OMSS Governing Council Report A – November 2021 Special Meeting

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NOTE: Items that are **highlighted in red** have not been accepted by the HOD Resolutions Committee. These items can still be considered by the OMSS, however they may not be considered by the HOD at the November meeting.

Item #	Ref Com	Title and Sponsor(s)	Proposed Policy	Governing Council Recommendation
1	CCB	CEJA 02 – Amendments to Opinions 1.2.11, "Ethical Innovation in Medical Practice"; 11.1.2, "Physician Stewardship of Health Care Resources"; 11.2.1, Professionalism in Health Care Systems"; and 1.1.6, "Quality"	RECOMMENDATION In light of the foregoing, the Council on Ethical and Judicial Affairs recommend that Opinion 1.2.11, "Ethically Sound Innovation in Medical Practice"; Opinion 11.2.1, "Professionalism in Health Care Systems"; Opinion 11.1.2, "Physician Stewardship of Health Care Resources"; and Opinion 1.1.6, "Quality," be amended as follows and the remainder of this report be filed: …. 2. Opinion 11.2.1, Professionalism in Health Care Systems Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships. Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.	Delegate instructed to support.

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			Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals. Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other ~~tools~~ mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented. Physicians in leadership positions within health care organizations and the profession should ~~ensure that practices for financing and organizing the delivery of care~~: (a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients. ~~(b) Reflect input from key stakeholders, including physicians and patients.~~ (c) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism. (d) Ensure ethically acceptable incentives that all such tools: (i) are designed in keeping with sound principles and solid scientific evidence. a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. b. Practice guidelines, formularies, and ~~other~~ similar tools should be based on best available evidence and developed in keeping with ethics guidance. c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.	

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			(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities; (iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism; (iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians. (e) Encourage, rather than discourage, physicians (and others) to: (i) provide care for patients with difficult to manage medical conditions; (ii) practice at their full capacity, but not beyond. (f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients. (g) ~~Are~~ Ensure that the use of financial incentives and other tools is routinely monitored to: (i) identify and address adverse consequences; (ii) identify and encourage dissemination of positive outcomes. All physicians should: (h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems. Advocate for changes ~~in health care payment and delivery models~~ how the delivery of care is organized to promote access to high-quality care for all patients.	
2	A	CMS 01 – End-of-Life Care	RECOMMENDATIONS The Council on Medical Service recommends that the following be adopted in lieu of Resolution 101-Nov-20, and that the remainder of the report be filed: 1. That our American Medical Association (AMA) support Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's hospice benefit. (New HOD Policy)	Delegate instructed to support.

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			2. That our AMA support study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's hospice and skilled nursing facility (SNF) benefits for the same condition. (New HOD Policy) 3. That our AMA support increased access to palliative care services by Medicare patients in skilled nursing facilities. (New HOD Policy) 4. That our AMA reaffirm Policy H-85.966, which maintains that hospice care should provide the patient and family with appropriate physical and emotional support, but not preclude the use of appropriate palliative therapies to continue to treat underlying disease. (Reaffirm HOD Policy) That our AMA reaffirm Policy H-70.915, which recognizes the importance of palliative care, encourages the education of health professionals and the public in caring for dying patients, and supports improved payment for health care practices that are important to good care of the dying patient. (Reaffirm HOD Policy)	
3	A	Res 101 – Standardized Coding for Telehealth Services (Virginia)	RESOLVED, That our American Medical Association advocate by regulation and/or legislation that telehealth services are uniformly identified by using place of service (02) without any additional requirements, such as modifiers imposed by third party payors, for claim submission and reimbursement. (Directive to Take Action)	Delegate instructed to support.
4	A	Res. 102 – 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	Delegate instructed to support.

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			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)	
5	A	Res. 115 – Bundled Payments and Medically Necessary Care (Texas)	RESOLVED, That our American Medical Association continue to support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments (Directive to Take Action); and be it further RESOLVED, That our AMA pursue and support passage of legislation and agency policies that expand site-neutral payment to equalize payments across sites of service for all outpatient services (Directive to Take Action); and be it further RESOLVED, That our AMA pursue policy that creates patient incentives for services to be performed in the most cost-effective location, such as a physician's office.(Directive to Take Action)	Delegate instructed to support.
6	A	Res. 118 – Expanding Site-of-Service Neutrality (Texas)	RESOLVED, That our American Medical Association continue to support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments (Directive to Take Action); and be it further RESOLVED, That our AMA pursue and support passage of legislation and agency policies that expand site-neutral payment to equalize payments across sites of service for all outpatient services (Directive to Take Action); and be it further RESOLVED, That our AMA pursue policy that creates patient incentives for services to be performed in the most cost-effective location, such as a physician's office.(Directive to Take Action)	Delegate instructed to support.
7	B	BOT 09 – Medical Marijuana License Safety	RECOMMENDATIONS The Board recommends that the following be adopted in lieu of Resolution 219-A-19 and the remainder of the report be filed. 1. That our American Medical Association (AMA) support efforts to limit information about medical cannabis in states' prescription drug monitoring programs to only whether a patient has been certified to receive medicinal cannabis consistent with AMA principles safeguarding patient privacy and confidentiality; (New HOD Policy)	Delegate instructed to seek discussion.

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			2. That our AMA continue its monitoring of state legislation relating to the inclusion of cannabis and related information in state PDMPs. (Directive to Take Action)	
8	B	BOT 10 – Physician Access to Their Medical and Billing Records	RECOMMENDATIONS In light of these considerations, the Board recommends that the following be adopted in lieu of Resolution 226-A-19 and the remainder of this report be filed: 1. That our AMA advocate that licensed physicians have unrestricted access to all their patients' billing records and associated medical records during employment or while under contract to provide medical or health care items or services. The records should also include any billing records submitted under the physician's name, regardless of whether the physician directly provided the item or service. (Directive to Take Action) 2. That our AMA advocate that, where physician possession of all his or her billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of his or her billing records subsequent to the termination of employment or contractual arrangement, when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (Directive to Take Action) 3. That our AMA advocate for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to his or her billing records and associated medical records, such as treating these records as trade secrets or proprietary. (Directive to Take Action)	Delegate instructed to support.
9	B	Res. 201 – Protection of Peer-Review Process (SC, AL, FL, MS, NJ, OK, WV, AK, & NC)	RESOLVED, That our American Medical Association use its full ability and influence to oppose any new attempt(s) to make peer review proceedings, regardless of the venue, discoverable, even if by the U.S. Congress or other U.S. governmental entity. (Directive to Take Action)	Delegate instructed to support.

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10	B	Res. 216 – Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers (Resident and Fellow Section)	RESOLVED, That our American Medical Association reaffirm Policies H-160.947 and H-160.950 (Reaffirm HOD Policy); and be it further RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to "supervise" midlevel providers (Directive to Take Action); and be it further RESOLVED, That our AMA oppose mandatory physician supervision of midlevel providers as a condition for physician employment ~~and in physician employment contracts, especially when physicians are not provided adequate resources and time for this responsibility (New HOD Policy);~~ and be it further RESOLVED, That our AMA advocate for the right of physicians to deny "supervision" to any midlevel provider whom they deem a danger to patient safety and the ability to report unsafe care provided by mid-levels to the appropriate regulatory board with whistleblower protections for physician employment. (Directive to Take Action)	Delegate instructed to support with amendment to text as shown.
11	B	Res. 218 – Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care (Resident and Fellow Section)	RESOLVED, That our American Medical Association study the impact that individual physician scope of practice advocacy has had on physician employment and contract terminations (Directive to Take Action); and be it further 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 (Directive to Take Action); and be it further RESOLVED, That our AMA study the utility of a physician-reported database to track and report institutions that replace physicians with midlevel providers in order to aid patients in seeking physician-led medical care as opposed to care by midlevel providers practicing without physician supervision. (Directive to Take Action)	Delegate instructed to support.
12	B	Res. 221 – Promoting Sustainability in Medicare Physician Payments (Texas)	RESOLVED, That our American Medical Association continue to advocate for legislation that prevents Medicare cuts from taking place prior to Jan. 1, 2022 (Directive to Take Action); and be it further RESOLVED, That our AMA seek annual and full Medicare Economic Index updates for Medicare Part B physician payments (Directive to Take Action); and be it further	Delegate instructed to support.

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			RESOLVED, That our AMA seek legislation that provides only for positive performance incentives (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services by instituting a three-year look-back period to correct Medicare conversion factor estimations. (Directive to Take Action)	
13	B	Res. 223 – Paying Physicians for Services According to the Physician Fee Schedule (Texas)	RESOLVED, That our American Medical Association advocate for Congress to require Employee Retirement Income Security Act (ERISA) self-funded employer-sponsored plans, state-regulated plans, Medicare, Medicaid, and TRICARE to pay physicians appropriately for a covered service provided as a telemedicine service to an enrolled patient by a contracted physician at least the same as the contracted rate that would have been paid if the service were provided in an in-person setting (Directive to Take Action); and be it further RESOLVED, That our AMA support state medical board licensure requirements in the state where the patient is located, but otherwise the geographic and originating site restrictions should be eliminated to allow patients to receive appropriate telehealth services in their homes, residential facilities, and other locations (New HOD Policy); and be it further RESOLVED, That our AMA advocate that the Centers for Medicare & Medicaid Services retain on a permanent basis the telehealth services added to the Medicare telehealth services list during the public health emergency.(Directive to Take Action)	Delegate instructed to support.
14	B	Res. 224 – Improve Physician Payments (Florida)	RESOLVED, That our American Medical Association make avoiding the Medicare payment cuts on physician practices a top priority (Directive to Take Action); and be it further RESOLVED, That our AMA utilize the necessary resources to avoid the pending Medicare physician payment cuts (Directive to Take Action); and be it further RESOLVED, That our AMA modify policy D-165.941, "Sequestration Budget Cuts," by addition and deletion to read as follows: **Sequestration Budget Cuts D-165.941** 1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and	Delegate instructed to support.

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			drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians. 2. Our AMA will take all necessary legislative and administrative steps to prevent extended ~~or~~ and deeper sequester cuts in Medicare payments to physician practices using the financial means necessary to do so and make this a top priority. (Modify Current HOD Policy); and be it further RESOLVED, That our AMA reaffirm and take immediate action on policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement," that: 1. supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;(calls for elimination of budget neutrality) (current policy) 2. aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (freedom of choice for patients), (current policy) 3. if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; (current policy); and 4. supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases. (current policy) (Reaffirm HOD Policy); and be it further RESOLVED, That our AMA reach out to the physicians of the United States via all possible means, to include but not be limited to email, US mail, social media, to encourage physicians to participate in the AMA campaign to improve physician payments (Directive to Take Action); and be it further RESOLVED, That our AMA have an open and transparent dialogue with Congressional leaders and the Centers for Medicare and Medicaid Services regarding continued devaluation of the American physician and communicate such with America's physicians (both member and non-member). (Directive to Take Action)	

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15	B	Res. 225 – End Budget Neutrality (Florida)	RESOLVED, That our American Medical Association work towards the elimination of budget 37 neutrality requirements under federal law (Directive to Take Action); and be it further Resolution: 225 (N-21) Page 2 of 7 1 RESOLVED, That our AMA amend Policy H-385.905, "Merit-based Incentive Payment System (MIPS) Update," by addition and deletion to read as follows: **Merit-based Incentive Payment System (MIPS) Update H-385.905** Our AMA will work toward creating and pursuing ~~supports~~ legislation that ensures Medicare physician payments are ~~is~~ sufficient to safeguard beneficiary access to care, ~~replaces or supplements budget~~ eliminate budget neutrality requirements within the MPFS and with respect to ~~in~~ MIPS ~~with~~ incentive payments, ~~or~~ and implements ~~positive~~ annual Medicare physician payment updates that keep pace with rising practice costs. (Modify Current HOD Policy); and be it further RESOLVED, That our AMA reaffirm D-400.989, "Equal Pay for Equal Work," with a special emphasis on the third bullet point and work to create legislation to eliminate budget neutrality: Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and **(3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.** (Reaffirm HOD Policy); and be it further RESOLVED, That our AMA reaffirm and take action on H-400.972, "Physician Payment Reform" **H-400.972, "Physician Payment Reform** It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of	Delegate instructed to support.

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			EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f)the need for RBRVS conversion factor updates that are not subject to budget neutrality requirements; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96); (2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients; (3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system; (4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors; (5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures; (6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992; (7) seek the elimination of regulations directing patients to points of service; (8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change; (9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs; (10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of	

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			1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes; (11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS 22 Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations; (12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index; (13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and (14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements. (created in 1992, reaffirmed 10 times) (Reaffirm HOD Policy)	
16	C	CME 01 – Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians	The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed. 1. That our American Medical Association (AMA) support the following Guiding Principles on the Assessment of Late Career Physicians: a) Evidence-based: Guidelines for assessing and screening late career physicians should be 16 based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Some physicians may suffer from declines in practice performance with advancing age. Research also suggests that the effect of age on an individual physician's competency can be highly variable; and since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.	Delegate instructed to support.

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			b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency. c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment. d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results. e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to a physician's practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. f) Transparent: Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations, and standards against which performance will be judged and the possible outcomes of the screening or assessment. g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive. h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to late career physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed late career physicians. Similar procedures and screening mechanisms should be available to late career physicians who are not employed by hospitals and health care systems. (Directive to Take Action)	

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			2. That our AMA encourage the Council of Medical Specialty Societies and other interested organizations to develop educational materials on the effects of age on physician practice. (Directive to Take Action) 3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)	
17	C	CME 03 – Rural Health Physician Workplace Disparities	RECCOMENDATIONS 1. That our AMA amend Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," by addition and deletion to read as follows: ~~Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.~~ (4) Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas. (5) Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs. (Modify Current HOD Policy) 2. That our AMA monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities. (Directive to Take Action) 3. That our AMA amend Policy H-200.954, "US Physician Shortage," by addition to read as follows: "(13) will monitor the impact of initiatives to address rural physician workforce shortages." (Modify Current HOD Policy) That our AMA reaffirm Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which states, in part "(1.a) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. (1.b) Our AMA	Delegate instructed to support.

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			encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians." (Reaffirm HOD Policy).	
18	C	Res. 311 – Improving Access to Physician Health Programs for Physician Trainees (Resident and Fellow Section)	RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education and other relevant stakeholders to ensure physician health programs (PHPs) are promoted by training programs and transparent information is disseminated by programs to their trainees about PHP reporting requirements, benefits of participation, and limitations of such programs (Directive to Take Action); and be it further RESOLVED, That our AMA recognize PHPs as one of many resources available to support physician trainee mental health. (New HOD Policy)	Delegate instructed to support.
19	C	Res. 313 – Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training (Resident and Fellow Section)	RESOLVED, That our American Medical Association support current efforts by the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and other relevant stakeholders to develop and align minimum requirements for parental leave during residency and fellowship training and urge these bodies to adopt minimum requirements in accordance with policy H-405.960 (New HOD Policy); and be it further RESOLVED, That our AMA petition the ACGME to recommend strategies to prevent undue burden on trainees related to parental leave; (Directive to Take Action) RESOLVED, That our AMA petition the ACGME, ABMS, and other relevant stakeholders to develop specialty specific pathways for residents and fellows in good standing, who take maximum allowable parental leave, to complete their training within the original time frame. (Directive to Take Action)	Delegate instructed to support.
20	D	CSAPH 01 – Drug Shortages: 2021 Update	SUMMARY The rate of new medical product shortages is decreasing, but the current COVID-19 public health emergency requires continued diligence in monitoring any shortage or supply chain issues due to manufacturing capacity prioritization for COVID-19 vaccines and treatments. The AMA's drug shortage policy is timely and already addresses a variety of issues that are under consideration by the White House, FDA, and other stakeholders including the improvement of quality assurance systems; expedited facility inspections and	Included for information purposes only. See Appendix for more.

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			manufacturing changes/improvements; necessary resiliency and redundancy in manufacturing capability; evaluation of root causes of drug shortages; transparent analysis of economic drivers and reasonable and sustainable payment rates for prescription drugs; greater transparency of the manufacturing process; and including drug manufacturing sites as part of the nation's critical infrastructure plan. Therefore, the Council feels that an update to AMA policy is not warranted at this time.	
21	D	CSAPH 02 – Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems	RECOMMENDATIONS The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 401-JUN-21 and the remainder of the report be filed. 1. That Policy D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems" be amended by addition and deletion to read as follows: Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; and ~~(2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending~~ (2) develop an organization-wide strategy on public health including ways in which the AMA can ~~to~~ strengthen the health and public health system infrastructure and report back as needed on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs. (Modify Current AMA Policy)	Delegate instructed to support. Note: CSAPH 02 is a first in a series of reports on this subject with further reports expected in coming meetings.

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			2. That Policy H-440.960, "Organized Medicine and Public Health Collaboration" be amended by addition and deletion to read as follows: Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice; (2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals, including representatives from governmental public health, and those representing physicians in private practice or those employed in health systems and in academic medicine (3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education~~; (4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program;~~ (~~5~~4) encourages public health agencies to focus on assessment of problems, assurance of healthy living conditions, policy development, and other related activities; and (~~6~~5) encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics; and (6) encourages state and local health agencies to communicate directly with physicians licensed in their jurisdiction about the status of the population's health, the health needs of the community, and opportunities to collectively strengthen and improve the health of the public. (Modify Current AMA Policy) 3. That AMA Policy H-440.912, "Federal Block Grants and Public Health" which calls on the AMA to collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated and urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; be reaffirmed. (Reaffirm Current AMA Policy)	

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			4. That AMA Policy H-440.989, "Continuation of the Commissioned Corps," be amended by addition to read as follows: Our AMA strongly supports the expansion and continuation of the Commissioned Corps of the US Public Health Service and recognize the need for it to be adequately funded. (Modify Current AMA Policy) 5. That our AMA reaffirm Policies D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion," and D-295.327, "Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum." (Reaffirm Current AMA Policy) 6. That our AMA reaffirm Policy H-440.89, "Support of the National Laboratory Response Network," and Policy D-460.971, "Genome Analysis and Variant Identification." (Reaffirm Current AMA Policy) 7. That our AMA amend Policy H-440.813, "Public Health Surveillance" by addition and deletion to read as follows: Our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data; (5) supports the CDC's data modernization initiative, including electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy	

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			and public health reporting laws; (6) will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete; (~~6~~7) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting; (~~7~~8) will advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments; and (~~8~~9) supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations. (Modify Current AMA Policy)	
22	F	CLRPD 01 – Minority Affair Section Five-Year Review	RECOMMENDATION The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Minority Affairs Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)	Delegate instructed to support.
23	F	CLRPD 02 – Integrated Physician Practice Section Five-Year Review	RECOMMENDATION 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 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)	Delegate instructed to support.
24 (item 24 is both Res. 603 and Res. 605)	F	Res. 603 – Abolishment of the Resolution Committee (Medical Student Section)	RESOLVED, That our American Medical Association abolish the Resolution Committee by amending the AMA Bylaws B-2.13.3, "Resolution Committee," as follows by deletion: ~~**Resolution Committee. B-2.13.3**~~ ~~The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~ ~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~ ~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~	Delegate instructed to seek discussion.

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			~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~ ~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~ ~~2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.~~ ~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~ ~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker. (Modify Bylaws)~~	
	F	Res. 605 – Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates (Texas)	RESOLVED, That the membership of the Resolution Committee reflect the diversity of the House of Delegates (New HOD Policy); and be it further RESOLVED, That the Resolution Committee rules be written to produce impartial results and appropriate changes be made to the AMA Bylaws as necessary to empower the committee. (Modify Bylaws)	Delegate instructed to seek discussion.
25	F	Res. 606 – Increasing the Effectiveness of Online Reference Committee Testimony (Texas)	RESOLVED, That our American Medical Association conduct a trial of no less than two-years during which all reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee report based on the written online testimony (Directive to Take Action); and be it further RESOLVED, That the preliminary reference committee document become the agenda for discussion at the in-person reference committee (Directive to Take Action); and be it further RESOLVED, That after the trial period there be an evaluation to determine if this procedure should continue (Directive to Take Action); and be it further RESOLVED, That AMA pursue any bylaw changes that might be necessary to allow this trial (Directive to Take Action); and be it further	Delegate instructed to support.

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			RESOLVED, That the period for online testimony be no longer than 10 days.) (Directive to Take Action)	
26	F	Res. 604 – The Critical Role of Physicians in the COVID-19 Pandemic (TX, FL, NJ, CA & WA)	RESOLVED, That our American Medical Association create and fund a public awareness campaign recognizing the vital role physicians have played in the COVID-19 pandemic and highlighting: • Physician leadership in public health messaging, raising awareness of vital prevention and treatment recommendations; • Medical treatment of patients during this time of great crisis; • Remembrance of physicians who died of COVID-19 while rendering care during the pandemic; • The personal sacrifices borne by physicians related to the pandemic; and • The emotional stress from the long hours spent taking care of patients (Directive to Take 39 Action); and be it further RESOLVED, That the target audience for this campaign be physicians, legislators, and the public (Directive to Take Action); and be it further RESOLVED, That the purpose of this campaign is to thank our physician colleagues and make government officials and the public aware of the personal costs physicians have shouldered during this crisis. (Directive to Take Action)	Delegate instructed to support.
27 (Note: two items here)	F	Res. 610 – Creation of Employed Physician Section (Florida)	RESOLVED, That our American Medical Association study the necessity and feasibility to create a Section for Employed Physicians (Directive to Take Action); and be it further RESOLVED, That the section would work toward determining problems associated with employment; recommend solutions; and utilize necessary resources when resolving conflicts and challenges between employed physicians and their employers. (Directive to Take Action)	See below for recommendations for Res. 615.
	F	Res 615 – Employed Physicians (AL, DC, GA, MS, NJ, NC, OK, SC, TN)	RESOLVED, That our American Medical Association dedicate full-time staff to the Employed Physician to aggressively address relevant AMA Policy pertaining to the Employed Physician (Directive to Take Action); and be it further RESOLVED, that our AMA study amending Policy G-615.105 as follows:	Delegate instructed to support Res 615 over 610. Within 615, Delegate instructed to support first two

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			1. Our AMA will become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. 2. As a benefit of membership our AMA will provide assistance, such as information, advice, and legal opinions, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts, contract negotiations and contract renewals, medical staff bylaws, sham peer review, economic credentialing, and the denial of due process. 3. Our AMA will also work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. (Directive to Take Action); and be it further RESOLVED, that the Representation of the Organized Medical Staff Section (OMSS) in the AMA House of Delegates be increased from the Current One Delegate to many Delegates based on AMA membership numbers of Employed Physicians using the mathematical model(s), to calculate the numbers of the New OMSS Delegates, currently being used at AMA for the Medical Student and Resident and Fellows Sections to calculate the numbers of Regional Medical Students and the numbers of Regional Resident/Fellows in the AMA House of Delegates. The AMA would develop a practical meaning of the phrase "Employed Physician" for the purposes of AMA membership counting, but as an editorial comment, the SED suggests starting with employed Non-Resident/non-Fellow physicians who have no ownership interest (or, say, less than 1% ownership each) in their employer organization. (New HOD Policy); and be it Further RESOLVED, that the Organized Medical Staff Section have one designated member who is a defined Employed Physician on all AMA Boards and Committees and Councils to match the MMS, the RFS and the YPS. (New HOD Policy)	Resolves, and refer other Resolves for study.
28	G	Res. 704 – Expanding the AMA's Study on the	RESOLVED, That our American Medical Association work with relevant organizations and stakeholders to study the economic impact and long-term recovery of the COVID-19	Delegate instructed to support.

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		Economic Impact of COVID-19 (Resident and Fellow Section)	pandemic on healthcare institutions in order to identify and better understand which groups of physicians, patients and organizations may have been disproportionately affected by the financial burdens of the COVID-19 pandemic (Directive to Take Action); and be it further RESOLVED, That our AMA work with relevant organizations and stakeholders to study the overall economic impact of office closures, cancellations of elective surgeries and interruptions in patient care, as well as the economic impact of utilizing telemedicine for an increasing percentage of patient care. (Directive to Take Action)	
29	G	Res. 706 – Support for State Medical Record Retention Laws (Texas)	RESOLVED, That our American Medical Association advocate that the Centers for Medicare & Medicaid Services do not supersede state medical record retention laws in the U.S. (Directive to Take Action)	Delegate instructed to support.
Item #30 is a special addition the OMSS has been asked to evaluate				
30	TBD	Res TBD – AMA Council on Ethical and Judicial Affairs (CEJA) Report on Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2 (Pennsylvania)	RESOLVED, that our AMA support a fair, objective, external and independent review for physicians who are requested to be assessed for a potential impairment, and support the availability of physician health programs to enable physicians who require assistance to provide safe and effective care (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that health system, corporate, and academic organizations provide a fair, objective, external and independent review for physicians who are requested to be assessed for a potential impairment (Directive to Take Action); and be it further RESOLVED, that CEJA consider the following amendment to Opinion E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment: (i) Advocating for supportive services including physician health programs and accommodations to enable physicians who require assistance to provide safe, effective care. …	No recommendation made. Governing Council seeks full Section discussion.

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			(k) Advocating for fair, objective, external, and independent review for physicians when a review is requested to assess a potential impairment and its duration. (New HOD Policy).	
Item #31 relates to a Board report originating from an OMSS-sponsored resolution (Previously referred to as a "Green Report").				
31	F	BOT 19 – Advocacy for Physicians with Disabilities	RECOMMENDATIONS 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) establish an advisory group composed of AMA members who themselves have a disability to work toward inclusion for physicians with disabilities in all AMA activities. (Directive to Take Action) 2. That our AMA promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent. (Directive to Take Action) 3. That our AMA develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians to manage their own disability-related needs in the workplace. (Directive to Take Action) 4. That our AMA communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians with visible and invisible disabilities. (Directive to Take 2 Action) That part 1 of Policy D-90.991, Advocacy for Physicians with Disabilities, be rescinded as having been accomplished by this report. (Modify Current HOD Policy)	Delegate instructed to support.