AMA
AMERICAN MEDICAL ASSOCIATION

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PRIVATE PRACTICE PHYSICIANS SECTION
Governing Council Report A
Interim 2026 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
- *Listen* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the Section
- *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.

Items highlighted in blue have been recommended for reaffirmation.
Items highlighted in red are items of interest for monitoring and have no current GC recommendation.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
1	E&B	BOT 18 – Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients	The Board of Trustees recommends that Policy D-65.968 be amended by deletion as accomplished by this report, and that the remainder of the report be filed: Our AMA continue to support efforts by EHR vendors, health systems, and physician practices, and work with relevant collaborators (e.g., the ASTP/ONC, LGBTQIA+ advocacy groups, and minors' privacy experts), to improve EHR usability for transgender and gender-diverse patients, with attention to strong privacy protections~~,~~ ~~and report back on this progress by I-26.~~ (Modify Current HOD Policy)	Delegate instructed to support.
2	E&B	CEJA 01 - Preserving Autonomy in the Patient-Physician Relationship	The Council on Ethical and Judicial affairs recommends that Policy D-140.944 be rescinded as having been accomplished by this report.	Delegate instructed to support.

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3	E&B	CEJA 03 – Guidelines on Chaperones for Sensitive Exams	The Council on Ethical and Judicial Affairs recommends the following be adopted and the remainder of the report be filed: 1. Opinion 1.2.4, "Use of Chaperones," be amended by deletion and addition as follows: Chaperones should be authorized members of the healthcare team. All chaperones should understand the responsibilities of the role and be aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality. Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive examinations and procedures while also empowering patients. ~~Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity.~~ Such ~~These~~ efforts ~~may~~ include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, clear~~ly explaining~~ explanations of various components of the physical examination, and the use of ~~having~~ a chaperone ~~available~~. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region, or the rectum, physicians should be aware that a patient's personal history, beliefs, or identity may broaden their definition of what constitutes a sensitive examination or procedure. Having a chaperone~~s~~ present ~~also~~ during a sensitive exam helps protect the integrity of the patient-physician relationship ~~prevent misunderstandings between patient and physician~~. Physicians should, as always, be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. Additionally, ~~P~~physicians should: (a) Make every reasonable effort to provide a chaperone for all sensitive exams, regardless of patient capacity, unless a delay in obtaining a chaperone would result in significant harm to the patient.	Delegate instructed to support.

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			(b) Allow patients to decline the presence of a chaperone, unless the physician deems a chaperone necessary for the exam: i. if the patient and physician cannot come to an agreement, then the physician may defer non-emergent examinations or procedures and refer the patient to another clinician; ii. in emergency situations, the physician may proceed in providing care with the presence of a chaperone and document the rationale. ~~(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.~~ ~~(d) In general, use a chaperone even when a patient's trusted companion is present.~~ ~~(e)~~(c) Minimize inquiries or history taking of a sensitive nature while a chaperone is present. (d) Make a reasonable effort to accommodate the expressed preferences of the patient regarding the characteristics of their chaperone, consistent with the interests of patients, physicians, and the maintenance of professional boundaries. (e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a parent or guardian is unavailable, or if their presence may interfere with the examination, another chaperone should be present. For adolescent patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision-making between patient and physician. All outpatient practices and inpatient services should have a policy regarding sensitive examinations and procedures that includes the use of chaperones to protect patients and minimize risk. For nonsensitive examinations and procedures, patients may request a chaperone, and reasonable efforts should be made to make one available upon request. (Modify HOD/CEJA Policy)	

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			2. Policy D-140.950 be rescinded, as it has been accomplished by this report. (Rescind HOD Policy)	
4	B	BOT 06 - Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care	The Board of Trustees recommends that the following be adopted and the remainder of the report be filed. 1. That our American Medical Association reaffirm: Policy H-385.991, "Balance Billing;" Policy D-380.996, "Balance Billing for All Physicians;" Policy D-390.985, "Medicare Balance Billing;" Policy D-390.986, "Medicare Balance Billing;" Policy H-390.854, "Freedom of Choice;" and Policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement." (Reaffirm HOD Policy) 2. That our AMA support the continuation of protections from balance billing for emergency care, Medicaid beneficiaries, and other vulnerable populations as currently required under state and federal law. (New HOD Policy) 3. That our AMA advocate at the federal level for clarification of standards governing physician waiver of patient cost-sharing obligations for patients experiencing documented financial hardship, including reduction of the administrative, documentation, and collection-effort burdens associated with existing hardship exceptions under federal fraud and abuse authorities; and that our AMA oppose payer contracting provisions that restrict physicians from exercising discretion permitted under those authorities. (New HOD Policy)	Delegate instructed to strongly support.
5	B	BOT 07 - Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians	The Board of Trustees recommends that the following be adopted in lieu of Resolution 209-I-25 and the remainder of this report be filed: 1. That Policies H-165.823, D-330.930, D-390.966, D-380.997, and D-390.957 be reaffirmed. (Reaffirm HOD Policy) 2. That our American Medical Association explore options to allow physicians who practice through separate practice entities in geographically distinct locations, where patients would not be likely to see the physician in more than one setting, to hold	Delegate instructed to strongly support.

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			different Medicare participation or opt-out statuses with respect to those entities. (Directive to Take Action) 3. That our AMA support an additional payment option in Medicare fee-for-service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient, ensuring that Medicare patients can keep their benefits when they privately contract with any physician of their choice. (New HOD Policy)	
6	B	Res. 201 - Artificial Intelligence Having Prescriptive Authority (American Association of Clinical Urologists)	RESOLVED, that our American Medical Association oppose the use of Artificial Intelligence (AI) without a physician or other health care professional's direct supervision to prescribe either new or refill prescriptions (New HOD Policy); and be it further RESOLVED, that our AMA develops model state legislation regulating AI prescriptive authority so that both new and refill prescriptions are under the direct supervision and control of a physician or other licensed healthcare professional. (Directive to Take Action)	Delegate instructed to support where possible, but acknowledge reaffirmation.
7	B	Res. 202 - Rapid Response Framework for Unsupported Medical Claims by Public Officials (Medical Student Section)	RESOLVED, that our American Medical Association study and develop a transparent, time-bound evidence review and response framework for evaluating and publicly responding to medical or public health claims made by elected or appointed government officials outside formal regulatory rulemaking that materially conflict with established scientific consensus or misrepresent the strength or certainty of available evidence, including consideration of: criteria for identifying high-impact claims warranting review, the responsible organizational entity, and associated timelines and processes for evidence assessment and public communication. (Directive to Take Action)	Delegate instructed to listen/support reaffirmation.
8	B	Res. 205 - Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and	RESOLVED, that our AMA adopt as policy the following Universal Standards for Patient Attribution: 1. Clinical Relationship: Attribution must be based on a documented clinical relationship, defined by recent clinical encounter(s) within an appropriate timeframe or a verified patient designation of the physician as their primary care provider (PCP); 2. Prospective Notification: Payers must provide physicians with an option for	Delegate instructed to support.

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		Value-Based Programs (Organized Medical Staff Section)	retrospective or prospective attribution methodology and, if opting for prospective attribution, they should provide physicians with a list of attributed patients at least 30 days before the start of a measurement period; 3. Transparency: Payers must disclose the attribution algorithms, claims thresholds, and patient designation processes used to assign patients to physicians; 4. Mandatory Exclusion: Patients subject to an active attribution dispute must be excluded from all quality scoring and financial performance calculations until the dispute is resolved; 5. Dispute Resolution: Payers must provide a standardized, timely mechanism for physicians to correct or suppress inaccurate attributions, with a determination required within 30 days of submission; (New HOD Policy); and be it further RESOLVED, that our AMA Board of Trustees report back at the 2027 Annual Meeting with recommendations to align and consolidate existing AMA policies related to patient attribution to ensure a streamlined advocacy strategy. (Directive to take Action)	
9	B	Res. 207 - Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety (Kentucky)	RESOLVED, that our American Medical Association oppose the independent, unsupervised establishment and operation of pain clinics, pain institutes, or similar practices by certified registered nurse anesthetists or other nonphysician clinicians, and oppose any expansion of scope of practice permitting the independent performance of complex interventional pain procedures absent active, onsite physician supervision (New HOD Policy); and be it further RESOLVED, that our AMA call upon relevant regulatory bodies to investigate pain practices reasonably suspected of operating outside applicable licensure scope-of-practice, or physician-oversight requirements and to enforce, where applicable, the physician ownership, on-site physician (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for enforceable transparency standards in advertising, clinic naming, informed consent, and other patient-facing communications that clearly identify the credentials and roles of the clinicians responsible for diagnosis,	Delegate instructed to support.

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			procedural selection, procedural performance, and longitudinal management. (Directive to Take Action)	
10	B	Res. 214 - Prohibiting Health Care Sale-Leaseback Transactions (American Academy of Emergency Medicine)	RESOLVED, that our American Medical Association advocate for laws and regulations prohibiting purchasers or acquirers of hospitals, health systems, physician practices, and other health care entities, or their affiliates, from requiring or causing the acquired health care entity to enter into a sale-leaseback transaction involving its real property or other material assets (Directive to Take Action); and be it further RESOLVED, that our AMA develops model federal and state legislation prohibiting the imposition of sale-leaseback provisions related to the purchase of health care entities as above. (Directive to Take Action)	Delegate instructed to support.
11	B	Res. 215 - Establishing Product Liability for Clinical Augmented Intelligence Failures (Washington)	RESOLVED, that our American Medical Association advocate for federal and state legislation establishing that when a clinical AI product produces an erroneous output and a physician has used the product as intended while exercising appropriate clinical judgment, the liability for resulting patient harm constitutes a product liability claim against the AI vendor, manufacturer, or distributor, not a medical malpractice claim against the physician (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that AI vendors and manufacturers be held to the same product liability standards as manufacturers of other medical devices under the Restatement (Third) of Torts: Products Liability, including strict liability for manufacturing defects, and liability for design defects and failure to provide adequate instructions or warnings (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for legislation requiring that AI vendors and manufacturers maintain product liability insurance adequate to cover claims arising from AI product failures in clinical settings, and that such insurance obligations be a condition of FDA marketing authorization (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for legislation prohibiting contractual provisions,	Delegate instructed to support.

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			including end-user license agreements and vendor contracts, that attempt to shift product liability for AI tool failures from the manufacturer to the physician or health system end user (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for federal legislation requiring AI vendors and manufacturers to disclose known failure rates, limitations, and performance data for their clinical AI products, including performance across different patient populations, so that physicians can make informed decisions about the clinical appropriateness of AI tool outputs (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that when a health system, hospital, payer, or other entity mandates the use of a specific AI tool and that tool produces an error resulting in patient harm, the mandating entity and the AI vendor bear the liability, and the physician who was required to use the tool and exercised appropriate clinical judgment is not liable for errors originating in the mandated product. (Directive to Take Action)	
12	B	Res. 230 - Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities (Private Practice Physicians Section)	RESOLVED, that our American Medical Association advocate for federal legislation and/or regulation requiring that, whenever a delegated third-party utilization management entity issues an adverse determination denying, reducing, or terminating requested care, the health plan make its own medical director — licensed in the state in which the patient is receiving care and of the same specialty or subspecialty as the ordering physician — directly available to the treating physician for peer-to-peer review, and that the health plan's medical director, rather than the delegated entity's reviewer, bear final accountability for the coverage determination (Directive to Take Action); and be it further RESOLVED, that our AMA will advocate for federal legislation and/or regulation when appropriate, irrespective of contract type, requiring health plans and their delegated utilization management entities to publicly disclose the material financial terms of their utilization management contracts, in particular whether any portion of compensation is contingent upon or proportional to denial rates, cost-savings targets, or return-on-investment guarantees (Directive to Take Action); and be it further	Delegate instructed to strongly support, speak against reaffirmation.

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			RESOLVED, that our AMA advocate for federal legislation and/or regulation establishing that delegated third-party utilization management entities and their clinical reviewers are subject to the same accountability standards applicable to health plan medical directors under AMA Policy H-285.939, and that the contracting health plan remain jointly accountable for adverse determinations issued on its behalf. (Directive to Take Action)	
13	F	CLRPD 02 - Underrepresented in Medicine Advocacy Section Five-Year Review	The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Underrepresented in Medicine Advocacy Section through 2031 with the next review no later than the 2031 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)	Delegate instructed to support.
14	F	CLRPD 03 - Integrated Physician Practice Section Five-Year Review	The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Integrated Physician Practice Section through 2031 with the next review no later than the 2031 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)	Delegate instructed to support.
15	J	BOT 11 - Opposing Unilateral Downcoding of Physician Services by Insurance Companies	The Board of Trustees recommends that the following be adopted, and the remainder of the report be filed: 1. That our American Medical Association (AMA), in collaboration with state medical associations, communicate legislative guardrails on health plans' downcoding policies to physician practices and provide guidance on how any payer noncompliance can be reported to the appropriate regulatory body for enforcement. (New HOD Policy) 2. That our AMA amend Policy D-70.940[3] to read as follows: Our AMA will develop, regularly update, ~~and~~ disseminate, and widely promote guidance and educational materials for physicians regarding insurer downcoding and recoding practices, including how to document, appeal, and report inappropriate payer conduct to regulators and AMA advocacy channels. (Modify Current HOD Policy) 3. That our AMA reaffirm Policy H-70.924, which states that the AMA Litigation Center will support lawsuits that seek redress from insurers engaging in inappropriate or inaccurate downcoding practices. (Reaffirm HOD Policy)	Delegate instructed to strongly support.

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			4. That our AMA rescind Policy D-70.940[2] as it has been fulfilled by this report. (Modify Current HOD Policy)	
16	J	CMS 01 – Transparency with the Terms "Emergency Department"	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) support the development of standardized emergency department (ED) descriptors that reflect a facility's level of on-site physician coverage and available services, easily discernible by the prudent layperson. (New HOD Policy) 2. That our AMA recommend that emergency care facilities without a dedicated on-site physician utilize these standardized ED descriptors to promote truth and transparency for patients. (New HOD Policy) 3. That our AMA support limiting the designations "emergency department" and "emergency room" to facilities that meet Emergency Medical Treatment and Labor Act (EMTALA) requirements and allowing any EMTALA-covered facility that meets those requirements to be classified as an emergency place of service for billing purposes, regardless of its level of on-site physician coverage. (New HOD Policy) 4. That our AMA support requiring facilities without continuous on-site physician staffing to prominently disclose, through physical and online signage, that physicians are not continuously on duty and on-site; and that our AMA support requiring advertisements for such facilities to include the same disclosure, consistent with Federal Trade Commission guidelines. (New HOD Policy) 5. That our AMA support community engagement to improve the education of patients and allow other healthcare team members to promote efficient and site appropriate care. (New HOD Policy) 6. That our AMA reaffirm Policy H-130.929, which recognizes that the AMA's preferred model of emergency care is the on-site presence of a physician in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing limited appropriate rural exceptions. (Reaffirm HOD Policy) 7. That our AMA reaffirm Policy D-35.976, which advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED. (Reaffirm HOD Policy)	TBD

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			8. That our AMA reaffirm Policy H-160.949, which opposes legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, vigorously supports and advocates for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine, and states that the AMA will continue to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician healthcare workers. (Reaffirm HOD Policy) 9. That our AMA reaffirm Policy D-130.958, which seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and supports all EDs be staffed 24 hours per day/7days per week by a qualified physician. (Reaffirm HOD Policy) 10. That our AMA reaffirm Policy H-240.958, which advocates to prohibit insurers from denying or reducing payment for a procedure based solely on the site of service in which it was performed, provided that the procedure is medically necessary and can safely be performed in that location. (Reaffirm HOD Policy)	
17	J	CMS 02 - The Impact of the Inflation Reduction Act on Physician Practices	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) advocate that Medicare prescription drug price negotiation and associated maximum fair price effectuation, for all Medicare-covered drugs, are implemented in a manner that minimizes financial risk and cash-flow burdens for physicians or community practices to front costs and supports the following: a. Practices' actual acquisition costs decrease commensurate with reductions in drug prices; b. Any drug payment covers the cost of acquisition, storage, inventory, drug administration, and any other necessary related clinical service(s); c. Administrative simplicity for physicians and their practices; d. Timely and affordable patient access to medications prescribed by their physician; and e. Drug price transparency for patients, physicians, and non-physician providers	Delegate instructed to support.

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			(New HOD Policy) 2. That our AMA amend Policy D-110.980 to read as follows: ~~Study on~~ Impact of ~~Inflation Reduction Act~~ Medicare Drug Price Negotiation on ~~Oncology, Other~~ Physician-Owned Practices ~~1. Our American Medical Association will work with relevant stakeholders to conduct a comprehensive study on the impact of the Inflation Reduction Act's (IRA) drug price negotiation provisions, particularly for drugs covered under Medicare Part B and physician-administered drugs due to concerns it could jeopardize patient access to critical therapies as the IRA's potential for reimbursement reductions may lead to less availability of these medications in smaller, community-based clinics where a significant amount of care is provided.~~ ~~2.~~ 1. Our AMA will ~~specifically evaluate the potential~~ continue to monitor and, when relevant, report on the impact of ~~the Inflation Reduction Act~~ Medicare drug price negotiation on the sustainability of community-based physician practices~~, with a particular focus on oncology practices~~. ~~3.~~ 2. Our AMA encourages ~~will consider using the findings of the study on the impact of the Inflation Reduction Act (IRA) drug price negotiation provisions on the sustainability of community based practices to inform its advocacy efforts to ensure that~~ any future drug pricing policies to balance patient affordability and access, with the stability of physician practices~~, patient access,~~ and the continued advancement of drug innovation. (Modify Current HOD Policy) 3. That our AMA reaffirm policy H-110.956 which ensures fair and timely payment for physicians and physician practices for biologic and biosimilar drugs. (Reaffirm HOD Policy)	
18	J	Res. 805 - Meaningful Enforcement of Prohibitions on the	RESOLVED, that our American Medical Association amend Policy H-215.981, "Corporate Practice of Medicine," by modification to read as follows: 1. Our American Medical Association vigorously opposes any effort to pass legislation or	Delegate instructed to strongly support.

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		Corporate Practice of Medicine (American College of Emergency Physicians)	regulation that removes or weakens state or federal laws prohibiting the corporate practice of medicine. 2. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups. 3. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations. 4. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues. 5. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the health care sector such that physician clinical autonomy and operational authority are preserved and protected. 6. Our AMA will create a state corporate practice of medicine template to assist state medical associations and ~~national medical~~ specialty societies as they navigate the intricacies of corporate investment in physician practices and health care ~~generally at the state level~~ and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices, including meaningful enforcement mechanisms, remedies, and protections against retaliation and provisions rendering unenforceable contractual restrictions that interfere with physicians' independent professional judgment, patient advocacy, or good-faith reporting] 7. Our AMA supports meaningful enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority ~~is~~ are preserved and protected, including appropriate enforcement authority and meaningful remedies for violations. 8. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and	

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			trainees by providing stable financing for hospitals, clinics, and other health care facilities. (Modify Current HOD Policy)	
19	J	Res. 808 - Increasing Payment for Patient Portal Messages (Women Physicians Section, Organized Medical Staff Section, Private Practice Physicians Section)	RESOLVED, that our American Medical Association amend Policy H-385.919, "Payment for Electronic Communication," by addition and deletion to read as followed: 1. Our American Medical Association will advocate that ~~pilot projects of innovative~~ physician payment models be structured to include ~~incentive~~ fair market payment for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, patient portal messages, and email and telephone communications. 2. Our AMA will continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices. 3. Our AMA will educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians. (Update current policy); and be it further RESOLVED, that our AMA advocate for employers to a.) educate physicians on how to effectively and fairly bill for electronic communications b.) create workflows and templates which make such billing easy to implement, and c.) incorporate protected time into a physician's schedule in order to adequately address patient portal messages (Directive to take Action); and be it further RESOLVED, that our AMA prioritize the promotion of already available toolkits and member education resources pertaining to how to more effectively manage inbasket work and bill for patient portal messages. (Directive to Take Action)	Delegate instructed to strongly support.
20	J	Res. 813 - Small Medical Practice Website and other Digital Service	RESOLVED, that our American Medical Association educates its members on ADA compliance requirements as they apply to medical practice websites and other digital services (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for legislation, regulation or other legal	Delegate instructed to support.

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		Compliance with ADA Regulation (New York)	mechanisms to provide hardship exemption, financial assistance, enforcement flexibility and/or legal immunity for solo and small-group medical practices that do not meet requirements of the Americans with Disabilities Act as it applies to medical practice websites and other digital services. (Directive to Take Action)	
21	K	BOT 12 – Rethink the Annual Medicare Wellness Visit	The Board of Trustees recommends that the following be adopted and that the remainder of the report be filed: 1. That our American Medical Association (AMA) reaffirm Policy H-425.984, "Clinical Preventive Services;" Policy H-425.994, "Medical Evaluations of Healthy Persons;" Policy H-460.894, "Value of Preventive Services;" and Policy H-160.908, "Payment Mechanisms for Physician-Led Team-Based Health Care." (Reaffirm HOD Policy) 2. That our AMA develop and promote educational resources to improve understanding and appropriate use of Medicare preventive visits among beneficiaries, physicians and other members of physician-led healthcare teams, and support broader education on evidence-based, high-value preventive care. (Directive to Take Action) 3. That our AMA advocate for greater physician flexibility to tailor the content and delivery of Medicare preventive visits to patients' individual risks, needs, clinical circumstances, and preferences. (Directive to Take Action) 4. That our AMA continue to advocate for payment policies and models that support individualized, longitudinal, physician-led, team-based preventive care. (New HOD Policy)	Delegate instructed to support.

END