AMA
AMERICAN MEDICAL ASSOCIATION
ama-assn.org
(312) 464-5000

ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Interim 2025 Meeting

Access full text of resolutions/reports in the HOD meeting handbook.

Recommendations key
Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Monitor* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the OMSS
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Note: Items highlighted in blue have been recommended for reaffirmation.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
1	E&B	CEJA 01 – Amendment to Opinion 1.1.1 "Patient-Physician Relationships"	Your Council on Ethical and Judicial Affairs recommends that Opinion 1.1.1, "Patient Physician Relationships" be amended by addition and deletion and the remainder of this report be filed. The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. ~~The relationship between a patient and a physician is based on trust, which gives rise to~~ The relationship that emerges between a patient and a physician must be based on trust. The physician's obligation to be trustworthy entails additional ethical duties such as a commitment to act for the good of patients; to uphold respect for patients as persons; to develop good communication skills; and to be professionally competent. This trust is fostered by physicians' ethical responsibility~~ies~~ to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. When external influences	Delegate instructed to support.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			negatively impact this trust, or the patient-physician relationship directly, physicians individually and collectively should advocate for changes to ameliorate the situation and promote a more hospitable environment in which patient-physician relationships may flourish. A patient-physician relationship ~~exists~~ commences when a physician begins to serve a patient's medical needs. ~~Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:~~ The contexts that may lead to a patient-physician relationship vary: they generally occur as a response to a request by a patient or a patient's surrogate, but can also include certain contractual, legally mandated, or emergency settings without the explicit request or consent of the patient. While the patient-physician relationship may involve one patient and one physician in today's complex health care system, such relationships often involve multiple members of a care team, patient family members and surrogates. The core values of the patient-physician relationship, however, remain unchanged. How these values are implemented will depend on many factors, including the setting, the needs of the patient, the duration of the relationship, and the training, expertise, and experience of the physician, and will necessarily reflect the myriad ways that patients and physicians interact. While every patient-physician relationship will be different and will change over time, the fundamental importance of establishing and sustaining trust through respect for persons, good communication, and professional competency will always be crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore, to uphold these values and support patients and the primacy of the patient-physician relationship to the best of their ability in all practice settings and at all times. ~~(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.~~	

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			~~(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.~~ ~~(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.~~	
2	E&B	CEJA 02 – Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	The Council on Ethical and Judicial Affairs recommends that the following recommendations be adopted and the remainder of the report be filed: 1. That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows: Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~ Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the wellbeing of patients in jeopardy. Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician wellbeing, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician wellbeing.	Delegate instructed to strongly support.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions: (a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing. (b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.~~ Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and wellbeing, and/or institutional culture that negatively affect patient care.	
3	E&B	Res. 005 – Preserving Autonomy in the Patient-Physician Relationship (Young Physicians Section)	RESOLVED, that our American Medical Association study relevant sections of the Code of Medical Ethics to address outside political and administrative influences on the patient physician relationship and its impact on shared decision making in the clinical setting. (Directive to Take Action)	Delegate instructed to support.
4	E&B	Res. 006 – Amendment to AMA Bylaws to Enable Continuity of Leadership (Resident and Fellows Section)	RESOLVED, that our American Medical Association amend AMA Bylaw 7.1.2 to allow the Resident and Fellow Section (RFS) Immediate Past Chair to serve in the position even if they have graduated from the RFS. (Modify Current HOD Policy)	Delegate instructed to support.

ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Interim 2024 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
5	E&B	Res. 008 – Health Plan In-Network Steering of Pathology/Laboratory Services (College of American Pathologists)	RESOLVED, that our American Medical Association support state and federal legislative efforts to expressly prohibit in-network steering by health insurance plans, or by laboratory benefit managers under contract with such plans, to "preferred" or "designated" in-network laboratories or pathologists, thereby excluding other in-network pathology and laboratory providers (New HOD Policy); and be it further RESOLVED, that our AMA advocate in partnership with state medical societies and medical specialty societies to protect ordering physician discretion to refer pathology and laboratory specimens to any in-network pathologist or in-network laboratory of their choice, based upon relevant medical considerations in the best interest of patient care, consistent with AMA Code of Medical Ethic. (Directive to Take Action)	Delegate instructed to support and engage in the House as necessary.
6	B	BOT 02 – Laser Surgery	The Board of Trustees recommends that the following be adopted in lieu of Resolution 210-I-24 and the remainder of the report be filed. 1. That our American Medical Association (AMA) amend Policy H-475.989, "Laser Surgery," to read: 1. Our American Medical Association adopts the policy that laser surgery should be performed only by ~~individuals~~ licensed physicians (defined as individuals who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency)~~to practice medicine and surgery~~ who meet appropriate professional standards, or by those categories of practitioners who are appropriately trained, credentialed, and currently licensed by the state to perform surgical services, and are working under the direct supervision of a physician who possesses appropriate training and privileges in performance of the procedure being supervised. ~~currently licensed by the state to perform surgical services.~~ (Modify Current HOD Policy) 2. That our AMA amend Policy H-475.980, "Addressing Surgery Performed by	Delegate instructed to strongly support.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			Optometrists," to read: 1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA Policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery". (Modify Current HOD Policy) 2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA Policies H-475.983, "Definition of Surgery," and H-475.989 ~~H-475.988~~, "Laser Surgery". (Modify Current HOD Policy)	
7	B	BOT 03 – Stark Law Self-Referral Ban	The Board of Trustees recommends that the following be adopted in lieu of Resolution 227-I-23 and BOT 03-I-24 and the remainder of the report be filed: 1. That our American Medical Association (AMA) recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs. (New HOD Policy) 2. That our AMA supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral." (New HOD Policy) 3. That our AMA supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care. (New HOD Policy)	Delegate instructed to support – would like to see recommendations go further.
8	B	BOT 04 – Addressing and Reducing Patient Boarding in Emergency Departments (EDs)	The Board of Trustees recommends that Policy D-130.957 be amended by deletion of the sixth clause since it has been accomplished by this report and the remainder of the report be filed:	Delegate instructed to strongly support.

ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Interim 2024 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
9	B	BOT 06 – Information Blocking Rule	The Board of Trustees recommends that the following be adopted in lieu of Resolution 226-I-24 and the remainder of the report be filed: 1. Our American Medical Association supports the use of patient-directed, short-term embargoes for results that indicate debilitating, life-limiting, or terminal illnesses, and supports individual tailoring of preferences for release of such information, consistent with the harm exception to the Information Blocking Rule. (New HOD Policy) 2. Our AMA supports the ability of patients to request physician or surrogate review of potentially life-altering report and result information prior to its release, when consistent with the harm exception to the Information Blocking Rule. (New HOD Policy) 3. Our AMA reaffirms Policy D-315.972, supporting expansion of the harm exception to the Information Blocking Rule to include emotional and psychological harm and urge relevant government agencies to adopt enforcement discretion that would afford medical practices additional compliance flexibilities. (Reaffirm HOD Policy)	Delegate instructed to listen.
10	B	BOT 16 – Preservation of Medicaid	The Board of Trustees recommends the following and that the remainder of the report be filed. The first item of Policy H-290-951, “Preservation of Medicaid” be amended by deletion as follows. 1. Our American Medical Association elevates Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility~~, and request report back on the Board of Trustees' actions at I-25~~. (Modify Current Policy)	Delegate instructed to strongly support.
11	B	Res. 204 – Addressing Anti-Physician Contractual Provisions	RESOLVED, that our American Medical Association develop model state legislation to prohibit the inclusion of clauses indemnifying employers in physician contracts (Directive to Take Action); and be it further RESOLVED, that our AMA will actively work to increase the education and	Delegate instructed to strongly support.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
		(Organized Medical Staff Section)	awareness of physicians on the implications of accepting employment contracts which require physicians to (i) pay for tail insurance, or (ii) indemnify their employers. (Directive to Take Action)	
12	B	Res. 211 – Access to, and Retention of, Electronic Medical Records (Utah)	RESOLVED, that our American Medical Association support federal legislation to standardize the duration of all medical record retention and to require that records of discharged patients be compiled, reviewed for completeness, and authenticated within 30 days of discharge (New HOD Policy); and be it further RESOLVED, that our American Medical Association adopt as its formal policy and also support federal legislation that mandates the following: a) All EMR vendors must retain patient data electronically to comply with state laws regardless of whether the provider or health-care system contract is still in effect; b) All EMR vendors must arrange for custodians of all electronic medical files to comply with state law regarding medical record retention in case of insolvency; and c) All EMR vendors must deliver an individual patient's medical records when requested to lawful recipients in a timely manner, at reasonable or no cost, and in formats that are readily accessible to the general public. (New HOD Policy)	Delegate instructed to listen.
13	B	Res. 213 – Pathways to U.S. Permanent Residency for H-1B Physicians (International Medical Graduates Section)	RESOLVED, that our American Medical Association urgently, aggressively, and continuously collaborate with the Office of the Inspector General, the Department of Veterans Affairs, U.S. Citizenship and Immigration Services, Congress, and the Executive Branch to advocate for establishing an expedited and separate pathway for physicians to obtain permanent residence and U.S. citizenship, enabling them to practice immediately and without restrictions—including within the Veterans Affairs healthcare system—to address the critical and rapidly worsening physician shortages threatening access to care across the United States. (Directive to Take Action)	Delegate instructed to strongly support.
14	B	Res. 218 – Amend AMA Policy D-160.921 on	RESOLVED, that our American Medical Association amend policy D-160.921 by addition and deletion as follows:	Delegate instructed to strongly support.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
		Sensitive Locations to Protected Areas (New York)	"Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as ~~sensitive locations~~ protected areas by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as ~~sensitive locations~~ protected areas where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as ~~sensitive locations~~ protected areas; and (4) opposes the presence of ICE enforcement at healthcare facilities." (Modify Current HOD Policy)	
15	B	Res. 221 – Not-for-Profit Status (New York)	RESOLVED, that our American Medical Association advocate that the granting and maintenance of healthcare entities of not-for-profit status be reassessed by both the state legislature and the US Congress. (Directive to Take Action)	Delegate instructed to listen.
16	B	Res. 225 – Federal Legislation to Prohibit the Corporate Practice of Medicine (American Academy of Emergency Medicine)	RESOLVED, that our American Medical Association advocate for federal legislation that prohibits lay corporations, including insurance companies, private equity firms, and other non-physician-owned entities, from owning or controlling medical practices and healthcare decision-making, and prohibits such entities from participation in federal healthcare payment programs, in order to protect physician autonomy and strengthen the physician-patient relationship (Directive to Take Action); and be it further RESOLVED, that our AMA amend Policy H-215.981 - Corporate Practice of Medicine under items #1 and #2 by addition and deletion as follows: 1. Our American Medical Association ~~vigorously opposes any effort to pass federal legislation or regulation preempting state laws~~ supports the passage of federal legislation prohibiting the corporate practice of medicine. 2. Our AMA vigorously opposes any effort to pass state or federal legislation or regulation that removes or weakens existing state laws prohibiting the corporate practice of medicine. (Modify Current HOD Policy)	Delegate instructed to listen, support referral.
17	B	Res. 226 – Transparency with the	RESOLVED, that our American Medical Association advocates for the designation of "emergency department" or "emergency room" to be restricted to	Delegate instructed to listen.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
		Term "Emergency Department"	facilities with the presence of at least one physician on-site and on-duty, who is responsible for the emergency department at all times (Directive to Take Action); and be it further RESOLVED, that our AMA recommends that facilities without physician staffing use alternative terminology, such as Acute Care Unit, as a matter of truth and transparency for patients, so that patients are not expecting care by a physician (New HOD Policy); and be it further RESOLVED, that our AMA work with the Joint Commission, Det Norske Veritas (DNV), and other authorities/regulators to educate them about this issue, and to encourage them to implement correct "emergency department" terminology designations to ensure truth and transparency at all times for our patients. (Directive to Take Action)	
18	B	Res. 229 – Protection of Medicaid Beneficiaries' Private Health Information from Immigration Enforcement (Underrepresented in Medicine Advocacy Section)	RESOLVED, that our American Medical Association amend H-315.966 "Patient and Physician Rights Regarding Immigration Status" by addition and deletion to read as follows: Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records, Medicaid, Children's Health Insurance Program (CHIP), or other health program data, including but not limited to Emergency Medicaid and related immigrant-specific programs, ~~to pursue immigration enforcement actions against patients who are undocumented~~ for immigration enforcement purposes (Modify Current HOD Policy); and be it further RESOLVED, that our AMA work with interested parties to educate physicians and patients about existing privacy protections and available legal remedies to safeguard confidential health information, particularly for immigrant and mixed-status families. (Directive to Take Action)	Delegate instructed to strongly support.

ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Interim 2024 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
19	B	Res. 230 – Banning Non-compete Agreements in States (American College of Rheumatology	RESOLVED, that our American Medical Association will work with state medical societies, national specialty societies and/or other interested parties to advocate for legislation or regulation that would prohibit covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers, across all states in which a ban on non-to-compete agreements is not in place. (Directive to Take Action)	Delegate instructed to strongly support.
20	B	Res. 237 – Protecting and Improving Rural Health (California)	RESOLVED, that our American Medical Association assist state medical associations, specialty societies and physician practices with the implementation of HR 1, The One Big Beautiful Bill Act, to mitigate the negative impact of the Medicaid, ACA and student loan cuts to physicians and patients, particularly in rural areas (Directive to Take Action); and be it further RESOLVED, that our AMA continue to assist state medical associations and physician practices with the HR 1 implementation of the Rural Transformation Program to ensure funding and assistance for physician practices (Directive to Take Action); and be it further RESOLVED, that our AMA support the provision and payment of physician-to-physician virtual telehealth consultations as an option to increase access to primary and specialty care in rural communities, acknowledging that significant investments in rural telehealth broadband must be made in order to effectively deliver telehealth services (New HOD Policy); and be it further RESOLVED, that our AMA encourage the development of programs and financial assistance models for rural physician practices in need of health information technology and other technological modernization and security, as well as access to specialty equipment to provide quality care (New HOD Policy); and be it further RESOLVED, that our AMA support investments in and payment for a wide variety of medical transportation options to connect rural residents to primary and specialty care services and return to their communities (New HOD Policy);	Delegate instructed to listen.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			and be it further RESOLVED, that our AMA continue to address the nation's obstetrics and gynecology training and workforce needs, including but not limited to increasing postgraduate positions in OB-GYN and family medicine OB fellowships, increasing ACGME funding, and evaluating other ways to increase physicians providing OB-GYN services in shortage areas (Directive to Take Action); and be it further RESOLVED, that our AMA support expansion of Family Practice Obstetricians (FPOB) who are family practice physicians that are certified after completing an obstetrics fellowship (New HOD Policy); and be it further RESOLVED, that our AMA urge the Centers for Medicare and Medicaid Services and others to provide funding for standby capacity payments to sustain obstetric services at hospitals at risk of closing access to maternity care (New HOD Policy); and be it further RESOLVED, that our AMA urge the Department of Defense to provide health care coverage, funding and improved access to labor and delivery services for military personnel, military families, and non-military individuals working on military bases in maternity care health professional shortages areas (Directive to Take Action); and be it further RESOLVED, that our AMA continue to research and distribute successful state and specialty society models that have improved access to maternal care in rural areas and reduced maternal mortality rates. (Directive to Take Action)	
21	F	CLRPD 01 – Private Practice Physicians Section Five-Year Review	The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Private Practice Physicians Section through 2030 with the next review no later than the 2030 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)	Delegate instructed to support.

ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Interim 2024 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
22	F	Res. 601 – Reimagining and Modernizing the U.S. Healthcare Delivery System (New England)	RESOLVED, that our American Medical Association will convene a multidisciplinary Task Force, under the direction of the Board of Trustees, that may include physicians and trainees, allied health professionals, leaders from hospitals and health systems, public and private payers, health economists, ethicists, patient advocates, and other relevant parties from across the health sector, to develop a legislative roadmap to reform the U.S. healthcare delivery system, drawing from and building upon existing AMA policy, and positioning our AMA as a convener of a broader national coalition to advance this vision; and that this roadmap will be structured around the following components: 1. Foundational Principles: The roadmap will specifically incorporate the following principles: a. Equitable access to affordable, high-quality healthcare for all as a basic human right; b. Physician autonomy and the primacy of the patient-physician relationship; c. Physician-led care as the foundation of clinical decision-making and healthcare delivery; d. Freedom of patients and physicians to choose care settings and models of practice; e. Physician practice sustainability through fair and predictable payment; f. Science-based innovation that improves healthcare value and efficiency; and g. Prevention, public health, and health equity as central pillars of a sustainable healthcare system; 2. Scope of Review: In developing the roadmap, the task force will consider issues related to healthcare delivery and financing, including, but is not limited to, the following systemic problems and potential solutions: a. Physician payment and workforce sustainability; b. Comprehensive valuation of physician work; c. Incentives that support timely, patient-centered care and uphold clinical judgment; d. Administrative, financial, and clinical interference by intermediaries; e. Uninsurance, underinsurance, and other cost-sharing issues; f. Universal coverage, including preventive services and public health;	Delegate instructed to listen.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			g. Equity in care delivery; h. Protection of physician-patient shared decision-making; i. Market consolidation, vertical integration, and profiteering; j. Drug pricing and access to evidence-based therapies; and k. Transparency and reporting of the true cost of care; 3. Environmental Scan: To inform the roadmap, the task force will conduct a comprehensive review of existing global and domestic healthcare programs and reform proposals to evaluate their strengths and weaknesses based on how each framework centers patients, upholds clinical judgment, and promotes healthcare system and physician practice sustainability; and 4. Reporting and Engagement: The task force will: a. Report at least annually to the AMA House of Delegates on its findings and progress; b. Provide recommendations to the AMA Board of Trustees on areas requiring further policy development to support this work; c. Regularly convene focus groups within and outside of the AMA House of Delegates to review draft elements of the roadmap as they are being developed; and d. Deliver a final comprehensive legislative roadmap to reform the U.S. healthcare delivery system for consideration by the AMA House of Delegates. (Directive to Take Action)	
23	J	BOT 18 – Published Metrics for Hospitals and Hospital Systems	The Board of Trustees recommends the following be adopted and the remainder of this report be filed: 1. Our American Medical Association supports the use of metrics that hospitals and hospital systems can use to improve physicians' experience, engagement,	Delegate instructed to support.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			and work environment in a manner accessible to physicians (New HOD Policy) 2. That Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems," be rescinded as being accomplished by this report. (Rescind HOD Policy)	
24	J	CMS 03 – Payment Models to Sustain Rural Hospitals	The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed: 1. That our American Medical Association (AMA) supports the following minimum standards for alternative payment models to rural hospitals in order to enhance their financial sustainability and ensure access to care: a. Fixed Cost Payment: Rural hospitals should be paid an agreed upon and fixed sum delivered on a predictable schedule that is not tied to patient volume. b. Adequate Payment Rates: All payers should ensure that payments made for variable services are adequate to cover the full cost of care provision. c. Patient Cost-Sharing: Any out-of-pocket payments made by patients should be reasonable and affordable. d. Accountability and Transparency: Care delivered should be of high-quality, evidence-based, and part of a physician-led team. e. Administrative Simplicity: Models should minimize administrative burdens. (New HOD Policy) 2. That our AMA believes that rural hospitals are essential to the communities they serve. To ensure that these hospitals have adequate support to remain open and financially viable, our AMA will continue to work with interested national medical specialty societies and state medical associations to: a. support and monitor novel payment models for rural hospitals and encourage uniform reporting; and b. support educating physicians, providers, and patients on alternative payment models for rural hospitals. (New HOD Policy) 3. That our AMA supports that funds allocated for rural hospitals be used to enhance or maintain rural health care. (New HOD Policy)	Delegate instructed to listen.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			4. That our AMA amend Policy D-465.999 by addition and deletion to read as follows: CRITICAL ACCESS HOSPITAL NECESSARY PROVIDER DESIGNATION, D-465.999 Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) ~~opposes the elimination~~ support the reintroduction of the state-designated Critical Access Hospital (CAH) "necessary provider" designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program. (Modify Current HOD Policy) 5. That our AMA amend Policy D-465.998 by addition to read as follows: ADDRESSING PAYMENT AND DELIVERY IN RURAL HOSPITALS, D-465.998 5. Our AMA supports educating patients and physicians on the impact of Medicare Advantage plans on rural hospitals and encourages all payers to provide adequate payment to support the financial stability of rural hospitals. (Modify Current HOD Policy) 6. That our AMA reaffirm Policy H-465.994 which outlines support for continued work with relevant and interested stakeholders to research, report, and improve rural health through strategies including telemedicine and innovative workforce strategies. (Reaffirm HOD Policy) 7. That our AMA reaffirm Policy H-465.982 which encourages states, and ensures AMA support, to support efforts related to managed care in rural settings. (Reaffirm HOD Policy)	

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			8. That our AMA reaffirm Policy H-465.997 which outlines support for local and federal efforts to improve rural health with initiatives that are holistic and community-based. (Reaffirm HOD Policy) 9. That the second clause of Policy D-190.969 be rescinded as it is accomplished by this report. (Rescind AMA Policy)	
25	J	Res. 805 – Shared Medical Appointments (New England)	RESOLVED, that our American Medical Association recognizes Shared Medical Appointments, also known as Group Medical Visits, as an effective model of care delivery (New HOD Policy); and be it further RESOLVED, that our AMA advocate to hospitals and health systems that they support physicians and other clinicians who desire to host Shared Medical Appointments, also known as Group Medical Visits (Directive to Take Action); and be it further RESOLVED, that our AMA advocate to Medicare, Medicaid, private insurers, and other appropriate indemnity organizations, for payment of in-person or telehealth Shared Medical Appointments, also known as Group Medical Visits, commensurate with standard Evaluation and Management billing codes (i.e., 99212-99215) based on Medical Decision Making criteria or the time spent in the delivery of individualized care, with individual assessments occurring either within the group setting or in private. (Directive to Take Action)	Delegate instructed to listen.
26	J	Res. 807 – Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Medications (Mississippi)	RESOLVED, that our American Medical Association assert that if an insurance company denies “full admission” status for a patient being hospitalized, that the insurance company must provide the ability to revert the status to observation so the hospital and patient are protected from total denial. (New HOD Policy)	Delegate instructed to support intent.
27	J	Res. 808 – No Prior Authorization for Inexpensive Medications	RESOLVED, that our American Medical Association identify through the Council on Medical Services or other professional content experts a cost threshold below which medical services and medications should not require	Delegate instructed to strongly support and to support Dr. Matt Gold’s

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
		(Organized Medical Staff Section)	prior authorization (Directive to Take Action); and be it further RESOLVED, that our American Medical Association advocate that low-cost medications and procedures should not require prior authorization. (Directive to Take Action)	proposed comments in the HOD Online Reference Committee.
28	J	Res. 809 – Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing (Organized Medical Staff Section)	RESOLVED, that our American Medical Association undertake a comprehensive study of hospital inpatient virtual nursing, including an assessment of its benefits and risks for patient safety and an analysis of guidelines for credentialing, privileging, and documentation standards and any policy gaps related to oversight by the Centers for Medicare & Medicaid Services and The Joint Commission (Directive to Take Action); and be it further RESOLVED, that our AMA recognizes that organized medical staffs, as leaders in hospital medicine who have a duty to protect patient safety within their institutions, should work collaboratively to ensure physician-led, high-quality, patient-centered care in the integration of inpatient virtual nursing, (New HOD Policy)	Delegate instructed to strongly support.
29	J	Res. 817 – Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service (New York)	RESOLVED, that our American Medical Association advocates for legislation or regulation that prohibit insurers in all States from denying payment for a procedure based on the site of service in which it was performed, provided that the procedure is medically necessary. (Directive to Take Action)	Delegate instructed to listen.
30	K	CSAPH 02 – Regulation of Ionizing Radiation Exposure for Health Care Professionals	Your Council on Science and Public Health recommends that the following be adopted and the remainder of this report be filed. That Policy H-455.975, "Regulation of Ionizing Radiation Exposure for Health Care Workers" be amended by addition and deletion to read as follows: ~~1.~~ Our American Medical Association encourages: (1) public and private health care institutions to ensure the availability of personal protective equipment (PPE) that provides comprehensive coverage of different body types ~~by providing readily available PPE that reduces~~ to reduce ionizing radiation	Delegate instructed to support.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			exposure to as low as reasonably achievable for employees and trainees of all genders and pregnancy statuses; (2) continued research on the health effects of low level and very-low level ionizing radiation, the effectiveness of PPE and administrative and engineering controls designed to reduce exposure (e.g., shielding, interlock systems, labeling,), barriers to PPE use (e.g., fit, availability, cost), and ways to improve PPE use fidelity (e.g., training, education, and access to appropriately sized and ergonomic PPE), and (3) education for all health care personnel, including trainees, exposed to ionizing radiation that includes awareness of and methods to limit radiation exposure to both patients and clinicians. Training programs should provide education specific to their specialties so trainees know which protective equipment and controls their facilities should have in place and know how to use them correctly. ~~2. Our AMA will work with the appropriate and interested parties to study how best to~~ ~~accomplish comprehensive protection from ionizing radiation for employees, taking into account variation in body types, pregnancy status, specifics of procedures being performed, as well as how exposure can be limited beyond PPE (personal protected equipment), with report back at I-25.~~	
31	K	Res. 905 – Standardizing Brain Death Policies (Organized Medical Staff Section)	RESOLVED, that our American Medical Association collaborate with appropriate stakeholders to identify “accepted medical standards” for determination of brain death/death by neurologic criteria (BD/DNC) as required by the Uniform Determination of Death Act (Directive to Take Action); and be it further ~~RESOLVED, that our AMA encourage and support legislative and regulatory efforts to have one uniform set of standards for brain death/death by neurologic criteria used throughout the United States. (New HOD Policy)~~ RESOLVED, that our AMA work with interested parties to develop and disseminate model hospital policy for a single, unified method of declaration or determination of brain death/death by neurologic criteria (BD/DNC) (Directive to Take Action).	Delegate instructed to strongly support, support substitute resolve clause.

END