Resolution 1-F18. Modifying the ACP BOG Resolutions Process to Capture Dissenting Opinions for Controversial Resolutions

(Sponsor: Alabama Chapter; Co-Sponsors: Council of Early Career Physicians, Council of Resident/Fellow Members, Mississippi and Nebraska Chapters)

WHEREAS, current ACP BOG resolutions are passed and reported with a simple majority vote; and

WHEREAS, there is currently no mechanism for reporting dissenting opinion on resolutions narrowly passed with a close vote; and

WHEREAS, the values of the ACP are to respect and reflect a diverse opinion of over 152,000 members of the ACP; and

WHEREAS, there are resolutions that will be deeply divisive within our membership and the voice of all ACP members should be valued; and

WHEREAS, one of the ACP goals is, "To unify the many voices of internal medicine and its subspecialties for the benefits of our patients, our members, and our profession" (ACP Goal VII); and

WHEREAS, a simple majority vote does not reflect the diversity and complexity of dissenting opinions on such topics; and

WHEREAS, sharing the opinion of the dissenting members is an expression of respect for the range of opinions within the ACP membership; therefore be it

RESOLVED, that the Board of Regents (BOR) modifies the ACP Board of Governors (BOG) Resolutions Process to specify that when a resolution passes with the support of less than 2/3rds of those voting:

- **the Chair of the BOG appoints representation from the reference committee and the dissenting Governors to write a brief summary of the dissenting opinions;**
- **the summary of dissenting opinions be included with the resolution resolves in the college compendium; and**
- **the summary of dissenting opinions be included in any ACP BOR approved policy papers based on resolutions that become policy without a 2/3rds majority.**

Resolution 2-F18. Establishing a Council of Independent Practice Internists

(Sponsor: Georgia Chapter; Co-Sponsors: Alabama, Alaska, District of Columbia, Florida, Mississippi, and Wyoming Chapters)

WHEREAS, the College has seen a precipitous drop over the past 10 years in the membership of internists in independent practices from 47% in 2007 to 19% in 2017[1]; and

WHEREAS, the College has seen a decline in overall regular dues paying members, and physicians in independent practice could represent a good source of membership recruitment; and

WHEREAS, studies have consistently shown that independent practicing physicians as a group provide better value of care than physicians employed by hospitals or health systems, making the preservation and expansion of independent internists an important priority of the College; and

WHEREAS, the composition of the BOR has typically included only a small minority of independently practicing internists; and

WHEREAS, the College has an established mechanism for recognizing the voice of important subgroups of internists through the establishment of Councils with representation on the BOR and BOG; therefore be it

RESOLVED, that the Board of Regents establishes a Council of Independent Practicing Internists, composed of internists practicing in both small and large independent practices, with an elected Vice Chair and Chair who serve on the BOG and BOR, respectively; and be it further

RESOLVED, that the Board of Regents allows this Council to serve to identify and give voice to the College the priorities and concerns of independent physicians, as well as strategies to improve work satisfaction, financial stability, and patient care in the independent practice setting.

[1]Weissman, Arlene. Director of ACP Research. "2017 Member Survey. 10 things to know about ACP Membership". Slide 7. Nov,18, 2017.

Resolution 3-F18. Developing ACP Policy Calling for Transparency and Community Learning Towards Physician Suicide Prevention

(Sponsor: Council of Early Career Physicians; Co-Sponsors**:** Council of Resident/Fellow Members and Council of Student Members)

WHEREAS, suicide among physicians occurs globally [1–8], at a higher rate than in the general population, and at a higher rate among women physicians than male physicians compared to their counterparts in the general population [9,10] (in this resolution, *physicians* refers to all in the life cycle, including medical students, resident and fellow physicians, and practicing, non-practicing or retired physicians); and

WHEREAS, those bereaved by the suicide of a physician, as defined above, include *patients,* who lose their physician; *physician colleagues,* who bear both emotional and practical strain due to the tragic loss of a colleague; and *friends and families**,*** who include partners, spouses, parents, children, relatives, and other companions [11]; and

WHEREAS, there is a well-established gap in the collection of reliable, detailed data in the wake of a physician's suicide beyond solely cause of death statistics and registers [12], especially for medical students [13], where more detailed insights are needed to better inform prevention efforts and increase awareness and open dialogue across the entire medical community; and

WHEREAS, there is also a wide implementation gap with respect to guidelines on postvention [14] after physician suicides, including the American Foundation of Suicide Prevention's published postvention toolkit tailored for residency and fellowship programs, which is endorsed by the Accreditation Council of Graduate Medical Education [15]; and

WHEREAS, social or institutional stigma and a culture or code of silence are significant barriers in understanding and intervening upon the complex phenomenon of physician suicide [16,17], leaving mainly grassroots efforts to stimulate public dialogue, offer postvention services to those survivors who speak up and seek help after physician suicides, and otherwise address the social consequences of physician suicide [18,19]; and

WHEREAS, the American College of Physicians (ACP) is one of many professional organizations developing and participating in Wellness and Physician Satisfaction initiatives, including, for example, the National Academy of Medicine Action Collaborative of Clinician Well-Being and Resilience, which are intended to promote physician or clinician well-being but do not yet fully address the disturbing issue of physician suicide [20–22]; and

WHEREAS, no independent organization or institution exists to require *mandatory reporting of physician suicide*; to perform rigorous, systematic investigation of root causes for *physician suicide as a public health issue*, such as the investigations performed by Centers for Disease Control and Prevention into adolescent suicide clusters [23]; or to measure the quality of physicians' health and *physician suicide as a quality imperative*, a paradigm that is widely accepted in the analogous context of measuring quality of patient care; therefore be it

RESOLVED, that the Board of Regents develops a policy statement, independent of, but in alignment with the existing ACP Physician Well-being and Professional Satisfaction initiative, that calls on

institutions to embrace *transparency, accountability*, and *collaboration* as core features of a comprehensive response to an individual physician suicide (including medical students, resident and fellow physicians, and practicing, non-practicing or retired physicians). These three core features should also guide partnerships with the public (e.g. media), the medical community, and other organizations to better understand and intervene upon the alarming nature and socio-organizational context of physician suicides; and be it further

RESOLVED, that the Board of Regents in such a policy statement calls for healthcare and medical education institutions to monitor and improve meaningful *physician health outcomes*, implement *standardized postvention activities and investigative activities*, including but not limited to:

1) **Investigative procedures (e.g. root cause analyses with attention to organizational/environmental contributors or related policies, psychological autopsy [24], and other activities, such as Morbidity & Mortality conferences, Schwartz Rounds [25]);**
2) **Systematic reporting of investigative findings, while maintaining respect of family members' wishes and abiding by ethical principles of communication about suicide; and**
3) **Provision of compassionate resources, in keeping with 'creating an environment of psychological safety' [26], to support appropriate grieving for peers, colleagues and members of the community of a physician who has completed suicide.**

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Resolution 4-F18. Energizing the Patients Before Paperwork Project

(Sponsor: Georgia Chapter; Co-Sponsors: Alaska, Florida, Mississippi, and Wyoming Chapters)

WHEREAS, the College has initiated a "Patients before Paperwork" campaign recognizing the detrimental toll on internists that administrative hassles, documentation burdens, irrelevant quality reporting, and EMR frustrations are causing; and

WHEREAS, these issues are causing an alarming increase in physician burnout and early retirement of internists; and

WHEREAS, there is universal support among the College membership of this project; and

WHEREAS, the effort being placed on this project has been ineffectively communicated to the membership in comparison with other health policy agendas; and

WHEREAS, these burdensome issues appear to only be getting more complex and require greater member support; and

WHEREAS, advancement in addressing these issues and communicating the progress to membership would help recruit more members; therefore be it

RESOLVED, that the Board of Regents energizes the Patients Before Paperwork Project and elevates this project as its highest priority in terms of strategic planning; and be it further

RESOLVED, that the Board of Regents develops specific short and long term goals to be accomplished in the "Patients Before Paperwork" campaign and develops a clear and specific regulatory and legislative strategy to accomplish these goals with increased resources; and be it further

RESOLVED, that the Board of Regents develops a communication strategy that frequently informs the membership and engages the membership in this endeavor.

Resolution 5-F18. Promoting the High Value Provided by Primary Care Internists

(Sponsor: BOG Class of 2021)

WHEREAS**,** studies show that states with a higher percentage health care expenditures going to primary care have lower overall costs (1); and

WHEREAS, outpatient Internists are increasingly seen by the public and payers as interchangeable with non-internist primary providers such as FPs, PAs, and NPs, and patients often seek low cost, convenient care by any willing provider, and market trends suggest that primary care Internists may be devalued and/or replaced by non-internists as a result (2); and

WHEREAS, Internists are highly trained in adult medicine, and demonstrate our unique value to patients by using our experience and evidence based medicine to triage, risk stratify, and lead teams to manage complex patients (3); and

WHEREAS, primary care Internists generally manage a more complex patient population (4); and

WHEREAS, General Internists and the ACP prioritize high value care (5); and

WHEREAS, if the ACP does not act to show the value of the primary care Internist, students and residents may lose interest in careers in Internal Medicine (6); therefore be it

RESOLVED, that the ACP Board of Regents promotes the high value primary care internists provide and commits to making it a priority to demonstrate and market the value of the General Internist to the public by:

1. **Supporting research to evaluate the care provided by internists vs. non-internists, with attention to quality, value, and health system cost savings**
2. **Establishing the ACP as the premiere educational resource for the entire primary care workforce by developing curricula to educate all primary care providers on how to improve quality and value**
3. **Developing a policy paper on the value of the Internist**
4. **Developing a sustainability plan for our profession which includes recruitment efforts directed at trainees to attract them to careers in primary care Internal Medicine.**

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Resolution 6-F18. Exploring Means for Promoting a Strong and Productive Doctor-Patient Relationship within the Framework of a Rapidly Evolving US Health Care System

(Sponsor: District of Columbia Chapter)

WHEREAS, the American College of Physicians has regularly provided policy recommendations on matters related to patient care and the role of physicians in providing such care; and

WHEREAS, one of the American College of Physicians' Missions and Goals is to advocate for responsible positions on individual health and on public policy relating to health care for the benefit of the public and our patients; and

WHEREAS, although actions by businesses, insurance companies and hospitals such as promoting narrow physician networks, requiring separate deductibles for physicians who are out of network for a patient's insurance, limiting hospitals patients can utilize and still receive insurance coverage, and requiring physicians to see so many patients that they can manage this task only by having other health care team members see patients in their place on a regular basis, may help reduce costs and increase accessibility, such actions do potentially also threaten the ability for doctors and patients to develop and maintain strong relationships with each other; and

WHEREAS, the ACP does believe in the benefit of a strong doctor-patient relationship; and

WHEREAS, many of us who are members of the ACP believe that it should be possible for health care systems to encourage and nurture the development of a strong Doctor-Patient Relationship while simultaneously working to improve the cost, quality, and accessibility of medical care; therefore be it

RESOLVED, that the Board of Regents charges an appropriate national ACP committee to prepare a position paper which explores (based upon a review of the medical literature) the benefits of the doctor-patient relationship and suggests a means for promoting strong doctor-patient relationships within a health care system which is of high quality, accessible, and affordable; and be it further

RESOLVED, that the Board of Regents also charges an appropriate national ACP committee to explore and suggest potential research settings and funding sources for such research which could develop a means for promoting stronger doctor-patient relationships within the rapidly changing American medical care environment.

Resolution 7-F18. Petitioning to Change Tramadol from DEA Schedule IV to Schedule III

(Sponsor: Arizona Chapter)

WHEREAS, the death rate from overdoses of all opioids has increased 429% from 8,050 in 1999 to 42,249 in 2016, and the death rate from synthetic opioids, including tramadol and fentanyl and its derivatives, has increased more than 2,000% from 730 in 1999 to 19,413 in 2016[1]; and

WHEREAS, Emergency Department visits for misuse or abuse of tramadol have increased 230% from 6,255 visits in 2005 to 21,649 visits in 2011[2]; and

WHEREAS, tramadol is an opioid agonist, with complex pharmacology[3,4], and the US Drug Enforcement Administration (DEA) lists tramadol in Schedule IV, which should "have a low potential for abuse relative to substances in Schedule III"; and

WHEREAS, codeine with acetaminophen is listed in Schedule III by the DEA, and codeine, as a single entity, is listed in Schedule II; and

WHEREAS, some studies suggest that tramadol has similar abuse potential as certain Schedule II narcotics, including single entity codeine[6]; and

WHEREAS, the US Drug Enforcement Administration allows Medical Societies to petition for a change in Schedule of a controlled substance; therefore be it

RESOLVED, that the Board of Regents petitions the United States Drug Enforcement Administration to change tramadol from a Schedule IV to a Schedule III controlled substance.

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Resolution 8-F18. Improving Reimbursement for Cognitive Services

(Sponsor: Michigan Chapter; Co-Sponsors: District of Columbia and Massachusetts Chapters)

WHEREAS, ACP Policy regarding Medicare Program revisions to payment policies under physician fee schedules and other revisions to Part B for CY 2018 (letter 9/11/17) states the request that "CMS simplify the documentation requirements necessary to bill chronic care management (CCM) services in order to ease the burden of documentation" and " to create better payment alignment to benefit Medicare beneficiaries and protect community-based care practices"; and

WHEREAS, ACP is concerned with the 1995 and 1997 evaluation and management (E/M) documentation guidelines that are "outdated and specify the required contents of the medical record in excruciating and often irrelevant detail. This level of unnecessary detail within the guidelines has redefined the cognitive office visit to focus on what was documented, rather than what service is actually provided. The detailed guidelines often cause clinicians to over-document, creating 'note bloat' and making the medical record an ineffective source of communication.[1]"; and

WHEREAS, internists and other primary care physicians are poorly reimbursed for cognitive services compared to reimbursement for interventional services; and

WHEREAS, the current highest E/M codes available for cognitive services provided by internists in the ambulatory setting are 99213 and 99214 (2017 receipts from the Centers for Medicare and Medicaid Services [CMS] and most payors are $75.00 and $110.00, respectively); and

WHEREAS, the applicable skills of cognitive services--assessment, disease management, communication, review/interpretation of test results, and medical record documentation--require significant time at point of service and after the visit, despite the paucity of reimbursement by CMS and other payors; and

WHEREAS, patient care quality metric demands and office administrative tasks contribute to the physician time burden and office overhead costs and restrict the number of patients seen per day by each physician, thus significantly limiting the physician's ability to balance quality with the generation of revenue. This high administrative burden coupled with a low profitability opportunity potentially deters new physicians from consideration of office-based internal medicine in favor of higher reimbursement and more satisfactory time for patient service in other physician specialties, thus limiting patient access to needed internal medicine primary care services; therefore be it

RESOLVED, that the American College of Physicians (ACP) Board of Regents works with the Centers for Medicare and Medicaid Services (CMS) and all third party payors to develop and support a more realistic valuation for the level of cognitive services provided and a more equitable alignment with the level of reimbursement paid, either by annual incremental increases in the receipts for evaluation and management (E/M) ambulatory visit codes 99213 and 99214 to double the current dollar values by the start of calendar year 2022 and/or by a decrease in the required level of cognitive service provided for E/M ambulatory visit codes 99213 and 99214, respectively.

[1] https://www.acponline.org/acp_policy/letters/comment_letter_to_cms_re_cy_2018_medicare_pfs_proposed_rule_2017.pdf

Resolution 9-F18. Paying for Physician Performance rather than Patient Performance

(Sponsor: Michigan Chapter; Co-Sponsors, District of Columbia and Massachusetts Chapters)

WHEREAS, the ACP supports transparency of reliable and valid price information and supports legislative action at the state level to require private and public health plans to submit data in a standardized manner to all payer claims database (Promoting Transparency and Alignment in Medicare Advantage: Position Paper 2017); and

WHEREAS, ACP recommends CMS simplify documentation requirements necessary to bill chronic care management (CCM) services in order to ease the burden of documenting each separate minute of care management (Medicare Program Revisions to Payment Policies Under Physician Fee Schedule and other revisions to Part B for CY 2018 (CMS-1676-P); and

WHEREAS, "pay for performance," is a term defined by payers and physicians first, to optimize self-care by patients and second, to support screening, education, oversight and continuity of care for patients by physicians such that both physicians and patients "perform " to promote the best clinical outcomes as determined by clinical guidelines; and

WHEREAS, the practice of primary care medicine is an adult-to-adult relationship or an adult-to-parent relationship, and reviewers and payers must recognize that patients have the freedom to choose from a number of goal-oriented health choices; and

WHEREAS, patients and/or their parents sometimes fail to make the best health care choices, including the possibility that their choice may even lead to self-harm; and

WHEREAS, the widespread use of electronic health records allows clearer documentation of both the advice given to patients and the clinical outcomes rather than just the claims data; and

WHEREAS, while physicians pledge to do their best for their patients by recommending the best preventative actions and disease treatments, patients may fail to comply or to pursue their physician's advice even though it is delivered repeatedly in the most thoughtful manner and in a supportive environment; and

WHEREAS, the "Pay-for-Performance" approach has led to physicians being held responsible for the patient's and/or parent's action(s) while obviating the patient's need for personal responsibility; and

WHEREAS, performance incentives should be linked to the performance of the physician in providing and documenting appropriate advice on preventative care and self-care to patients and/or their parents; and

WHEREAS, such performance incentives earned through delivery and documentation of appropriate advice should be considered equal to performance incentives based on clinical outcomes (example: a physician's recommendation to obtain a screening colonoscopy would earn a performance incentive whether or not the patient completed the colonoscopy); therefore be it

RESOLVED, that the Board of Regents works with third party payers and other physician performance review organizations nationally to establish a new standard that physicians should be measured not

on what patients decide to do for themselves but rather on the advice and guidance physicians provide for patients and how that advice is communicated and documented; and be it further

RESOLVED, that the Board of Regents works with the American Medical Association and any other organizations measuring physicians through incentive or performance programs to adopt standards that do not penalize physicians for the actions of patients who cannot or who will not comply with excellent clinical recommendations.

Resolution 11-F18. Calling Upon Pharmacies to Refrain from Providing Patients with Rewards or Gifts for Receiving Immunizations or Acute Care in Their Stores

(Sponsor: District of Columbia Chapter)

WHEREAS, the American College of Physicians has promoted policy aimed at improving the cost, safety, and appropriateness of medication prescribing to patients; and

WHEREAS, one of the American College of Physicians' Missions and Goals is to advocate for responsible positions on individual health and on public policy relating to health care for the benefit of the public and our patients; and

WHEREAS, the practice of some pharmacies to provide financial incentives to patients to receive immunizations or acute care treatment in their stores may influence patients to receive immunizations or medical care which is inappropriate for them and for which their patients might otherwise first check with their providers as to the appropriateness of such treatment; therefore be it

RESOLVED, that the Board of Regents develops policy calling upon pharmacy/drug stores to refrain from offering gifts or rewards for providing immunizations or health care services since such "giftmanship" may inappropriately influence patients to receive services they do not need and may incentivize patients to receive medical procedures/care from sources other than their own physicians who may know the patients' health care needs best.

Resolution 12-F18. Calling Upon Pharmacies to Refrain from Requesting Physicians to Renew Medications Not Requested or Required by Patients

(Sponsor: District of Columbia Chapter)

WHEREAS, the American College of Physicians has promoted policy aimed at improving the cost, safety, and appropriateness of medication prescribing to patients; and

WHEREAS, one of the American College of Physicians' Missions and Goals is to advocate for responsible positions on individual health and on public policy relating to health care for the benefit of the public and our patients; and

WHEREAS, more and more pharmacies are automatically requesting physicians to refill prescriptions that physicians have written for patients which are no longer needed by the patients and for which the patients neither requested their pharmacies to refill or even know that their pharmacies are requesting renewal from their providers; and

WHEREAS, this practice on the part of pharmacies can lead physicians to believe patients need medication they do not actually need (and thereby result in physicians authorizing the renewal of unnecessary medications) and confuse patients into taking medication they do not need any longer; and

WHEREAS, this can lead to inappropriate prescribing and medication side effects which might be otherwise avoided; therefore be it

RESOLVED, that the Board of Regents develops policy that calls for pharmacies to refrain from requesting physicians to renew medications not requested or necessarily required by patient; and be it further

RESOLVED, that the Board of Regents disseminates to insurance plans and appropriate federal committees and health care policy makers any new ACP policy prepared that calls for pharmacies to refrain from requesting physicians to renew medications not requested or necessarily required by patients.

Resolution 13-F18. Developing ACP Policy Opposing the Requirement for Ninety-Day Prescribing in Order That Prescriptions be Covered by Insurance Companies

(Sponsor: District of Columbia Chapter)

WHEREAS, the American College of Physicians has promoted policy aimed at improving the cost, safety, and appropriateness of medication prescribing to patients; and

WHEREAS, one of the American College of Physicians' Missions and Goals is to advocate for responsible positions on individual health and on public policy relating to health care for the benefit of the public and our patients; and

WHEREAS, some insurance companies require physicians to prescribe a minimum of ninety days of medication at a time in order for the patient to receive coverage from the insurance company for the medication; and

WHEREAS, there are situations where physicians may not want patients to receive ninety days of medications if, for example, the patients may need to have changes made in their medication regimens before ninety days (but having ninety days of medication may defer patients from returning for necessary and timely follow up) or if the patients' physicians have reason to be concerned that their patients may not follow up appropriately with their physicians in a timely fashion if problems with their medications are occurring; therefore be it

RESOLVED, that the Board of Regents develops ACP policy opposing the requirement for ninety-day prescribing as certain insurance companies currently practice in order that prescriptions be covered by insurance companies; and be it further

RESOLVED, that the Board of Regents disseminates to insurance companies and to appropriate governmental committees and health care policy makers/influencers any new ACP policy developed which opposes requirements by insurance companies for ninety-day prescribing by physicians.

Resolution 14-F18. Calling Upon the ACP to Publicly Support the Consensus Statement Recently Prepared by a Collection of Medical/Health Care Associations Requesting Improvement in the Prior Authorization Process

(Sponsor**:** District of Columbia Chapter)

WHEREAS, the American College of Physicians has promoted policy aimed at improving the cost, safety, and appropriateness of medication prescribing to patients, including drafting policy relating to the preauthorization process; and

WHEREAS, one of the American College of Physicians' Missions and Goals is to advocate for responsible positions on individual health and on public policy relating to health care for the benefit of the public and our patients; and

WHEREAS, the American Hospital Association, American's Health Insurance Plans, American Medical Association, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association recently announced a consensus statement[1] delineating that they agree that the health care industry can improve the prior authorization process; therefore be it

RESOLVED, that the Board of Regents provides formal public support to at least the broad aspects of the recently published consensus statement[2] of multiple other organizations which calls for an improvement in the Prior Authorization Process thereby increasing the likelihood that the health care industry will work on improving the preauthorization process.

[1] https://www.ama-assn.org/sites/default/files/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf

[2] https://www.ama-assn.org/sites/default/files/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf

Resolution 15-F18. Seeking Legislation to Require Medicare Advantage, Medicaid, and Commercial Insurers Pay for Advance Care Planning

(Sponsor: Arizona Chapter)

WHEREAS, Advance Care Planning (ACP) consists of discussions of preferences for End of Life Care, Advance Directives (AD), Selection of a Surrogate Decision Maker or Healthcare Proxy in a Durable Power of Attorney (DPOA), and often, Physician Orders for Life Sustaining Treatment (POLST); and

WHEREAS, Advance Care Planning is important in helping patients to have the care that they and their families desire, near and at the End of Life; and

WHEREAS, Advance Care Planning saves money for the medical system, by decreasing unnecessary treatment, hospitalizations, Intensive Care Unit admissions and procedures; and

WHEREAS, Advance Care Planning is important for younger patients because, if they have a life-threatening injury or illness, it is more likely to be unexpected, compared to older patients; and

WHEREAS, Medicare pays for Advance Care Planning using E & M codes 99497 and 99498, at whatever age the physician feels is appropriate and as often as necessary; and

WHEREAS Medicare Advantage (Medicare C), Medicaid and Commercial Insurance often do not pay for Advance Care Planning, or limit it to patients with a terminal illness; therefore be it

RESOLVED, that the Board of Regents seeks Federal Legislation to require Medicare Advantage, Medicaid, and Commercial Insurance to pay for Advance Care Planning whenever and as often as the patient's physician believes that it is appropriate.

References

Institute of Medicine. Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Washington, DC: National Academy Press; 2014.
Lawrence, Leah. Advance Care Planning should be standard. ACP Internist, 2016: 13-15.