOD Policy) 3. That our AMA encourage initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations. (New HOD Policy) 4. That our AMA encourage telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations. (New HOD Policy) 5. That our AMA support efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities. (New HOD Policy) 6. That our AMA reaffirm Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services. (Reaffirm HOD Policy) 7. That our AMA encourage hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth. (New HOD Policy) 8. That our AMA support expanding physician practice eligibility for programs that assist providers in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use	Support intent, and seek amendment to achieve consistency of physician/ provider language

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			among historically marginalized, minoritized and underserved populations. (New HOD Policy) 9. That our AMA reaffirm Policy D-480.969, which advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. (Reaffirm HOD Policy) 10. That our AMA support efforts to ensure payers allow all contracted physicians to provide care via telehealth. (New HOD Policy) 11. That our AMA oppose efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians. (New HOD Policy) 12. That our AMA advocate that payments should consider the resource costs required to provide all physician visits and payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. (New HOD Policy)	
9	A	Res 101 - Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits	RESOLVED, That our American Medical Association study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternative sites of care when it is appropriate to their symptoms and/or condition instead of hospital emergency departments. (Directive to Take Action)	Support intent
10	A	Res. 102 – Bundling Physicians Fees with Hospital Fees (New York)	RESOLVED, That our American Medical Association oppose bundling of physician payments with hospital payments, unless the physician has agreed to such an arrangement in advance. (New HOD Policy)	Support intent
11	A	Res. 111 – Towards Prevention of Hearing-Loss Associated Cognitive Impairment (Senior Physicians Section)	RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment in later life, to physicians as well as to the public (Directive to Take Action); and be it further RESOLVED, That our AMA promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote, the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment and amenable to correction (Directive to Take Action); and be it further	Support intent

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			RESOLVED, That our AMA advocate for increasing hearing screening and avenues for coverage for effective hearing loss remediation beginning in mid-life or whenever detected, including third party insurance coverage, especially when such loss is shown conclusively to contribute significantly to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take Action)	
12	B	Res. 204 – Insurers and Vertical Integration (New York)	RESOLVED, That our American Medical Association seek legislation and regulation to prevent health payers (except non-profit HMO's) from owning or operating other entities in the health care supply chain. (Directive to Take Action)	Support intent
13	B	Res. 205 – Protection of Peer-Review Process (South Carolina, Alabama, Florida, Mississippi, New Jersey, Oklahoma, West Virginia, Arkansas, North Carolina)	RESOLVED, That our American Medical Association use its full ability and influence to oppose any new attempt(s) to make Peer Review proceedings, regardless of the venue, discoverable, even if by the US Congress or other US Governmental entity. (Directive to Take Action)	Support intent
14	B	Res. 210 – Ransomware and Electronic Health Records (Illinois)	RESOLVED, That our American Medical Association adopt policy acknowledging that healthcare data interruptions are especially harmful due to potential physical harm to patients and calling for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients (New HOD Policy); and be it further RESOLVED, That our AMA seek to introduce federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and indirect patient care, to the fullest extent of the law. (Directive to Take Action)	Oppose resolves 1 and 2, and seek amendment by addition of a new resolve: RESOLVED, That our AMA encourage hospital systems and integrated networks that are under threat of ransomware attacks to upgrade their cybersecurity

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				and to back up their data in a robust and timely fashion.
15	C	Res. 313 – Fatigue Mitigation Respite for Faculty and Residents (Women Physicians Section)	RESOLVED, That our American Medical Association work with appropriate stakeholders, including hospital accreditation organizations, to make available resources to institutions and physicians that support self-care and fatigue mitigation, help protect physician health and well-being, and model appropriate health promoting behaviors (Directive to Take Action); and be it further RESOLVED, That the AMA work with appropriate stakeholders, including hospital accreditation organizations, to advocate for policies that support fatigue mitigation programs, which ~~include, but are not limited to,~~ might include quiet places to rest and funding for alternative transport including return to work for vehicle recovery at a later time for all medical staff who feel unsafe driving due to fatigue after working. (Directive to Take Action)	Seek amendment to include stakeholders in these efforts (as shown at left).
16	D	Res. 407 – Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities (Oregon)	RESOLVED, That our American Medical Association study the impact of SARS-CoV-2 pandemic on post-acute care services and long-term care and residential facilities and collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of these facilities during public health emergencies and natural disasters with policy recommendations to include but not limited to: a. Planning for adequate funding and access to resources; b. Planning for emergency staffing of health care and maintenance personnel; c. Planning for ensuring safe working conditions of LTC staff; and d. Planning for mitigation of the detrimental effects of increased isolation of residents during a natural disaster, other environmental emergency, or pandemic, or similar crisis. (Directive to Take Action)	Support intent
17	D	Res. 414 – Call for Improved Personal Protective Equipment (PPE) Design and Fitting (Medical Student Section)	RESOLVED, That our American Medical Association encourage the diversification of personal protective equipment design to better fit all body types among healthcare workers. (Directive to Take Action)	Support intent

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18	D	Res. 415 – Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles (Medical Student Section)	RESOLVED, That our American Medical Association amend policy H-440.847 by addition and deletion to read as follows: Pandemic Preparedness ~~for Influenza~~ H-440.847 In order to prepare for a ~~potential influenza~~ pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a~~n influenza~~ a pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, ~~and~~ anti-~~viral~~ microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to~~, and protect the population from illness and death in an influenza~~ a pandemic or other serious public health emergency; (3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency; (4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency; (~~3~~5) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an ~~influenza~~ epidemic, pandemic, or other serious public health	Seek referral

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			emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (~~4~~6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (7) will monitor progress in developing a contingency plan that addresses future ~~influenza~~ vaccine production or distribution problems and in developing a plan to respond to a~~n~~ ~~influenza~~ pandemic in the United States. (Modify Current HOD Policy)	
19	G	BOT Report 13 – Amending the AMA's Medical Staff Rights and Responsibilities	The Board of Trustees recommends that the following be adopted in lieu of Resolution710-NOV-20 and that the remainder of the report be filed: 1. That AMA Policy H-225.942, "Physician and Medical Staff Member Bill of Rights," be amended by addition and deletion: Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities: Preamble The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated. The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders	Support intent

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			in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients. Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care. From this fundamental understanding flow the following Medical Staff Rights and Responsibilities: **I. Our AMA recognizes the following fundamental responsibilities of the medical staff:** a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body. b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities. c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members. d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation. e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct. f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review. **II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:** a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and	

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			removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members. b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities. c. The right to be provided with the resources necessary to continuously improve patient care and outcomes. d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments. e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body. f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests. **III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:** a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety. b. The responsibility to provide patient care that meets the professional standards established by the medical staff. c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff. e. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities. f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff. g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.	

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			h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large. **IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:** a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws. b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers. c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care ~~or~~, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities. e. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty. f. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments. g. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body. (Modify Current HOD Policy)	
20	G	CMS Report 06 – Urgent Care Centers	The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:	Support intent

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			1. That our American Medical Association (AMA) reaffirm Policy D-35.985 supporting the physician-led health care team. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-385.926 supporting physicians' choice of practice and method of earning a living. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted to the patient's primary care physician and the administrator of the vaccine should enter the information into an immunization registry, when one exists. (Reaffirm HOD Policy) 4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology (CPT) codes, including those for off-hour services. (Reaffirm HOD Policy) 5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles: a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community; b. UCCs must transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it; c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information; d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made; e. UCCs should use local physicians as medical directors or supervisors; f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers; and	

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			g. UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided. (New HOD Policy) 6. That our AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending. (New HOD Policy) 7. That our AMA support patient education including notifying patients if their physicians are providing off-hours care, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, and asking for their patients to notify their physician or usual source of care before seeking UCC services. (New HOD Policy)	
21	G	CMS Report 09 – Addressing Payment in Delivery in Rural Hospitals	The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed: 1. That our American Medical Association (AMA) reaffirm Policy D-290.979 directing our AMA to support state efforts to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates. (Reaffirm HOD Policy) 3. That our AMA support that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate: a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume; b. Provide adequate service-based payments to cover the costs of services delivered in small communities; c. Pay for physician standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner; d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability; e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and	Support intent

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			f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone. (New HOD Policy) 4. That our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes. (New HOD Policy)	
22	G	Res. 701 – Physician Burnout is an OSHA Issue (New York)	RESOLVED, That our American Medical Association seek legislation/regulation to add physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and Health Administration (OSHA) oversight. (Directive to Take Action)	Seek referral
23	G	Res. 704 – Eliminating Claims Data for Measuring Physician and Hospital Quality (Oklahoma)	RESOLVED, That our American Medical Association collaborate with the US Centers for Medicare and Medicaid Services (CMS) and other appropriate stakeholders to ensure physician and hospital quality measures are based on the delivery of care in accordance with established best practices (Directive to Take Action); and be it further RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of claims data for measuring physician and hospital quality. (Directive to Take Action)	Support intent
24	G	Res. 705 – Improving the Prior Authorization Process (Arizona, Colorado)	RESOLVED, That our American Medical Association promote that all medication denials from insurance companies, pharmacy benefit managers or retail pharmacies provide the approved formulary alternatives in the same class of medications or the step edit requirements at the time of the denial to the prescribing physician (Directive to Take Action); and be it further RESOLVED, That at the time of denial by insurance companies, pharmacy benefit managers, or retail pharmacies, that our AMA advocate they be required to inform the patient of the lowest cash or discount card price for that medication. (Directive to Take Action)	Support intent
Recommendations 25 and 26 relate to Board/Council reports originating from OMSS-sponsored resolutions. (These were previously referred to as "green reports.")				
25	G	BOT Report 09 – Preservation of the Patient-Physician Relationship	The Board of Trustees recommends that Resolution 703-A-19 not be adopted and that this report be filed.	Support intent

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26	G	CMS Report 05 – Medical Center Patient Transfer Policies	The Council on Medical Service recommends that the following be adopted in lieu of Resolution 818-I-19 and that the remainder of the report be filed: 1. That our American Medical Association (AMA) amend Policy H-130.982 by addition and deletion as follows: H-130.982 Interfacility Patient Transfers ~~of Emergency Patients~~ Our AMA: (1) supports the following principles for ~~the~~ interfacility patient transfers ~~of emergency patients~~: (a) all physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility patient transfer ~~of an unstabilized emergency patient~~ should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical ~~service~~ care at the receiving facility rather than the transferring facility; and (c) all interfacility patient transfers ~~of emergency patients~~ should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges ~~county medical societies~~ physician organizations to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to physician organizations that are ~~their county medical societies as they~~ developing such protocols and interhospital agreements with their local hospitals. (Modify Current HOD Policy) 2. That our AMA amend subsection II(d) of Policy H-225.942 by addition and deletion as follows: d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to	Support intent

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			grant exclusive contracts, ~~or~~ close medical staff departments, or to transfer patients into, out of, or within the health care organization. (Modify Current HOD Policy) 3. That our AMA amend Policy H-130.965 by addition as follows: Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association (AHA) and other interested parties to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred. (Modify Current HOD Policy) 4. That our AMA amend Policy H-320.939 by addition of a fourth section as follows: 4. Our AMA advocates for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. (Modify Current HOD Policy) 5. That our AMA reaffirm Policy H-225.957, which provides principles for strengthening the physician-hospital relationship. Policy H-225.957 sets forth parameters for collaboration and dispute resolution between the medical staff and the hospital governing body, and it establishes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff. (Reaffirm HOD Policy) 6. That our AMA reaffirm Policy H-225.971, which details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing. Policy H-225.971 states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should report to and be accountable to the medical staff committee responsible for quality improvement activities. (Reaffirm HOD Policy) 7. That our AMA reaffirm Policy H-285.904, which sets forth principles related to unanticipated out-of-network care. (Reaffirm HOD Policy)	

OMSS Governing Council Report A – HOD Handbook Review – June 2021 Special Meeting

The following items are noted for OMSS member awareness only:

- Memorial Resolution – Lawrence “Larry” Monahan (sponsored by the Organized Medical Staff Section)
- CEJA Opinion 01 – Amendment to Opinion 1.2.2., “Disruptive Behavior and Discrimination by Patients”
- CEJA Opinion 02 – Amendment to Opinion 8.7, “Routine Universal Immunization of Physicians”