

ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Annual 2022 Meeting

Access full text of resolutions/reports in the [HOD meeting handbook](#).

Items that are **BOLD and highlighted in red** are items of high priority for the Organized Medical Staff Section, as determined by the Governing Council.

Items that are *italicized and highlighted in yellow* are items that the Governing Council recommends making amendments to in the House of Delegates.

Item #	Ref Com	Title and Sponsor(s)	Proposed Policy	Governing Council Recommendation
1	A	<u>Res. 102</u> – Bundling Physician 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)	Delegate instructed to support.
2	A	<u>Res. 113</u> – Prevention of Hearing-Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation (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 RESOLVED, That our AMA advocate for increased hearing screening, and expanding all avenues for third party coverage for effective hearing loss remediation beginning in mid-life or whenever detected, 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)	Delegate instructed to support.

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3	B	<u>Res. 202</u> – AMA Position on All Payer Database Creation (New York)	RESOLVED , That our American Medical Association advocate that any All Payer Database should also provide true payments that hospitals are making to their employed physicians, not just the amount of payment that the insurer is making on the physician's behalf to the hospital. (Directive to Take Action)	Delegate instructed to support.
4	B	<u>Res. 205</u> – 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)	Delegate instructed to support.
5	B	<u>Res. 211</u> – Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program (American Academy of Neurology)	RESOLVED, That our American Medical Association Policy H-320.940, "Medicare's Appropriate Use Criteria Program," be amended by addition and deletion to read as follows: Our AMA will continue to advocate to Congress for delay the effective date either the full repeal of the Medicare Appropriate Use Criteria (AUC) Program or legislative modifications to the program in such a manner that until the Centers for Medicare & Medicaid Services (CMS) can adequately addresses technical and workflow challenges, with its implementation and any interaction between maximizes alignment with the Quality Payment Program (QPP), and the use of advanced diagnostic imaging appropriate use criteria, creates provider flexibility for the consultation of AUC or advanced diagnostic imaging guidelines using a mechanism best suited for their practice, specialty and workflow. (Modify Current HOD Policy)	Delegate instructed to support.
6	B	<u>Res. 212</u> – Medication for Opioid Use Disorder in Physician Health Programs (Michigan)	RESOLVED, That our American Medical Association reaffirm policy H-95.913, "Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders" (Reaffirm HOD Policy); and be it further RESOLVED, That our AMA modify policy D-405.990, "Educating Physicians About Physician Health Programs and Advocating for Standards," by addition to read as follows: Our AMA will: (1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure	Delegate instructed to support.

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			<p>physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;</p> <p>(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;</p> <p>(3) in conjunction with the FSPHP, develop <u>model state legislation and/or</u> legislative guidelines addressing the design and implementation of physician health programs <u>including, but not limited to, the allowance for safe-haven or non-reporting of physicians to a licensing board, and/or acceptance of Physician Health Program compliance as an alternative to disciplinary action when public safety is not at risk, and especially for any physicians who voluntarily self-report their physical, mental, and substance use disorders and engage with a Physician Health Program and who successfully complete the terms of participation;</u></p> <p>(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;</p> <p>(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and</p> <p>(6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.</p> <p>(Modify Current HOD Policy)</p>	
7	B	<u>Res. 217 – Preserving the Practice of Medicine</u> <u>(Resident and Fellow Section)</u>	<p><i>RESOLVED, That our American Medical Association oppose mandates from employers to supervise non-physician providers as a condition for physician employment and in physician employment contracts (New HOD Policy); and be it further</i></p> <p><i>RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to “supervise” non-physician providers (Directive to Take Action); and be it further</i></p>	<i>Delegate instructed to support first and second resolves, strike others.</i>

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			<p><i>RESOLVED, That our AMA conduct a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in fields which are not a core part of those physicians' completed residencies and fellowships (Directive to Take Action); and be it further</i></p> <p><i>RESOLVED, That our AMA study the impact scope-of practice advocacy by physicians has had on physician employment and termination (Directive to Take Action); and be it further</i></p> <p><i>RESOLVED, That our AMA study the views of patients on physician and non-physician care to identify best practices in educating the general population on the value of physician-led care, and study the utility of a physician-reported database to track and report institutions that replace physicians with non-physician providers in order to aid patients in seeking physician-led medical care (Directive to Take Action); and be it further</i></p> <p><i>RESOLVED, That our AMA work with relevant stakeholders to commission an independent study comparing medical care provided by physician-led health care teams vs. care provided by unsupervised non-physician providers, which reports on the quality of health outcomes, cost effectiveness, and access to necessary medical care, and to publish the findings in a peer-reviewed medical journal. (Directive to Take Action)</i></p>	
8	B	<u>Res. 218</u> – Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians (American Association of Physicians of Indian Origin)	RESOLVED, That our American Medical Association lobby US Congress and the US Administration that the J-1 visa waiver physicians serving in underserved areas be given highest priority in visa conversion to green cards upon completion of their service commitment obligation and be exempted from per country limitation of H-1 to green card visa conversion. (Directive to Take Action)	Delegate instructed to support.
9	B	<u>Res. 219</u> – Due Process and Independent Contractors	RESOLVED, That our American Medical Association develop a model state legislative template and principles for federal legislation in order to protect physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of	Delegate instructed to support.

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		(American College of Emergency Physicians)	work (licensed health care institution) or in the government, which includes independent and third-party contractors providing patient services at said facilities. (Directive to Take Action)	
10	B	<u>Res. 222</u> – To Study the Economic Impact of Mid-Level Provider Employment in The United States of America (Mississippi)	<i>RESOLVED, That our American Medical Association encourage and support studies sponsored by relevant state and federal agencies to determine the economic impact of mid-level unsupervised practice on American consumers (Directive to Take Action); and further be it RESOLVED, That our AMA develop model state legislation that opposes enactment of legislation and reversal of such legislation, if present, that would authorize the independent practice of medicine by any individual who is not a physician. (Directive to Take Action)</i>	<i>Delegate instructed to support, ask Ref Com to review wording for improvements.</i>
11	B	<u>Res. 225</u> – Public Listing of Medical Directors for Nursing Facilities (AMDA – The Society for Post-Acute and Long-Term Care Medicine)	RESOLVED, That our American Medical Association advocate for the Centers for Medicare & Medicaid Services to promote health care transparency and consumer access to quality health care by hosting a public listing of medical directors of all nursing facilities (NFs) in the country. (Directive to Take Action)	Delegate instructed to support.
12	B	<u>Res. 241</u> – Unmatched Graduate Physician Workforce (Missouri)	RESOLVED, That our American Medical Association work with state societies to support these unmatched graduate physicians through their legislators and regulators to allow these physicians to work in underserved areas, in primary care, only in collaboration with a licensed physician (Directive to Take Action); and be it further RESOLVED, That our AMA work with appropriate parties and the Centers for Medicare and Medicaid Services to reimburse for services rendered by these graduating physicians working in their collaborative practices as do private insurers and state Medicaid programs (Directive to Take Action); and be it further	Delegate instructed to support.

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			<p>RESOLVED, That the AMA allow these graduating physicians, working in collaboration with a licensed physician, to become members of an AMA subgroup (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA oppose any effort by these graduating physicians working in collaboration with licensed physicians, to become independent licensed physicians without satisfactorily completing formal residency training. (Directive to Take Action)</p>	
13	B	<u>Res. 243</u> – Appropriate Physician Payment for Office-Based Services (Ohio)	RESOLVED, That our American Medical Association advocate for improvement in physician payment by Medicare and other third-party payers so that physician reimbursement covers current office practice expenses at rates that are fair and equitable, and that said equity include annual updates in payment rates to account for increased costs of running a medical practice. (Directive to Take Action)	Delegate instructed to support.
14	B	<u>Res. 244</u> – Prohibit Reversal of Prior Authorization (Ohio)	<p>RESOLVED, That once the physician's office has received prior authorization for testing, a procedure, or a medication, the insurance company should not be permitted to refuse payment for that test or procedure or medication unless the patient is no longer insured by that company at the time the test or procedure is done or the medication is given; and be it further</p> <p>RESOLVED, That a health insuring corporation or utilization review organization that authorizes a proposed admission, treatment, or health care service by a participating provider based upon the complete and accurate submission of all necessary information relative to an eligible enrollee should not retroactively deny this authorization if the provider renders the health care service in good faith and pursuant to the authorization and all of the terms and conditions of the provider's contract with the health insuring corporation, and be it further</p> <p>RESOLVED, That our American Medical Association seek federal legislation/rules to prohibit denial of payment by a Medicare Advantage plan for a previously prior approved medication, procedure, or test unless the patient is no longer insured by that company at the time of service (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA redistribute its model legislation on retrospective</p>	Delegate instructed to support.

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			denial of payment to all state societies, especially those who have not already passed such legislation. (Directive to Take Action)	
15	C	<u>CME Rep. 02</u> – An Update on Continuing Board Certification	<p>That our American Medical Association (AMA) amend Policy D-275.954 clauses 1, 22, and 38 by addition and deletion to read as follows:</p> <p>1. (1), “Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process when necessary <u>as determined by the Council on Medical Education.</u>”</p> <p>2. (22), “Continue to participate in the <u>Coalition for Physician Accountability</u>, formerly known as the National Alliance for Physician Competence forums.”</p> <p>3. (38), “Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs by 2020 that will address the Commission’s recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.” (Modify Current HOD Policy)</p>	Delegate instructed to support.
16	C	<u>CME Rep. 05</u> – Education, Training, and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training	<p>The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolve 8 of Resolution 305-J-21 and the remainder of this report be filed:</p> <p>1. That our AMA support the concept that interprofessional education include a mechanism by which members of interdisciplinary teams learn about, with, and from each other; and that this education include learning about differences in the depth and breadth of their educational backgrounds, experiences, and</p>	Delegate instructed to listen.

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			<p>knowledge and the impact these differences may have on patient care. (New HOD Policy)</p> <p>2. That our AMA support a clear mechanism for medical school and appropriate institutional leaders to intervene when undergraduate and graduate medical education is being adversely impacted by undergraduate, graduate, and postgraduate clinical training programs of non-physicians. (New HOD Policy)</p> <p>3. That Policies D-295.934, "Encouragement of Interprofessional Education Among Health Care Professions Students," and D-275.979, "Non-Physician "Fellowship" Programs," be reaffirmed. (Reaffirm HOD Policy)</p> <p>4. That our AMA encourage medical education regulatory bodies to review their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision. (Directive to Take Action)</p> <p>5. That Policy D-275.949, "Non-Physician Postgraduate Medical Training," be rescinded, as having been accomplished by the writing of this report.</p> <p>Or AMA will study and report back to the House of Delegates on curriculum, accreditation requirements, accrediting bodies, and supervising boards for undergraduate, graduate and postgraduate clinical training programs for non-physicians and the impact on undergraduate and graduate medical education. (Rescind HOD Policy)</p>	
17	D	<u>Res. 407</u> – Study of Best Practices for Acute Care of Patients in the Custody of the Law (American Thoracic Society)	<p>RESOLVED, That our American Medical Association study best practices for interactions between hospitals, clinicians, and members of law enforcement or correctional agencies to ensure that patients in custody of such law enforcement or correctional agencies (including patients without decision-making capacity), their surrogates, and the health care providers caring for them are provided the autonomy and privacy protections afforded to them by law and in concordance with professional ethical standards and report its findings to the AMA House of Delegates by the 2023 Annual Meeting. (Directive to Take Action)</p>	Delegate instructed to support.

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18	E	<u>Res. 503</u> – Pharmacy Benefit Managers and Drug Shortages (New York)	RESOLVED, That our American Medical Association conduct a study which will investigate the role pharmacy benefit managers play in drug shortages. (Directive to Take Action)	Delegate instructed to support.
19	E	<u>Res. 514</u> – Oppose Petition to the DEA and FDA on Gabapentin (Oklahoma)	RESOLVED, That our American Medical Association actively oppose the placement of (a) gabapentin (2-[1-(aminomethyl) cyclohexyl] acetic acid), including its salts, and all products containing gabapentin (including the brand name products Gralise and Neurontin) and (b) gabapentin enacarbil (1-{{(1RS)-1-[(2- methylpropanoyl)oxy]ethoxy} carbonyl]amino]methyl) cyclohexyl) acetic acid), including its salts, (including the brand name product Horizant) into schedule V of the Controlled Substances Act (Directive to Take Action); and be it further RESOLVED, That our AMA submit a timely letter to the Commissioner of the U.S. Food and Drug Administration for the proceedings assigned docket number FDA-2022-P-0149 in opposition to placement of gabapentin and gabapentin enacarbil into the schedule V of the Controlled Substance Act. (Directive to Take Action)	Delegate instructed to support.
20	F	<u>BOT Rep. 11</u> – Procedure for Altering the Size of Composition of Section Governing Councils	Your Board of Trustees recommends that the following recommendations be adopted and that the remainder of this report be filed: 1. That AMA Bylaws be amended to include the size and core composition (chair cycle, delegate/alternate delegate) of each section governing council. (Modify Bylaws) 2. That the Council on Long Range Planning and Development develop criteria for reviewing requests to alter the size or core composition (chair cycle, delegate/alternate delegate) of section governing councils. (Directive to Take Action) 3. That the Council on Long Range Planning and Development be assigned responsibility for reviewing and making recommendations to the House of Delegates as to the disposition of any request to alter the size or core composition (chair cycle, delegate/alternate delegate) of a section governing council. (Modify Bylaws)	Delegate instructed to support.

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21	F	<u>Res. 609</u> – Surveillance Management System for Organized Medicine Policies and Reports (Georgia)	<p>RESOLVED, That our American Medical Association develop a prioritization matrix across both global and reference committee specific areas of interest (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA develop a web-based surveillance management system, with pre-defined primary and/or secondary metrics, for resolutions and reports passed by their respective governance body (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA share previously approved metrics and results from the surveillance management system at intervals deemed most appropriate to the state and local membership of organized medicine, including where and when appropriate to their patients. (Directive to Take Action)</p>	Delegate instructed to support.
22	F	<u>Res. 610</u> – Making AMA Meetings Accessible (Senior Physicians Section)	<p><i>RESOLVED, That all future American Medical Association meetings be structured to provide accommodations for members who are able to physically attend, but who need assistance in order to meaningfully participate (Directive to Take Action); and be it further</i></p> <p><i>RESOLVED, That our AMA investigate ways of allowing meaningful participation in all meetings of the AMA by members who are limited in their ability to physically attend meetings (Directive to Take Action); and be it further</i></p> <p><i>RESOLVED, That our AMA revisit our criteria for selection of hotels and other venues for the HOD in order to facilitate maximum participation by members with disabilities (Directive to Take Action); and be it further</i></p> <p><i>RESOLVED, That our AMA report back to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize HOD meeting participation for members with disabilities. (Directive to Take Action)</i></p>	<i>Delegate instructed to support with amendment to broaden criteria for selection of future venues for meetings.</i>
23	F	<u>Res. 615</u> – Anti-Harassment Training (Medical Student Section)	<p>RESOLVED, That our American Medical Association require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA; (Directive to Take Action) and be it further</p> <p>RESOLVED, That our AMA work with the Women Physician Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based</p>	Delegate instructed to refer.

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			anti-harassment and sexual harassment prevention training to administer to leadership. (Directive to Take Action)	
24	F	<u>Res. 619</u> – Focus and Priority for the AMA House of Delegates (Texas)	<p>RESOLVED, That the Resolutions Committee be formed as a standing committee of the house, the purpose of which is to review and prioritize all submitted resolutions to be acted upon at the annual and interim meetings of the AMA House of Delegates (Directive to Take Action); and be it further</p> <p>RESOLVED, That the membership of the Resolutions Committee be composed of one Medical Student Section (MSS) member, one Resident and Fellow Section (RFS) member, and one Young Physicians Section (YPS) member, all appointed by the speakers through nominations of the MSS, RFS, and YPS respectively; six regional members appointed by the speakers through nominations from the regional caucuses; six specialty members appointed by the speakers through nominations from the specialty caucuses; three section members appointed by the speakers through nominations from sections other than the MSS, RFS, and YPS; and one past president appointed by the speakers (Directive to Take Action); and be it further</p> <p>RESOLVED, That the members of the Resolutions Committee serve staggered two-year terms except for the past president and the MSS and RFS members, who shall serve a one-year term (Directive to Take Action); and be it further</p> <p>RESOLVED, That members of the Resolutions Committee cannot serve more than four years consecutively (Directive to Take Action); and be it further</p> <p>RESOLVED, That if a Resolutions Committee member is unable or unwilling to complete his or her term, the speakers will replace that member with someone from a similar member group in consultation with that group the next year, and the new member will complete the unfulfilled term (Directive to Take Action); and be it further</p> <p>RESOLVED, That each member of the Resolutions Committee confidentially rank resolutions using a 0-to-5 scale (0 – not a priority to 5 – top priority) based on scope (the number of physicians affected), urgency (the urgency of the resolution and the impact of not acting), appropriateness (whether AMA is the appropriate organization to lead on the issue), efficacy (whether an AMA stance would have a positive impact), history (whether the resolution has been submitted previously and not accepted), and existing policy (whether an AMA</p>	Delegate instructed to refer.

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			<p>policy already effectively covers the issue). Resolutions would not have to meet all of these parameters nor would these parameters have to be considered equally (Directive to Take Action); and be it further</p> <p>RESOLVED, That the composite (or average) score of all members of the Resolutions Committee be used to numerically rank the proposed resolutions. No resolution with a composite average score of less than 2 would be recommended for consideration. The Resolutions Committee would further determine the cutoff score above which resolutions would be considered by the house based on the available time for reference committee and house discussion, and the list of resolutions ranked available for consideration would be titled “Resolutions Recommended to be Heard by the HOD” (Directive to Take Action); and be it further</p> <p>RESOLVED, That the Resolutions Committee also make recommendations on all resolutions submitted recommending reaffirmation of established AMA policy and create a list titled “Resolutions Recommended for Reaffirmation,” with both lists presented to the house for acceptance (Directive to Take Action); and be it further</p> <p>RESOLVED, That the membership of the Resolutions Committee be published on the AMA website with a notice that the appointed members should not be contacted, lobbied, or coerced; any such activity must be reported to the AMA Grievance Committee for investigation; and should the alleged violations be valid, disciplinary action of the offending person will follow (Directive to Take Action); and be it further</p> <p>RESOLVED, That the bylaws be amended to add the Resolution Committee as a standing Committee with the defined charge, composition, and functions as defined above for all AMA HOD meetings effective Interim 2022. (Directive to Take Action)</p>	
25	G	<u>Res. 702</u> – Health System Consolidation (Private Practice Physicians Section)	RESOLVED, That our American Medical Association undertake an annual report assessing nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation. (Directive to Take Action)	Delegate instructed to support.

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26	G	<u>Res. 704</u> – Employed Physician Contracts (New York)	RESOLVED, That our American Medical Association advocate in support of all employed physicians receiving all rights and due process protections afforded all other members of the medical staff. (New HOD Policy)	Delegate instructed to support.
27	G	<u>Res. 706</u> – Government Imposed Volume Requirements for Credentialling (New York)	RESOLVED, That our American Medical Association create guidelines and standards for evaluation of government-imposed volume requirements for credentialing that would include at least the following considerations: (a) the evidence for that volume requirement; (b) how many current practitioners meet that volume requirement; (c) how difficult it would be to meet that volume requirement; (d) the consequences to that practitioner of not meeting that volume requirement; (e) the consequences to the hospital and the community of losing the services of the practitioners who can't meet that volume requirement; and (f) whether volumes of similar procedures could also reasonably be used to satisfy such a requirement. (Directive to Take Action)	Delegate instructed to support.
28	G	<u>Res. 709</u> – Physician Well-Being as an Indicator of Health System Quality (New York)	RESOLVED, That our American Medical Association support policies that acknowledge physician well-being is both a driver and an indicator of hospital and health system quality (New HOD Policy); and be it further RESOLVED, That our AMA promote dialogue between key stakeholders (physician groups, health-system decision makers, payers, and the general public) about the components needed in such a quality-indicator system to best measure physician and organizational wellness (Directive to Take Action); and be it further RESOLVED, That our AMA (with appropriate resources) develop the expertise to be available to assist in the implementations of effective interventions in situations of suboptimal physician wellness. (Directive to Take Action)	Delegate instructed to support.
29	G	<u>Res. 714</u> – Prior Authorization Reform for Specialty Medications	RESOLVED, That our American Medical Association encourage Congress and the President to issue a moratorium on the specialty medicine prior authorization process for one year to allow further study (New HOD Policy); and be it further RESOLVED, That our AMA work with other stakeholders to encourage	Delegate instructed to support.

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		(Organized Medical Staff Section)	pharmaceutical companies and other entities that offer assistance programs to increase eligibility for their assistance programs. (Directive to Take Action)	
30	G	<u>Res. 716</u> – Discharge Summary Reform (Organized Medical Staff Section)	RESOLVED, That our American Medical Association coordinate with the American Hospital Association with input from the Centers for Medicare & Medicaid Services and other professional organizations as appropriate to revive the concise discharge summary that existed prior to electronic medical records for the sake of much improved patient care and safety (Directive to Take Action); and be it further RESOLVED, That our AMA internally develop a model hospital discharge summary in such a manner as to be concise but informational, include to promote excellent, safe patient care and improve coordinated discharge planning. This model use shall be promoted to our AMA and Federation of Medicine colleagues. (Directive to Take Action)	Delegate instructed to support.
31	G	<u>Res. 719</u> – System Wide Prior Authorization Delays and Effects on Patient Care Access (Ohio)	RESOLVED, That our American Medical Association encourage and advocate health care insurers and Medicare/Medicaid Products to ensure that the systems of communication for prior authorization include: live personnel access, simplification of website navigation, immediate response with confirmation number of submission and an expedient decision for authorizations. (Directive to Take Action)	Delegate instructed to support.
32	G	<u>Res. 721</u> – Amend AMA Policy H-215.981, “Corporate Practice of Medicine” (Resident and Fellow Section)	RESOLVED, That our American Medical Association amend policy H-215.981, “Corporate Practice of Medicine,” by addition to read as follows: <u>4. Our AMA acknowledges that the corporate practice of medicine has led to the erosion of the physician-patient relationship, erosion of physician-driven care and created a conflict of interest between profit and training the next generation of physicians.</u> (Modify Current HOD Policy)	Delegate instructed to support.
33	G	<u>Res. 722</u> – Eliminating Claims Data for Measuring Physician and Hospital Quality	RESOLVED, That our American Medical Association collaborate with the 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	Delegate instructed to support.

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Item #	Ref Com	Title and Sponsor(s)	Proposed Policy	Governing Council Recommendation
		(Oklahoma)	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)	
34	G	<u>Res 723</u> – Physician Burnout (American Medical Women's Association)	RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and The Joint Commission to assure that clinician, including physician, wellbeing is a component of standards for hospital certification (Directive to Take Action); and be it further RESOLVED, That our AMA work with hospitals and other stakeholders to determine areas of focus on clinician wellbeing, to include the removal of intrusive questions regarding clinician physical or mental health or related treatments on initial or renewal hospital credentialing applications. (Directive to Take Action)	Delegate instructed to support.
35	G	<u>Res. 725</u> – Compensation to Physicians for Authorizations and Preauthorizations (Texas)	RESOLVED, That the American Medical Association support legislation that requires insurance and managed care companies, including companies managing governmental insurance plans (“payers”), to compensate physicians for the time physicians and their staff spend on authorization and preauthorization procedures. Such legislation is recommended to include the following: Compensation shall be paid in full by payers to physicians without deductible, coinsurance, or copayment billable to patients; thus, patients will not bear the burden for such processes imposed by payers. Physicians shall bill payers for time spent by physicians and their staff in performing such tasks at a rate commensurate with that of the most highly trained professionals. Payers shall pay physicians promptly upon receiving such a bill with significant interest penalties assessed for delay in payment. Billable services for authorization and preauthorization include, but are not limited to, time spent filling out forms, making telephone calls (including time spent negotiating phone trees and hold time), documenting in the patient’s medical record, communicating with the patient, altering treatment plans (such as changing medications to comply with formularies), printing, copying, and faxing. (Directive to Take Action)	Delegate instructed to support.