Reference Committee - Andrew S. Dunn, MD, FACP, Chair

Omar T. Atiq, MD, FACP  Arkansas
Janet A. Jokela, MD, FACP  Illinois Southern
Steven R. Peskin, MD, FACP  New Jersey Southern
Joyce E. Wipf, MD, FACP  Washington

Outstanding Business from the Spring 2014 BOG Meeting

1-S14. Devising Strategies that Increase the Representation of Private Practitioners/Self-Employed Physicians within ACP Leadership
13-S14. Aiding ACP Members in Optimally Prescribing for Their Patients
14-S14. Using the Beers Criteria for Drug Utilization Review (DUR) and Medication Therapy Management (MTM)

Spring 2015 BOG Resolutions

1-S15. Educating ACP Chapters on How to Engage National ACP in Local/State Issues that Impact the Patient-Physician Relationship
2-S15. Approving Chapter Dues Collection at Time of Member Application
3-S15. Stopping Unnecessary Distracted Driving Deaths – Especially Newly Licensed Youth (SUDDENLY)
4-S15. Advocating for Federal Approval of Environmentally Safe Controlled Substance Waste Disposal
5-S15. Limiting the Use of the Pain Scale to Support a Move Away from Excessive Narcotic Prescribing
6-S15. Advocating for Health Research and Services Administration Designation of Individuals with Intellectual and Developmental Disabilities as a Medically Underserved Population
7-S15. Studying the Economic Viability of Rural Sole Community Hospitals
8-S15. Eliminating CMS Penalties for Not Using Certified Electronic Medical Records (EMRs)
9-S15. Introducing Legislation to Ensure Immunity from Federal Prosecution for Marijuana-Prescribing Physicians
10-S15. Raising Awareness about the Transition of Care from Pediatric to Adult Health Care through ACP Educational Sessions, Electronic Publications, and Chapter Outreach
11-S15. Adopting Principles for Appropriate Use of Direct-to-Patient Telehealth

A Reminder about Providing Testimony on BOG Resolutions

Governors are expected to review background in advance, consult with their councils, conduct member outreach, and engage in pre-BOG meeting discussion on LeaderNet as the opportunity to provide testimony at the hearing will likely be limited.

Keep in mind that online discussions carry the same weight as live testimony given at the meeting and will be submitted to the Reference Committee for their consideration before the meeting and during their report writing deliberations. To assure your viewpoint is heard on behalf of your chapter, we strongly encourage Governors to comment on the Resolutions page of LeaderNet and subscribe to the resolution discussions.

As done in the past, you may propose amendments via your BOG Class on Wednesday morning, April 29th, during the Class Breakfast Caucuses, when the Reference Committee Report with recommendations will be discussed.
Resolution 1-S15. Educating ACP Chapters on How to Engage National ACP in Local/State Issues that Impact the Patient-Physician Relationship

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP already has a "Statement of Principles on the Role of Governments in the Patient-Physician Relationship", enacted in July, 2012; and

WHEREAS, ACP's Mission and Goals include advocating for responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession, and our members; and

WHEREAS, the very basis of the confidential doctor-patient relationship is to protect and promote patient safety and care; and

WHEREAS, any legal imposition of physician speech has historically been to promote patient safety and care, such as informed consent laws, and not as a response to various political lobbying efforts; and

WHEREAS, state laws already exist which require physicians to give a type of speech (nominally for patient safety but of questionable significance and mostly due to anti-abortion lobbying efforts) to patients; and

WHEREAS, in 2011, the state of Florida passed the Firearms Owners' Privacy Act, which bars physicians from discussing firearms safety with their patients not out of a concern for patient safety but due to lobbying efforts of gun rights; and

WHEREAS, this law has been recently upheld by a federal appeals court in July 2014, which may embolden more states to pass laws based on political lobbying efforts to prohibit OR require certain types of speech given by physicians to patients; and

WHEREAS, many laws related to the doctor-patient relationship are state laws rather than federal laws; and

WHEREAS, it is national ACP's practice not to involve itself in state legislation unless specifically requested to do so by the state's ACP chapter and only when ACP has existing policy relevant to the state legislation in question, despite the fact that it is a national ACP policy to promote the sanctity of the doctor-patient relationship and the communication involved in this relationship; therefore be it

RESOLVED, that the Board of Regents educates ACP chapters on how to engage national ACP in local/state issues that impact the patient-physician relationship. This education should include resource material detailing what types of help are potentially available from national ACP and accepted procedures for chapters to contact appropriate national staff.
BACKGROUND INFORMATION

Resolution 1-S15. Educating ACP Chapters on How to Engage National ACP in Local/State Issues that Impact the Patient-Physician Relationship

RESOLVED, that the Board of Regents educates ACP chapters on how to engage national ACP in local/state issues that impact the patient-physician relationship. This education should include resource material detailing what types of help are potentially available from national ACP and accepted procedures for chapters to contact appropriate national staff.

1. PREVIOUS RELATED RESOLUTIONS:

8-S10. Reinstating the State Health Policy Networking Session at the ACP Annual Meeting, RESOLVED, that the Board of Regents enthusiastically supports the State Health Policy Networking Session as an important source of member concerns and an example of an effective advocacy program; and be it further, RESOLVED, that the Board of Regents develops forums for state health policy networking to occur.

At the April 2010 Business Meeting, the Board of Governors (BOG) recommended that the Board of Regents (BOR) adopt this resolution as amended. At their April 2010 meeting, the BOR referred Resolution 8-S10 to the Health and Public Policy Committee (HPPC) for study and report back.

The HPPC discussed Resolution 8-S10 at their May 2010 meeting and reviewed a staff memo providing background and analysis on their February 2011 webinar.

Two State Health Policy Networking Session webinars will be held in 2011 focusing on emerging policy issues that are expected to have a significant impact on the states, largely as a result of the Affordable Care Act (ACA) but not exclusive to the ACA. The topics slated for discussion during these webinars are meant to be timely in helping ACP members, and chapters specifically, understand and prepare for implementation at the state level of certain policies under the ACA that are expected to impact internal medicine physicians, their practices and patients. The webinars will function as virtual State Health Policy Networking Sessions.

The HPPC therefore recommended adoption of Resolution 8-S10 with plans to reinstate the networking sessions in the format of webinars. At their April 2011 meeting, the BOR approved the HPPC recommendation to adopt BOG Resolution 8-S10.

7-S05. Encouraging ACP Interaction with State Medical Societies, RESOLVED, that the Board of Regents explicitly authorize the HPPC and ACP Washington Office to increase communications through ACP Chapters, to share strategies, to work for common goals, and to share ACP publications dealing with health policy with state medical societies that have common objectives with ACP.

At the April 2005 Business Meeting, the BOG recommended that the BOR adopt Resolution 7-S05 as amended. The BOR adopted and referred Resolution 7-S05 to HPPC staff for implementation.

The HPPC discussed this resolution and agreed with its intent. Staff will increase efforts to improve communications with state medical societies, and HPPC and staff will seek to work more closely with state medical societies on issues where there are common objectives with ACP. During 2006-07, HPPC
and staff expect to work more closely with state medical societies on issues related to expanding access to health care, recognizing that progress on this issue is more likely to occur at the state level rather than at the national level.

12-S03. State Medical Association Advocacy, RESOLVED, that the Board of Regents facilitate the cooperation of chapters and their state medical societies to support resolutions to the AMA House of Delegates which advance the College’s agenda.

At its April 2003 Business Meeting, the BOG recommended that the BOR adopt Resolution 12-S03. At its April 2003 Organizational Meeting, the BOR adopted and referred this resolution to the HPPC for implementation.

The HPPC considered Resolution 12-S03 at its 2003-04 meetings and agreed that the best way to implement this resolution is on a selective basis. The HPPC noted that building support for the ACP/Bingaman proposal to expand access to health insurance might be a good test. However, at the Annual and Interim meetings of the AMA House of Delegates, the AMA adopted further policy focusing on tax credits for the purchase of individually owned health insurance by low-income persons to replace Medicaid and SCHIP programs. ACP worked with other medical societies (AAFP, AAP, ACOG, APA, NME, and National Hispanic Medical Association) to substitute alternative language that was more consistent with the ACP/Bingaman proposal, but this was defeated. Staff drafted another resolution for submission to the AMA to influence AMA policy. This resolution may serve as an example for resolutions that chapters could also bring to their state medical associations in accord with the intent of Resolution 12-S03.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Division of Governmental Affairs and Public Policy
ACP national has generally engaged chapters on issues that have both national and state impact and on which we have approved policy, such as our current advocacy campaigns - ACA Medicaid expansion, health insurance exchanges enrollment, and Medicaid pay parity issues. For these campaigns, we have provided both educational tools and advocacy resources to help chapters advocate on the issues.

Additionally, we have responded to specific requests from chapters (on an ad hoc basis) on state issues that come up in their state such as reviewing a bill on Managed care network adequacy, gun gag legislations, and Medicaid expansion initiatives.

To do anything significantly broader, beyond what we are currently doing, would require more resources, both financially and in terms of staff. Specifically, we do not have the resources to analyze state legislation or provide educational/advocacy resources for every state issue presented to us.

3. FINANCIAL IMPACT ESTIMATE:

- None (0-$999)
- Minimal ($1,000-$14,999)
- Moderate ($15,000 - $50,000)
- Significant ($50,000 - $100,000)
- Substantial ($100,000 or more)

What percentage of these funds is unbudgeted? ___100___ %
Resolution 2-S15. Approving Chapter Dues Collection at Time of Member Application

(Sponsor: New York Chapter)

WHEREAS, the American College of Physicians does not collect chapter dues at the time new and/or reinstated members are processed; and

WHEREAS, promoting the advantages of both national and chapter membership strengthens the College and enhances the reasons to join by adding the value of Chapter benefits; and

WHEREAS, new members must pay dues at the time of application, therefore adding chapter dues at the time of application will reinforce the value of both national and chapter membership and will eliminate what currently appears to be a dues increase in year two of their membership when chapter dues are billed; and

WHEREAS, currently membership in the Chapter is afforded to new members without the benefit of dues to support the activities for that member within his/her Chapter; therefore be it

RESOLVED, that the Board of Regents approves the collection of Chapter dues at initial and reinstated membership application.
BACKGROUND INFORMATION

Resolution 2-S15. Approving Chapter Dues Collection at Time of Member Application

RESOLVED, that the Board of Regents approves the collection of Chapter dues at initial and reinstated membership application.

1. PREVIOUS RELATED RESOLUTIONS:

13-S10. Requiring New ACP Members and Fellows to Pay Chapter and National Dues with Their First Membership Payment, RESOLVED, that the Board of Regents requires all new Members and invited or direct ACP Fellows to pay both Chapter and National dues with their first membership payment.

At the April 2010 Business Meeting, the BOG recommended that the BOR refer this resolution for study. At its April 2010 meeting, the BOR referred Resolution 13-S10 to the EVP/CEO for study and report back.

BOG Resolution 13-S10 was referred to the EVP/CEO for study and report back to the BOR. In turn, this resolution was referred to the Membership, SVP who obtained input from the Membership Management Advisory Committee.

Requiring all first year members to pay chapter dues would add significant complexity and cost to recruitment efforts, resulting in lower response rates and very likely lower overall chapter dues collections.

Because of the overall adverse financial impact on national and chapter dues collections, and the complexity and cost of implementation, it was recommended that members in their first year of Membership not pay chapter dues and that BOG Resolution 13-S10 not be adopted. The Membership Management Advisory Committee voted in support of the staff recommendation. At its July 31-August 1, 2010 meeting, the BOR approved a recommendation to not adopt Resolution 13-S10.

18-F07. Recognizing Chapter-Initiated Membership Recruitment, RESOLVED, that the Board of Regents recognizes chapter-initiated membership recruitment efforts, encourages new members to pay chapter dues, and rewards the ACP Chapter responsible for recruiting a new member with a portion of the initial national dues payment associated with each new membership.

At the September 2007 Business Meeting, the BOG recommended that the BOR adopt Resolution 18-F07 as a reaffirmation of College policy. At their October 2007 meeting, the BOR adopted Resolution 18-F07 as a reaffirmation of current College policy.

23-S07. Constituting a Task Force to Address Mechanisms that Will Provide Adequate Financial Support to Chapters, RESOLVED, that the Board of Regents immediately constitutes a task force with representation from the Board of Governors and the Board of Regents to address mechanisms by which adequate financial support be made available to ACP Chapters, such as mandatory chapter dues, payment to chapters for dues lost, designation of 25% of any future national dues increases, and/or other means to directly support ACP Chapters; and be it further RESOLVED, that this task force provides an interim report at the fall Board of Governors meeting on the impact of the recent statement change
on chapter fiscal resources; and be it further RESOLVED, that this task force provides an action plan to the Board of Governors by the spring 2008 meeting.

At the April 2007 Business Meeting, the BOG recommended that the BOR adopt Resolution 23-S07 as amended. At their April 2007 Organizational Meeting, the BOR adopted and referred Resolution 23-S07 to the Executive Committee of the Board of Regents for implementation.

At the June 2007 Executive Committee of the Board of Regents meeting, Dr. Bronson announced the formation of the BOG Resolution 23-S07 Task Force chaired by Lynne M. Kirk, MD, MACP, with the following representatives from the Board of Governors and Board of Regents: Virginia U. Collier, MD, FACP, Sara L. Rusch, MD, FACP, Frederick E. Turton, MD, MBA, FACP, and Sara L. Wallach, MD, FACP. Staff assigned to support the Task Force included: Mary Bieter, Ralph Hibbs, and James Ott.

Dr. Levine explained that the Task Force will have a broader discussion about the role of the ACP Chapters in advancing the College’s agenda. He emphasized the importance of unification of the ACP Chapters and the national ACP as part of a whole.

At the October 2007 BOR meeting, Dr. Kirk presented an Interim Report of the Resolution 23 Task Force. The BOR approved the recommendation for the implementation of mandatory chapter dues. At the July 2008 BOR meeting, the Board approved a final report with six recommendations aimed at addressing mechanisms for chapter support.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Membership Development
Requiring chapter dues at the time of initial membership enrollment will add administrative complexities and will negatively affect our member recruitment results.

The College is experiencing a number of membership challenges including limited new Member growth and high attrition rates among existing members (especially early-career internists). ACP national plans a modest $5 increase in national dues for FY 2015-16. Adding Chapter dues, which on average are $54 per year, will increase the cost of membership for newly elected members and will likely result in fewer new member elects.

- Marketing Complexity and Added Costs – Because Chapter dues differ, this change would require that different dues rates be represented in our direct marketing offers. Segmenting our membership marketing offers by Chapter would add to the complexity of these promotions and thus, would increase the costs of the campaigns. Perhaps more importantly, it would add complexity to implement the different dues rates in our standard member inquiry kits and membership applications. These collateral marketing materials are pre-printed. As such, printing and administrative costs would increase to ensure that non-members who inquire about membership receive the correct dues rate for their chapter. An alternative approach would be to send all non-member inquiries to the ACP Web site for dues information, thus adding another step to the application process.

- Introductory Dues Rates - The current member acquisition strategy being used in ACP’s national marketing campaigns is to offer special “introductory dues rates” (a minimum of a 25% discount off
the full dues rate). This provides new Members an opportunity to “sample” ACP membership at a reduced rate during their first year of membership and assess the value of ACP membership. The current policy of not requiring Chapter dues for this initial year makes this low first-year dues rate possible. If ACP national was required to reimburse Chapters for Chapter dues from first-year dues revenues then these special offers would be cost prohibitive.

- **Price Sensitivity** – Unlike national dues, Chapter dues do not account for differences in ACP membership classes. As such, early-career physicians, who now pay $235 at the time of initial election would be charged $289 (based on average chapter dues of $54). That represents 23% of their total dues, versus a full member newly elected who will now be paying $544 versus $490, where chapter dues represents 11% of their total dues. In both cases, prospective members who are price sensitive will now have an even more difficult time making the decision to join.

  Additionally, ACP elects about 2,400 new Resident/Fellow Members to full Membership each year. This is an especially price sensitive group. Renewal rates for this group are around 55%. Adding chapter dues at an average of $54 domestically, will increase their dues by 23% and would probably cause a further decline in renewal rates.

- **Recruit-a-Colleague Chapter (RaCC) Program** – The RaCC program provides a financial incentive of $100 per newly-elected member to domestic Chapters for promoting membership in their local area. This program provides chapters who are actively engaged in member recruitment an opportunity to generate revenue without requiring first-year Chapter dues from the newly elected member. Staff sees this program as a win-win as it offsets the national cost of member acquisition and still allows for a lower first-year dues rate for new members. If chapters were to receive Chapter dues at the time of election, the College would likely need to eliminate the RaCC program.

3. **FINANCIAL IMPACT ESTIMATE:**

   - None (0-$999)
   - Minimal ($1,000-$14,999)
   - Moderate ($15,000 - $50,000)
   - Significant ($50,000 - $100,000)
   - Substantial ($100,000 or more)

**Assumptions:**
- Lost revenue to ACP resulting from a decline in the number of new Members recruited due to a new member rate that jumped from $385 to $544 ($490 + $54 for average domestic chapter dues rate).
- Increased marketing costs for variable fill in direct mail and additional materials needed for the pre-printed pieces to allow for the rate differentials.
- Lost revenue resulting from fewer transitional members maintaining their membership in the College because their rate will jump from $119 in residency to $289 ($235 plus $54 chapter dues).

What percentage of these funds is unbudgeted? **100** %
Resolution 3-S15. Stopping Unnecessary Distracted Driving Deaths – Especially Newly Licensed Youth (SUDDENLY)

(Sponsor: Idaho Chapter)

WHEREAS, ACP supports investing in the nation’s public health infrastructure and promoting critical public health objectives and has clearly written policy regarding accident prevention and injury via bicycle helmets and drunk drivers of motor vehicles; and

WHEREAS, internists have the opportunity to educate adult drivers, young and old, regarding distracted driving or texting and driving; and

WHEREAS, internists likely have the opportunity to educate parents of newly licensed youth and young adults regarding the risks of distracted driving; and

WHEREAS, distracted driving from cell phone use is a major cause of morbidity and mortality, 78% of teenagers and young adults have read or sent a text message while driving; and

WHEREAS, a report from the Centers for Disease Control and Prevention claim each day, more than nine people are killed and 1,060 more are injured in crashes that involve a distracted driver. “In 2011, 3,331 people were killed in crashes involving a distracted driver, and 421,000 people were injured in 2012 in motor vehicle crashes involving a distracted driver; and

WHEREAS, only 14 states prohibit all cell phone use while driving; and drivers can claim they were dialing the phone and not texting in states where cell phone use while driving is still legal; therefore be it

RESOLVED, that the Board of Regents develops a strategy for comprehensive education for members to advocate responsible positions on individual health, particularly to young adults and parents of newly licensed youth, regarding distracted driving mortality and provide educational resources.

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BACKGROUND INFORMATION

Resolution 3-S15. Stopping Unnecessary Distracted Driving Deaths — Especially Newly Licensed Youth (SUDDENLY)

RESOLVED, that the Board of Regents develops a strategy for comprehensive education for members to advocate responsible positions on individual health, particularly to young adults and parents of newly licensed youth, regarding distracted driving mortality and provide educational resources.

1. PREVIOUS RELATED RESOLUTIONS:

29-S11. Developing a Strategic Theme to Improve the Health of the Public by Promoting Health and Preventing Disease in Populations as well as Individuals, RESOLVED, that the Board of Regents adopts a strategic theme to improve the health of the public by promoting health and preventing disease in both individuals and populations.

At the April 2011 Business Meeting, the BOG recommended that the BOR adopt Resolution 29-S11. At their April 2011 meeting, the BOR referred Resolution 29-S11 to the Executive Committee of the Board of Regents (ECBOR) for study.

At its July 2011 meeting, the ECBOR approved a recommendation that BOG Resolution 29-S11 be referred to the BOR Planning Retreat Task Force for discussion at the 2012 Strategic Planning Retreat. In January 2012, members of the BOR and invited guests (including members of the Executive Committee Board of Governors, Senior Staff, Immediate Past President and BOR Chair, and representatives from the ACP Foundation) received Resolution 29-S11 along with additional input for possible revisions to ACP’s Strategic Plan for FY 2012-13. In addition, David A. Fleming, MD, MA, FACP, Chair BOG, presented the resolution for discussion.

In consideration of Resolution 29-S11, retreat participants developed and approved Priority D as follows: “To support changes in the U.S. healthcare system and in the delivery of care that lead to better care for patients, better health for the population, and lower costs.”

At its February 14, 2012 meeting, the BOR approved ACP’s FY 2012-13 Strategic Plan, including the language for Priority D as noted above.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Health Policy and Regulatory Affairs
No relevant ACP policy.

Medical Education
ACP does not have a curriculum or educational resources on distracted teen driving and driving mortality. Other organizations have already developed excellent resources for physicians, parents, and teens. A few examples include the American Automobile Association’s program on teen driving safety, parent teen driving agreement, and teen driving safety videos. The Centers for Disease Control and
Prevention has educational materials on motor vehicle safety and specific chapters on teen drivers and distracted driving. Similar resources have been developed by the American Academy of Pediatrics.

Increasing effort in a new curricular initiative will necessarily mean decreasing staff effort and resources for existing programs and products currently under development such as MKSAP 17, Board Basics, ACP Board Prep Curriculum, and practice assessment programs for MOC.

Based upon Medical Education’s previous experience in developing an educational program of similar size and scope, the minimal cost will be $9,000. Staff physician time is estimated to be 50 hours. Digital Product Development Time is estimated to be 10 hours. Time and cost for Web Operations support, external peer review, Marketing, and Communications is not included.

3. **FINANCIAL IMPACT ESTIMATE:**

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<th>None (0-$999) Health Policy &amp; Regulatory Affairs</th>
<th>Minimal ($1,000-$14,999) Medical Education **</th>
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<td>Substantial ($100,000 or more)</td>
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What percentage of these funds is unbudgeted? 100 %

**This financial estimate is predicated on developing a curriculum and associated program materials on teen driving safety emphasizing distracted driving. The costs are informed by the developmental costs of programs of similar size and scope.
Resolution 4-S15. Advocating for Federal Approval of Environmentally Safe Controlled Substance Waste Disposal

(Sponsor: New York Chapter)

WHEREAS, current hospital practice for discarding unusable controlled substance waste varies and includes flushing down the toilet or pouring into the sink; and

WHEREAS, drugs flushed down the toilet pass unaltered through wastewater treatment plants into water tables, rivers, and lakes; and

WHEREAS, nationwide studies have found low levels of many drugs in our country’s rivers and streams; and

WHEREAS, studies have found that fish and other aquatic wildlife are adversely affected by exposure to low levels of medications demonstrating reduced fertility, sexual affects and abnormal spawning; and

WHEREAS, the Environmental Protection Agency recommends destroying unused medications by mixing them in undesirable substances like coffee grounds or kitty litter; and

WHEREAS, companies that the Bureau of Narcotics has approved for disposal of controlled substances from hospitals can only accept intact medications, and not “waste” which includes partial doses and open pills; and

WHEREAS, there is no accepted method for disposal of controlled substance waste besides flushing or pouring down the drain; and

WHEREAS, there are controlled substance drug disposal devices and systems that incinerate the waste commercially available for hospitals but are not approved by various federal entities; therefore be it

RESOLVED, that the Board of Regents advocates for federal approval of controlled substance drug disposal systems specifically designed to provide a safe and responsible method for disposing of unusable discarded controlled substance waste.

1 http://www.dec.ny.gov/chemical/45083.html
RESOLVED, that the Board of Regents advocates for federal approval of controlled substance drug disposal systems specifically designed to provide a safe and responsible method for disposing of unusable discarded controlled substance waste.

1. PREVIOUS RELATED RESOLUTIONS:

(See Resolution 3-S15 for previous related Resolution 29-S11.)

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Health Policy and Regulatory Affairs
The 2012 paper Strengthening the Public Health Infrastructure recommends “funding priority should go to programs that a review of the evidence shows have been effective in promoting the following critical public health objectives....reduce illnesses relating to environmental pollution, global climate change, and other environmental risks.”

The supporting language for the recommendation mentions pharmaceutical waste and the threat it poses to the environment:

In addition, there have been reports of traces of pharmaceuticals in drinking water in the U.S. In 2002, the U.S. Geological Survey (USGS) documented the presence of pharmaceuticals and metabolites of medications in many of the nation’s streams. USGS also found that some of these pharmaceutical contaminants survived the water treatment process and were present in drinking water supplies. Researchers have found ill effects in fish and other aquatic animals, although the human health impact is still unknown. Pharmaceutical contamination of our waters can be prevented through proper disposal of pharmaceuticals. In 2007, guidelines for disposing of prescription drug products were issued by the White House Office of National Drug Control Policy (ONDCP).

3. FINANCIAL IMPACT ESTIMATE:

X  None (0-$999)
_____ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
_____ Substantial ($100,000 or more)

What percentage of these funds is unbudgeted? __100__ %
Resolution 5-S15. Limiting the Use of the Pain Scale to Support a Move Away from Excessive Narcotic Prescribing

(Sponsor: Maine Chapter)

WHEREAS, there is an epidemic of narcotic abuse in the USA; and

WHEREAS, the rate of death from drug overdoses has more than doubled in the last 15 years; and

WHEREAS, narcotics are of questionable benefit for chronic non-cancer pain and frequently lead to addiction; and

WHEREAS, the pain scale was created when the dangers of drug addiction were less well appreciated; and

WHEREAS, a higher number on the pain scale can often be misinterpreted by patients, clinicians and insurers as a mandate for increased intensity of opiate prescribing; and

WHEREAS, it is better to focus patients with chronic non-cancer pain on improving functional status rather than on pain and limitations; and

WHEREAS, the Board of Regents supports a national standard of rational use of opioid narcotics and that the decision to prescribe narcotics should be evidence-based and remain that of the practitioner after complete assessment of the patient. (04 F11); therefore be it

RESOLVED, that the Board of Regents will work toward limiting the use of pain scales in outpatient medicine except in post-operative settings and hospice care; and be it further

RESOLVED, that the Board of Regents discuss the pain scale issue with the Joint Commission and the Centers for Medicaid and Medicare Services (CMS) and encourage them to base chronic non-cancer pain treatment on maximizing function.
BACKGROUND INFORMATION

Resolution 5-S15. Limiting the Use of the Pain Scale to Support a Move Away from Excessive Narcotic Prescribing

RESOLVED, that the Board of Regents will work toward limiting the use of pain scales in outpatient medicine except in post-operative settings and hospice care; and be it further

RESOLVED, that the Board of Regents discuss the pain scale issue with the Joint Commission and the Centers for Medicaid and Medicare Services (CMS) and encourage them to base chronic non-cancer pain treatment on maximizing function.

1. PREVIOUS RELATED RESOLUTIONS:

4-F11. Providing Educational Programs and Specific Guidelines for Outpatient Pain, Management, and Supporting a National Standard of Rational Use, RESOLVED, that the Board of Regents provides education and guidelines for outpatient pain management; and be it further RESOLVED, that the Board of Regents supports a national standard of rational use of opioid narcotics. The decision to prescribe narcotics should be evidence-based and remain that of the practitioner after complete assessment of the patient.

At the September 2011 Business Meeting, the BOG recommended that the BOR adopt Resolution 4-F11 as amended. At its November meeting, the BOR adopted and referred Resolution 4–F11 to the Clinical Guidelines Committee for implementation.

The Clinical Guidelines Committee (CGC) discussed the BOG resolution during the February and June 2012 meetings. The CGC discussed the possibility of developing a guideline or a guidance statement on opioid use, and committee members recognized that although it is an important issue for ACP membership, the evidence in the field may be lacking. CGC reviewed the list of current guidelines on opioid treatments and effects, and noted that most of the guidelines are out of date. The evidence for recommendations is often low quality because there are limited data from randomized controlled trials, although there is some evidence on high-dosage based on epidemiologic data and limited evidence about benefits.

The CGC is also aware of considerable interest in the topic at the Federal level and there is a possibility that the Centers for Disease Control (CDC) may develop a systematic review. CDC contacted Dr. Qaseem regarding a survey that they would like to conduct of ACP members on their needs related to this topic but no plans for a systematic review at this point. CGC felt that the needs survey would provide a focus and a good first step before a full systematic evidence review. Once completed, the next step would be for either an external organization to complete an evidence review of this topic or ACP to commission a systematic review out of its operational funds that CGC can use to develop a guideline.

The costs of a systematic review are substantial and range from $100,000 to $300,000. The final costs will be dependent on the scope of the project and the questions that the Clinical Guidelines Committee will decide to address in the evidence report based on the results of the CDC survey. The timeline of this project is dependent on when CDC conducts the survey followed by ACP's nomination of the topic.
to Agency for Healthcare Research and Quality (AHRQ) for a possible evidence review to reduce the cost burden for ACP. This will take a minimum of 12 months. Regardless of whether AHRQ accepts or rejects the topic, it will take another 24 to 36 months before the completion of the evidence review followed by a guideline.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Clinical Policy Department
ACP does not currently have an active guideline that addresses the use of pain scales in outpatient care. ACP develops all guidelines based on systematic evidence reviews, and would need to commission a review on this topic in order to develop a guideline. The cost of the evidence review would be approximately $300,000.

Health Policy and Regulatory Affairs Department
ACP currently has a policy on Prescription Drug Abuse that recommends consideration of various treatments for the management of pain, and is consistent with the resolution. However, ACP’s SmartMedicine recommends using pain scales to screen older patients and those with cancer or other chronic conditions for pain at every visit, which can be viewed as conflicting with this resolution. An evidence review and related evidence-based clinical guideline that supports the reduction in use of pain scales would be needed to support the resolution.

We are unaware of CMS promoting the use of pain scales, and generally CMS is not prescriptive on procedures physicians employ in addressing symptoms. The Joint Commission has encouraged the use of pain scales in the past to better recognize and address patient pain.

3. FINANCIAL IMPACT ESTIMATE:

  X None (0-$999) Health Policy & Regulatory Affairs
  _____ Minimal ($1,000-$14,999)
  _____ Moderate ($15,000 - $50,000)
  _____ Significant ($50,000 - $100,000)
  X Substantial ($100,000 or more) Clinical Policy Department

What percentage of these funds is unbudgeted? ____100__ %
Resolution 6-S15. Advocating for Health Research and Services Administration Designation of Individuals with Intellectual and Developmental Disabilities as a Medically Underserved Population

(Sponsor: Texas Chapter; Co-Sponsor: Oregon Chapter)

WHEREAS, the American College of Physicians is committed to advocating for increased access to quality health care for all, regardless of race, ethnicity, socioeconomic status or other factors¹; and

WHEREAS, intellectual and developmental disabilities affect up to 3% of people in the United States²; and

WHEREAS, persons with intellectual and developmental disabilities are less likely to receive adequate medical care than the general population despite their increased burden of chronic health problems and shortened life expectancy³; and

WHEREAS, the federal government defines "medically underserved populations" according to a formula that weights a population's lack of primary care providers, its experience with poverty and increased infant mortality and its percentage of people age 65 and older and then applies that result to a population within a defined geographic area⁴ ⁵; and

WHEREAS, persons with intellectual and developmental disabilities are not limited to particular geographic areas; and

WHEREAS, few physicians have had formal training regarding the specific needs of this population or may not possess the comfort level required to treat people with intellectual and developmental disabilities and only 25% of medical schools include content regarding people with such disabilities in their curricula⁶; and

WHEREAS, training and increased familiarity with individuals with disabilities leads to favorable outcomes of greater confidence and willingness to provide care; therefore be it

RESOLVED, that the Board of Regents advocates for HRSA to include persons with intellectual and developmental disabilities as medically underserved populations; and be it further

RESOLVED, that the Board of Regents encourages medical schools and graduate medical education programs to include disability-related competencies and objectives in their curricula.

¹ Racial and ethnic disparities in health care: a summary of a position paper approved by the American College of Physicians Board of Regents April, 2010.
⁵ Section 330 of the Public Health Service Act. 42 USC § 254b(b)(3)(A)2010.
Additional references:

**Intellectual Disability (Intellectual Developmental Disorder)**

Intellectual disability involves impairment of general mental abilities that impact adaptive function in three domains. These domains determine how well an individual copes with everyday tasks.

- Conceptual domain includes skills in language, reading, writing, math, reasoning, knowledge and memory
- Social domain refers to empathy, social judgement, interpersonal communication, ability to make and retain friendships
- Practical domain centers on self-management in areas such as personal care, job responsibilities, money management, recreation, organizing school and work tasks.

Symptoms begin during the developmental period and are diagnosed based on severity of deficits in adaptive function.

*Source: American Psychiatric Association*

**Developmental Disability**

The current definition under the DD Act defines “developmental disability” as a severe, chronic disability of an individual that:

(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(ii) is manifested before the individual attains age 22;
(iii) is likely to continue indefinitely;
(iv) results in substantial functional limitations in 3 or more of the following areas of major life activity:
   (I) Self-care.
   (II) Receptive and expressive language.
   (III) Learning.
   (IV) Mobility.
   (V) Self-direction.
   (VI) Capacity for independent living.
   (VII) Economic self-sufficiency; and
(v) reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

*Source: Title 42 U.S. Code § 15001 Section 102 (8).*

American Medical Association House of Delegates Policy H-90.968 Medical care of persons with developmental disabilities.

BACKGROUND INFORMATION

Resolution 6-S15. Advocating for Health Research and Services Administration Designation of Individuals with Intellectual and Developmental Disabilities as a Medically Underserved Population

RESOLVED, that the Board of Regents advocates for HRSA to include persons with intellectual and developmental disabilities as medically underserved populations; and be it further

RESOLVED, that the Board of Regents encourages medical schools and graduate medical education programs to include disability-related competencies and objectives in their curricula.

1. PREVIOUS RELATED RESOLUTIONS:

9-F06. Developing Alliances that Facilitate a Linkage between Medical Education and Care for the Medically Underserved

RESOLVED, that the Board of Regents work with the Association of American Medical Colleges (AAMC) and other organizations to encourage medical schools’ leadership in developing alliances that facilitate a linkage between medical education and care for the underserved, thereby creating a program with the potential of 1) enhancing our students’ interests in primary care, 2) expanding ambulatory clinical training for our increasing enrollment of medical students and 3) expanding cost effective access to primary care for Medicaid and uninsured patients.

At the October 2006 Business Meeting, the BOG recommended that the BOR adopt this resolution as amended. At their October 2006 meeting, the BOR adopted and referred Resolution 9–F06 to the Education Committee for implementation with input from the Health and Public Policy Committee.

ACP as part of its published Position Paper on Redesigning Training for Internal Medicine (Ann Intern Med. 2006; 144:927-932), called for significant changes in ambulatory education. These changes include an increase in the relative proportion of time spent in the ambulatory environment during residency training, as well as a change in the structure of ambulatory training to maximize the value for trainees and facilitate the greatest satisfaction with their ambulatory training experience. Although not explicitly stated in the Position Paper, an important component of ambulatory redesign is the opportunity for trainees to practice in a variety of ambulatory settings, including healthcare settings for underserved patient populations.

In addition, as part of one of the ACP’s background position papers that served as the foundation for this summary published paper, ACP advocated for increases in the quality and quantity of ambulatory training experiences for medical students. An understanding of the satisfactions of longitudinal ambulatory care of patients with complex and chronic illness(es) is important for both medical students and residents, particularly as we attempt to reverse the trend of decreasing numbers of students entering general internal medicine and planning to practice in general ambulatory practice settings.

In June 2007, the College supported the Minority Health Improvement and Disparity Elimination Act, a bill that would enhance cultural competency training for health care providers, provide grants for the improvement of health care access and outreach to underserved populations, and reauthorize the
Health Research Services Administration health professions training program under Title VII of the Public Health Service Act.

The College continues to support legislation that would expand access to health care for the uninsured. The Health CARE Act, which is based on the College’s Seven Year Plan to Expand Access to All Americans was reintroduced in the 110th Congress. The College has also supported legislation that calls for state experimentation with access to care including the State-Based Health Care Reform Act introduced in May 2007. The Health and Public Policy Committee has developed a white paper in support of state experimentation with access to care that the Board of Regents approved in July 2007.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Center for Ethics and Professionalism
The Ethics, Professionalism and Human Rights Committee (EPHRC) has published a case study entitled “Preventive Health Screening, Ethics and the Cognitively Impaired Patient” that addresses the ethical challenges of treating the increasing number of cognitively impaired patients. In particular, the case study states that “Physicians have a duty to not exclude persons with cognitive disabilities from their practices and should become familiar with the medical needs of this population of patients.” EPHRC recognizes that there is an increasing number of individuals with cognitive disabilities living in the community, and the case study states that “physicians have a shared responsibility not to exclude patients with intellectual disabilities from their practices but to accept these persons as patients and to be knowledgeable about their needs and treatment.”

The Ethics Manual states that physicians have an obligation and duty to treat all persons, and the “denial of appropriate care to a class of patients for any reason is unethical.” Physicians must “work toward ensuring access to health care for all persons; act to eliminate discrimination in health care; and help correct deficiencies in the availability, accessibility, and quality of health services, including mental health services, in the community.”

Health Policy and Regulatory Affairs
The College does not have policy on criteria for HRSA designations, including Medically Underserved Populations.

The College does not have policy on health care for individuals with intellectual disabilities specifically, but supports high quality care for all patients, regardless of a variety of factors including disability in general.

From ACP position paper Eliminating Racial and Ethnic Disparities in Health Care:
2. All patients, regardless of race, ethnic origin, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion, deserve high quality health care.

Medical Education
The Residency Review Committee-Internal Medicine has developed guidelines regarding the inclusion of disability-related competencies and objectives into training program curricula:

The accreditation standards for internal medicine IV.A.5.f) Professionalism Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)
Residents are expected to demonstrate:

V.A.5.f.(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

This accreditation guideline is reflected in milestone 18:

Responds to each patient’s unique characteristics and needs (Prof3)
Recognizes and accounts for the unique characteristics and needs of the patient/caregiver.
 Appropriately modifies the care plan to account for a patient’s unique characteristics and needs.

Below is the result of an American Association of Medical Colleges survey of accredited medical schools that include the topic of rehabilitation/care of the disabled in required and elective courses. There are 141 accredited medical schools. For the 2013-2014 survey year, 140 responded to the survey and 132 schools indicated that they include the topic in either a required or elective course.

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Number of Medical Schools Including Topic in Required Courses and Elective Courses

Please select a topic: Rehabilitation/Care of the D

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<thead>
<tr>
<th>Year</th>
<th>Required Course</th>
<th>Elective Course</th>
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<tr>
<td>2011-2012</td>
<td>116</td>
<td>75</td>
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<tr>
<td>N = 134</td>
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<tr>
<td>2012-2013</td>
<td>126</td>
<td>84</td>
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<tr>
<td>N = 136</td>
<td></td>
<td></td>
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<tr>
<td>2013-2014</td>
<td>126</td>
<td>86</td>
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<tr>
<td>N = 140</td>
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Survey Items: Check the topics listed below that are included in the curriculum as part of a required course and/or an elective course. 

n indicates the total number of medical schools that included the topic in either a required or elective course in the given academic year.

N indicates the total number of medical schools that participated in the survey for the given academic year.

3. **FINANCIAL IMPACT ESTIMATE:**

   - [ ] None (0-$999) Ethics; Health Policy & Regulatory Affairs; Medical Education
   - [X] Minimal ($1,000-$14,999)
   - [ ] Moderate ($15,000 - $50,000)
   - [ ] Significant ($50,000 - $100,000)
   - [ ] Substantial ($100,000 or more)

What percentage of these funds is unbudgeted? 100%
Resolution 7-S15. Studying the Economic Viability of Rural Sole Community Hospitals

(Sponsor: New Mexico Chapter)

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) has developed a complex definition for a hospital to be designated as a Sole Community Hospital (SCH)\(^1\), primarily applicable to small rural hospitals that are located at least 25 miles from any similar facility; and

WHEREAS, SCHs have their own payment schedule under CMS\(^1,2\), including occupancy based adjustments that are theoretically designed to help maintain the economic viability of SCHs; and

WHEREAS, some hospitals that were formerly classified as Essential Access Community Hospitals have now been re-designated for payment purposes as SCHs; and

WHEREAS, many rural hospitals designated as SCHs have had to reduce the services they offer because of reduced funding and increased costs; and

WHEREAS, failures of Congress and CMS to enact laws and regulations that would provide increased financial stability and predictability have led to great concern about the possibility of further decreases in funding while costs continue to increase, and have greatly compromised the ability of SCHs to make rational planning decisions; and

WHEREAS, the loss of services provided by SCHs will likely prove devastating to the health care systems and the patients served by these facilities in many states but most especially in poor rural states; therefore be it

RESOLVED, that the Board of Regents advocates that MedPAC or a similar federal entity studies the complex economic factors that threaten the viability of Sole Community Hospitals.

References:
\(^1\) Sole Community Hospital, Rural Health Fact Sheet Series, Department of Health and Human Services, Centers for Medicare & Medicaid Services, \[https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SoleCommHospfctsht508-09.pdf\]
\(^2\) Summary of Medicare’s special payment provisions for rural providers and criteria for qualification, MEDPAC, \[http://www.medpac.gov/publications/congressional_reports/Jun01_AppB.pdf\]
BACKGROUND INFORMATION

Resolution 7-S15. Studying the Economic Viability of Rural Sole Community Hospitals

RESOLVED, that the Board of Regents advocates that MedPAC or a similar federal entity studies the complex economic factors that threaten the viability of Sole Community Hospitals.

1. PREVIOUS RELATED RESOLUTIONS:

15-F02. Eliminating Geographic Inequities in Medicare Payments, RESOLVED, that the Board of Regents support legislation and/or regulation that seeks to resolve the Medicare geographic inequities in physician payments, particularly those in rural states, which threaten the ability of internists to continue to serve the elderly.

At its September 2002 Business Meeting, the BOG recommended that the BOR adopt Resolution 15-F02. At its October 2002 meeting, the BOR adopted Resolution 15-F02 and referred it to the Medical Service Committee for implementation.

The Medical Service Committee (MSC) determined that American Medical Association (AMA) policy supports rather than opposes geographic pay differentials. The MSC also reviewed bills addressing this resolution before the U.S. Congress and determined that the bills which best addressed College concerns and most deserved College support were Senator Bingaman’s S.881, and its parallel House bill, Representative Bereuter’s H.R. 33. The College has formally endorsed this legislation, which raise the physician work geographic factor for rural physician payments, without diminishing the rates paid to physicians above the current national average.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Health Policy and Regulatory Affairs
The College does not have specific policy on Sole Community Hospitals. The College has the following broader policy that includes rural hospitals:

Support for the Health Care Infrastructure
National legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations, and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. Such legislation should also include sufficient and continuing federal funding for special programs, including the National Health Service Corps, to enhance the recruitment and retention of physicians for practice in underserved areas. (ACP AMA Del A-94; reaffirmed BoR 04)
3. **FINANCIAL IMPACT ESTIMATE:**

   - x  None (0-$999)
   -  Minimal ($1,000-$14,999)
   -  Moderate ($15,000 - $50,000)
   -  Significant ($50,000 - $100,000)
   -  Substantial ($100,000 or more)

   What percentage of these funds is unbudgeted? ___100___ %
Resolution 8-S15. Eliminating CMS Penalties for Not Using Certified Electronic Medical Records (EMRs)

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP is committed to supporting internists in providing high quality and compassionate medical care to their patients; and

WHEREAS, ACP's Mission and Goals include serving the professional needs of the membership, supporting healthy lives for physicians, and advancing internal medicine as a career which means helping clinicians be successful in maintaining their medical practices; and

WHEREAS, there is little (if any) high quality research or other evidence associating the use of currently available certified EMRs to higher quality more cost effective medical care (a goal of the ACP); and

WHEREAS, the cost of implementing and maintaining certified EMRs is a significant burden for internists in small and medium sized practices; and

WHEREAS, CMS is beginning to penalize internists not using certified EMRs; and

WHEREAS, CMS is planning to prohibit internists not using certified EMRs from receiving the new Chronic Care Management payments even when these internists provide high quality chronic care management to their patients; and

WHEREAS, these actions by CMS will make it increasingly difficult for internists in small and medium sized practices to maintain their practices and provide care for their Medicare patients; therefore be it

RESOLVED, that the Board of Regents calls upon CMS to indefinitely eliminate penalties on internists not using certified EMRs until there is strong research based evidence demonstrating that the use of certified EMRs results in superior quality and cost effectiveness in clinical care; and be it further

RESOLVED, that the Board of Regents calls upon CMS to award Chronic Care Management payments to internists who provide chronic care management regardless of whether or not they are using certified EMRs.
BACKGROUND INFORMATION

Resolution 8-S15. Eliminating CMS Penalties for Not Using Certified Electronic Medical Records (EMRs)

RESOLVED, that the Board of Regents calls upon CMS to indefinitely eliminate penalties on internists not using certified EMRs until there is strong research based evidence demonstrating that the use of certified EMRs results in superior quality and cost effectiveness in clinical care; and be it further

RESOLVED, that the Board of Regents calls upon CMS to award Chronic Care Management payments to internists who provide chronic care management regardless of whether or not they are using certified EMRs.

1. PREVIOUS RELATED RESOLUTIONS:

6-F11. Encouraging Further Research into the Added Burdens and Decreased Productivity that EMRs Have on a Physician’s Practice
RESOLVED, that the Board of Regents encourages continual assessment and further research into improving the usability, functionality and workflow efficiencies of incorporating electronic health records (EHR) into medical practice to include patient, physician, trainee, and other healthcare professional satisfaction; and be it further
RESOLVED, that the Board of Regents encourages continual assessment and research to include estimates of the direct cost of implementing and updating EHR technology, including conversion of ICD codes both current and future, and the indirect costs (or savings) from the resulting changes in practice (e.g., staffing, facility, productivity); and be it further
RESOLVED, that the Board of Regents communicates on behalf of ACP members on the impact of EHR implementation on productivity to vendors, government regulators, payors and physician employers.

At the September 2011 Business Meeting, the BOG recommended that the BOR adopt Resolution 6-F11 as amended. At its November 2011 meeting, the BOR adopted and referred Resolution 6–F11 to the Medical Informatics Committee for implementation.

The first Resolved calls for “…continual assessment and further research into improving the usability, functionality and workflow efficiencies...” ACP continues to invest a considerable amount of time and energy into AmericanEHR Partners (www.americanehr.com). The program, initiated in July 2010 in collaboration with Cientis Technologies, Inc., now has almost 15,000 registered users in over 12,000 practices. Surveys from over 3,000 validated physicians have already been completed and new surveys are being collected from AAFP and AMA members. On the basis of these data, AmericanEHR provides free, readily accessible data and ratings about EHRs in 12 major categories:

1. Satisfaction
2. Overall Usability
3. Prescribing
4. Workflow Management
5. Order Management
6. Population Management
7. Implementation Experience
8. Training
9. Support Experience
10. Interfaces
11. Billing
12. Purchase Experience

These ratings and results are continuously updated based on new survey data. Further, the ratings can now be filtered by size of practice so that users can see ratings from practices of a similar size.

- The Correlation of Training Duration with EHR Satisfaction: Implications for Meaningful Use Market Share and,
- Top 10 Rated Ambulatory Products by Practice Size

AmericanEHR Partners (ACP and Cientis Technologies) are currently working on a study commissioned by Doctors Helping Doctors Transform Healthcare (DHDTH), to access clinician needs related to the electronic exchange of patient health information across different settings to support the delivery of high-quality, cost-conscious care. The results of the study will be used to help inform both the College’s advocacy activities as well as those of DHDTH and the Bipartisan Policy Center, a non-profit organization founded by former U.S. Senate Majority Leaders. The results of the survey will be released on October 3, 2012, as part of the report being issued by the Bipartisan Policy Center on the use of health IT to support high quality, coordinated, patient-centered care. We hope that the results of the survey will help ensure that the rapidly emerging policies and market actions surrounding health information exchange reflect the needs of physicians and their patients.

The second Resolved calls for “…continual assessment and research to include estimates of the direct cost of implementing and updating EHR technology, including conversion of ICD codes both current and future, and the indirect costs (or savings) from the resulting changes in practice.” Given current staffing, funding limitations, and the complexity of these types of analyses, ACP is not currently able to assess the direct/indirect costs (or savings). Ample research is being conducted by others in this area as noted by articles in Health Affairs and other policy and health IT-related journals.

ACP and key ACP experts are involved in many committees, meetings, Federal Advisory Committees and roundtables where our policy provides the opportunity to influence debate and decisions. For example, in December 2011, ACP members participated in a two-day meeting on this topic organized by the American Medical Informatics Association (AMIA). The title of the invitation-only meeting was "The Future State of Clinical Documentation and Data Capture." A white paper summarizing the results of the meeting and suggesting directions for future work will be published online shortly. ACP staff has been in ongoing discussion with AMIA staff to try to leverage this work into future public policy activities aimed at improving the usability of clinical systems and documentation.

The third Resolved asks the Board of Regents to communicate the impact of EHRs on practice. The ACP Medical Informatics Committee has spent (and will continue to spend) a considerable amount of time reviewing/analyzing/commenting on meaningful use proposed rules on behalf of ACP members to advocate for reasonable practice expectations and appropriate EHR certification criteria. For both Stage 1 and Stage 2 of Meaningful Use, the committee has submitted voluminous comments solicited from
not only committee members but for Stage 2 comments, a working group comprised of volunteer physicians and staff accessed by the Center for Practice Improvement & Innovation.

The following are recent examples of the comments/letters submitted:

- ACP Comments to CMS on the Stage 2 Meaningful Use NPRM (7-May-12)
- ACP Comments to ONC on the Stage 2 Meaningful Use NPRM (7-May-12)
- Medical Informatics Committee letter to the Office of the National Coordinator regarding concerns with Stage 2 Meaningful Use requirements (12-Jan-12)
- ACP Comments Concerning ONC Metadata ANPRM (8-Sept-11)
- ACP Comments on Proposed Rule - HIPAA Accounting of Disclosures - July 2011 (26-July-11)
- ACP Testimony to the Health Information Technology Committee Quality Measurement Work Group (May 19, 2011)
- ACP comments on the NQF eMeasure specifications (April 1, 2011)
- Joint Letter to ONC on Health Information Technology Policy Committee's and Meaningful Use of Electronic Health Records (February 28, 2011)
- ACP Comments on the Health Information Technology Policy Committee's proposed Meaningful Use Stage 2 and 3 objectives and measures (Feb 25, 2011) Letter to Office of the National Coordinator for Health Information Technology

With respect to ICD-10, ACP submitted the following letters:

- ACP comments to HHS regarding proposed delay of compliance date for ICD-10 (17-May-12)
- ACP Letter to Secretary Sebelius - ICD-10 Delay (5-Apr-12)

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Health Policy and Regulatory Affairs

The College has consistently supported the use of EHRs, but has offered substantial comment regarding the implementation of the Meaningful Use program. Since non-certified EHRs are of unknown quality and functionality, the College has, in general, supported the certification program and recommended the use of certified EHRs.

Policy Regarding the EHR Incentive Program

- The final rule should specify in greater detail that the definition of meaningful use was created for an incentive program and as such certified EHR technology may not meet all the needs of a practice. The Certification Commission for Health Information Technology (CCHIT) did try to assess such functionality and usability in practice. Future iterations of meaningful use should include such features. [Letter to ONC – March 10, 2010]

- Physicians are diligently working towards incorporating well-developed EHRs into their practices to improve quality of care delivery, enhance patient safety, as well as support practice efficiencies. Inflexible, overly ambitious incentive program requirements will only hinder health IT transitions underway today. Promoting greater flexibility to meet meaningful use requirements will help us achieve the desired outcome for the Medicare/Medicaid EHR incentives—accelerating the widespread use of technology to improve our nation’s health care delivery system.
We strongly recommend that many of the measures for Stage 2 include an exclusion option so that a physician can opt out of the measure if the measure has little relevance to the physician’s routine practice. [Letter to ONC - Feb. 25, 2011]

- ACP has been deeply involved in the national policy issues surrounding the use of health information technology to facilitate effective clinical data sharing—including the EHR Incentive Program as initiated with the HITECH act. In our most recent comments on the notice of proposed rulemaking from both 10 CMS11 and ONC12 on Stage 2 Meaningful Use, we highlighted our support of the government’s vision to use EHRs and health IT to improve care, but believe that more needs to be done to align the measures across all of the initiatives currently underway including CMS PQRS and e-prescribing programs. While CMS has made strides in aligning the measures, at a high level the technical requirements in each of the programs are different enough that dual processes must be undertaken. We are also concerned about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, ePrescribing Incentive Program, and Physician Quality Reporting System (PQRS) by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear. [Statement for the Record – July 18, 2012]

- Increased Need to Prioritize EHR Usability within the Certification Process --- The EHR as a clinical tool has great potential to assure that the physician has the appropriate information available for patient care and to assist in the coordination of patient care across different physicians and even different systems. The American Medical Association (AMA) recently commissioned a study of physician satisfaction performed by the RAND Corporation. One of the findings is that physicians are highly dissatisfied with the usability of EHR systems. The lack of usability and the resulting disruption of the workflow in the office is a major source of physician dissatisfaction. The lack of usability is a major barrier to physicians effectively using the EHRs and as a result is a major barrier to the clinical benefits of the EHR. We strongly encourage the ONC to prioritize expanded usability requirements within the EHR system certification process. [Letter to HHS, CMS, and ONC – Feb. 3, 2014]

Related General Policy on Incentive Programs

Position 2: To the extent that payment and delivery reforms include financial rewards and/or penalties linked to performance, the reward framework (i.e., type and magnitude of incentives) should be incorporated into systems-based payment reforms designed to permit and facilitate broad-scale positive behavior change and achievement of performance goals within targeted time periods. Potential rewards should be:

- Significant enough to drive desired behaviors and support continuous quality improvement;
- Reflective of the cost and other resources needed to participate in a performance assessment-based payment program, including the cost to measure and design improvements that will take, for example, system supports and program management;
- Balanced between rewarding high performance and rewarding substantial improvement over time;
- Graduated to create stronger incentives for physicians to participate in performance improvement programs and to ensure that a physician’s level of commitment to quality improvement activities is recognized;
- Directed at positive rather than negative rewards;
- Timely and followed closely upon the achievement of performance;
- Designed to encourage physicians and health care systems to care for vulnerable patients with complex health care needs, reflect the level of care required, and avoid adverse, unintended consequences resulting from performance assessment-based payment program implementation; and
- Adjusted as the complexity of performance measure requirements change.

(Use of Incentives to Promote Quality of Care, BoR 2011)

3. **FINANCIAL IMPACT ESTIMATE:**

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<tr>
<th></th>
<th>None (0-$999)</th>
<th>Minimal ($1,000-$14,999)</th>
<th>Moderate ($15,000 - $50,000)</th>
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What percentage of these funds is unbudgeted? _100_ %
Resolution 9-S15. Introducing Legislation to Ensure Immunity from Federal Prosecution for Marijuana-Prescribing Physicians

(Sponsor: New York Chapter)

WHEREAS, as of July 2014 more than 20 states have enacted some form of law permitting medical marijuana. The NY law, also known as the Compassionate Care Act, is carefully crafted and allows only doctors who have completed a special course and have registered with the health department to prescribe marijuana for patients who have any of a list of “Serious Conditions” or complications of one of the aforementioned “Serious Conditions.”; and

WHEREAS, although prescribing medical marijuana may be legal in a given state, marijuana remains illegal under the federal Controlled Substances Act; and

WHEREAS, the United States Department of Justice (“USDOJ”) has issued sometimes conflicting guidance on state laws allowing medical marijuana; and

WHEREAS, such guidance from USDOJ as the 2013 notification to attorneys indicated that enforcement of state law by state and local law enforcement and regulatory bodies should remain the primary (but not sole) means of addressing marijuana-related activity; and

WHEREAS, the USDOJ could change its position at any point in the future; and

WHEREAS, notwithstanding any position taken by the USDOJ, the status of marijuana under federal law is determined by Congress and not the USDOJ; and

WHEREAS, physicians who prescribe or dispense marijuana pursuant to their state’s law may nonetheless be subject to criminal prosecution under federal law; therefore be it

RESOLVED, that the Board of Regents introduces legislation ensuring or providing immunity against federal prosecution for physicians who prescribe marijuana in accordance with their state’s laws.
BACKGROUND INFORMATION

Resolution 9-S15. Introducing Legislation to Ensure Immunity from Federal Prosecution for Marijuana-Prescribing Physicians

RESOLVED, that the Board of Regents introduces legislation ensuring or providing immunity against federal prosecution for physicians who prescribe marijuana in accordance with their state’s laws.

1. PREVIOUS RELATED RESOLUTIONS:

14-S07. Supporting Research into the Therapeutic Role of Marijuana, RESOLVED, that the Board of Regents support scientifically rigorous research into the potential therapeutic role of marijuana; and be it further RESOLVED, that the Board of Regents urge the Federal government to enforce current policy that requires the National Institute on Drug Abuse to provide research-grade marijuana to entities who wish to conduct FDA-approved clinical trials on the therapeutic role of marijuana; and be it further RESOLVED, that the Board of Regents adopt policy that affirms that in states where patients are permitted to use marijuana to treat serious and/or chronic illnesses, and a patient’s physician has prescribed its use in accordance with state law and medical practice standards, neither the physician nor the patient should be subject to Federal criminal penalties; and be it further RESOLVED, that the Board of Regents’ position on medical marijuana research, treatment and legal exposure be referred to the American Medical Association for further action.

At the April 2007 Business Meeting, the BOG recommended that the BOR adopt Resolution 14-S07 as amended. At their April 2007 Organizational Meeting, the BOR referred Resolution 14-S07 to the Health and Public Policy Committee (HPPC) for study and report back with input from the Education Committee.

The HPPC reviewed Resolution 14-S07 at its May meeting and found that ACP supports the 1st and 2nd resolves, and directed staff to research existing policy and report back regarding the others. A background memo was prepared for the September HPPC meeting. HPPC reviewed the memo and asked staff to also examine an existing IOM report and available research on comparative effectiveness.

A policy monograph was then prepared and approved by HPPC for posting on the GIC for comment. The final paper was submitted and approved at the January 2008 BOR meeting.

In response to extensive comments on the paper, an Addendum was prepared to clarify the College’s positions, particularly regarding the recommendation to review the classification of marijuana as a Schedule I Controlled Substance. The BOR approved the Addendum in July 2008.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Health Policy and Regulatory Affairs
ACP’s 2008 position paper Supporting Research into the Therapeutic Role of Marijuana included policy explicitly stating the College believes physicians and patients should not be criminally or civilly
prosecuted or penalized by federal authorities for dispensing or using medical marijuana in accordance with state law:

ACP strongly supports exemption from federal criminal prosecution; civil liability; or professional sanctioning, such as loss of licensure or credentialing, for physicians who prescribe or dispense medical marijuana in accordance with state law. Similarly, ACP strongly urges protection from criminal or civil penalties for patients who use medical marijuana as permitted under state laws.

As of December 2014, federal regulations effectively prohibit the Department of Justice (DOJ) from enforcing federal marijuana laws against individuals legally dispensing or using medical marijuana under state law. An amendment included in the Consolidated and Further Continuing Appropriations Act, 2015, by Rep. Dana Rohrabacher (CA) blocks the DOJ from using any funds to prevent states where medical marijuana is legal from “implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana.” A rider to the bill preventing any funds from enacting “any law, rule, or regulation to legalize or otherwise reduce penalties associated with the possession, use, or distribution of any schedule I substance...” is targeted to recreational marijuana legalization in the District of Columbia and is not in conflict with the Rohrabacher amendment.

3. **FINANCIAL IMPACT ESTIMATE:**

   X  None (0-$999)
   ____ Minimal ($1,000-$14,999)
   ____ Moderate ($15,000 - $50,000)
   ____ Significant ($50,000 - $100,000)
   ____ Substantial ($100,000 or more)

What percentage of these funds is unbudgeted? __100__ %
Resolution 10-S15. Raising Awareness about the Transition of Care from Pediatric to Adult Health Care through ACP Educational Sessions, Electronic Publications, and Chapter Outreach

(Sponsor: District of Columbia Chapter)

WHEREAS, ACP, in position papers such as "The Health Care Needs of the Adolescent" *(Annals of Internal Medicine, 1989)* and in its coauthoring of the "Transition Clinical Report, Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home" *(2011)* has expressed support for efforts to improve health care provided to adolescents and young adults; and

WHEREAS, ACP’s Mission and Goals include being the premier provider of education and information for internists and their health care team; and

WHEREAS, there is an estimated 18 million adolescents (ages 18-21), of whom one quarter have chronic illness and disabilities, and many millions of young adults (ages 21-26) who must transition from pediatric to adult-centered care; and

WHEREAS, the majority of youth/young adults are ill-prepared for this change and gaps in care are common resulting in poorer outcomes, increased costs, and dissatisfaction with care; and

WHEREAS, surveys of health care professionals consistently show that health care professionals lack a systematic approach to support youth, families and young adults in this transition from pediatric to adult-centered care including integration of young adults to adult health care; therefore be it

RESOLVED, that the Board of Regents works to raise awareness about pediatric to adult health care transition by arranging for educational sessions at national ACP meetings, publishing articles in the *ACP Internist* and creating/promoting the presence of a section on the ACP website containing information to help internists in this transition process (including links to other helpful websites such as the "Got Transition: Center for Health Care Transition Improvement" website); and be it further

RESOLVED, that the Board of Regents calls upon ACP chapters to reach out to their American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP) state chapters to improve this transition process through methods such as holding joint meetings around transition information and education and by encouraging quality improvement initiatives on transition.
BACKGROUND INFORMATION

Resolution 10-S15.  Raising Awareness about the Transition of Care from Pediatric to Adult Health Care through ACP Educational Sessions, Electronic Publications, and Chapter Outreach

RESOLVED, that the Board of Regents works to raise awareness about pediatric to adult health care transition by arranging for educational sessions at national ACP meetings, publishing articles in the ACP Internist and creating/promoting the presence of a section on the ACP website containing information to help internists in this transition process (including links to other helpful websites such as the "Got Transition: Center for Health Care Transition Improvement" website); and be it further

RESOLVED, that the Board of Regents calls upon ACP chapters to reach out to their American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP) state chapters to improve this transition process through methods such as holding joint meetings around transition information and education and by encouraging quality improvement initiatives on transition.

1. PREVIOUS RELATED RESOLUTIONS:

1-F09. Developing a Database to Assist ACP Chapters with Satisfying Practice Gaps Requirements and Support Future CME Applications, RESOLVED, that the Board of Regents develops and makes available annually a shared, searchable database of CME topics along with supporting documentation to assist ACP chapters with satisfying practice gaps requirements and support future CME applications.

At the October 2009 Business Meeting, the BOG recommended that the BOR adopt Resolution 1-F09. At its October 2009 meeting, the BOR referred Resolution 1-F09 for study to Medical Education and Publishing Division staff with input from Information Services (IS), Interactive Publishing, and Web Operations staff, and with a timely report back to the Executive Committee of the Board of Governors.

A compendium of practice gaps was posted on the Chapter Leader Network Web site in Fall 2009. The compendium includes practice gaps identified by the Scientific Program Subcommittee, Clinical Skills Subcommittee, other College committees, chapter meeting planning committees, and staff. The compendium, organized by content area, is easily searched. Each entry contains a brief description of the practice gap, a citation, and a pdf of the article. The compendium is continually updated as new gaps are identified.

ACP’s CME application and related forms are posted as Word documents on the Chapter Leader Network Web site. The application and forms can be downloaded, saved, completed electronically and returned by fax or sent as an email attachment. In light of the resources needed to create a web-based CME application and the ease with which the current CME application can be completed, creation of a web-based application was not pursued.

At its July 31-August 1 meeting, the BOR approved a recommendation from the Education, Quality, and Publication Policy Committee:
1) To adopt the first RESOLVED clause of BOG Resolution 1-F09, Developing a Database to Assist ACP Chapters with Satisfying Practice Gap Requirements and Support Future CME Applications, that reads:

RESOLVED, that the Board of Regents develops and makes available annually a shared, searchable database of CME topics along with supporting documentation to assist ACP chapters with satisfying practice gaps requirements and support future CME applications.

2) To not adopt the second RESOLVED clause where developing a web-based CME application was requested.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Governor and Chapter Activities
BOG staff produces a Meeting Resource Guide that provides valuable guidance to Governors and chapter staff about essential steps required to plan and promote a chapter meeting as well as assure that programming qualifies for CME credit. Generally speaking programmatic decisions are reached at the local level after considering various factors. If the BOR adopted this resolution, BOG staff would communicate the BOR’s intent to the chapters via the usual channels (e.g., LeaderNet Alert) encouraging the outreach described, but Governors and their program committees will have the ultimate authority to proceed with a joint meeting if this approach is feasible.

Medical Education
Curricular decisions related to the ACP annual scientific meeting are determined by the Scientific Program Committee. The Scientific Program Committee receives requests for a finite number of topics to be included in the annual program from College Divisions. Recommendations regarding topics related to medicine and pediatrics originate from the Medicine-Pediatrics Group and are channeled through the Membership Division to the Scientific Program Committee. The Committee has selected the following topic to be presented in 2016 based upon a request from Membership:

Transiting the Complex Special Needs Patient to Your Practice: Lessons from a Med-Peds Trained Developmental Pediatrician

1. Learn about the core elements for implementing the new clinical report and algorithm developed jointly by the AAP/AAFP/ACP to improve health care transition for youth and families.
2. Identify specific issues outside of a standard office visit that need to be addressed when you are seeing these patients and tips for efficiency
3. Learn basic tips for managing complications related to G tubes, respiratory equipment, and other medical technology for patients with disabilities.

In general, the ACP website content reflects policies, clinical and educational content, products, programs and services the College has already developed and that have already been determined by the organization to be of interest to our members and/or reflect an ACP strategic priority. ACP does not generally create entire new sections of the website (or new websites) unless they are directly related to an existing College program, product, service, or policy. ACP does not generally refer website visitors to an external website, thus causing them to leave the ACP website.
ACP Internist is an editorially independent publication and as such, Medical Education and others can suggest topics for articles but content development is at the discretion of the editor.

3. **FINANCIAL IMPACT ESTIMATE:**

   - **X** None (0-$999) Governor and Chapter Activities
   - **X** Minimal ($1,000-$14,999) Medical Education
   - _____ Moderate ($15,000 - $50,000)
   - _____ Significant ($50,000 - $100,000)
   - _____ Substantial ($100,000 or more)

   What percentage of these funds is unbudgeted? __100____ %
Resolution 11-S15. Adopting Principles for Appropriate Use of Direct-to-Patient Telehealth

(Sponsor: Virginia Chapter)

WHEREAS, telehealth is a rapidly evolving medical technology, and The American College of Physicians has not updated its position paper on telehealth since 2008; and

WHEREAS, numerous private telehealth companies now offer medical diagnosis and treatment via the internet (Direct-to-Patient Primary and Urgent Care Telehealth); and

WHEREAS, third party payers have now begun to reimburse patients when utilizing these private companies; and

WHEREAS, there are limited data regarding the safety and efficacy of diagnosing and treating human disease without performing a physical examination and such practice is not considered current standard of care in most cases; and

WHEREAS, there is limited regulation and legislation regarding the use of Direct-to-Patient telehealth; therefore be it

RESOLVED, that the Board of Regents adopts the following principles for the appropriate use of direct-to-patient telehealth:

1. Direct-to-Patient telehealth should primarily be reserved as an adjunct for physicians/providers and patients with an established relationship.

2. A physician-patient relationship can only be established via telemedicine if the encounter a) provides information equivalent to an in-person exam, b) conforms to the standard of care expected of in-person care (for example, if a component of a physical examination is generally the considered standard of care in diagnosing and treating a particular condition, then such a physical examination must also be performed), including through the use of peripheral devices appropriate to the patient’s condition, and c) incorporates appropriate diagnostic tests sufficient to provide an accurate diagnosis (for example, if a diagnostic test is required for an accurate diagnosis of streptococcal pharyngitis then such diagnostic test should be performed).

3. A physician-patient relationship may be established via telehealth if there is a duly licensed telepresenter (such as a nurse, NP, or PA) with the patient.

4. Only physicians or other licensed health care providers, using their professionalism, can determine if any given patient encounter is appropriate for telehealth.

5. Physicians should receive appropriate reimbursement for telehealth encounters for patients with whom they have an established physician-patient relationship.

6. Insurance companies must disclose any financial relationships with telehealth companies to prospective patients.

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2 An example of an insurance company offering telehealth services: [http://members.optimaehealth.com/federaldocs/Options%20for%20Care.pdf](http://members.optimaehealth.com/federaldocs/Options%20for%20Care.pdf)
BACKGROUND INFORMATION

Resolution 11-S15. Adopting Principles for Appropriate Use of Direct-to-Patient Telehealth

RESOLVED, that the Board of Regents adopts the following principles for the appropriate use of direct-to-patient telehealth:

1. Direct-to-Patient telehealth should primarily be reserved as an adjunct for physicians/providers and patients with an established relationship.

2. A physician-patient relationship can only be established via telemedicine if the encounter a) provides information equivalent to an in-person exam, b) conforms to the standard of care expected of in-person care (for example, if a component of a physical examination is generally the considered standard of care in diagnosing and treating a particular condition, then such a physical examination must also be performed), including through the use of peripheral devices appropriate to the patient’s condition, and c) incorporates appropriate diagnostic tests sufficient to provide an accurate diagnosis (for example, if a diagnostic test is required for an accurate diagnosis of streptococcal pharyngitis then such diagnostic test should be performed).

3. A physician-patient relationship may be established via telehealth if there is a duly licensed telepresenter (such as a nurse, NP, or PA) with the patient.

4. Only physicians or other licensed health care providers, using their professionalism, can determine if any given patient encounter is appropriate for telehealth.

5. Physicians should receive appropriate reimbursement for telehealth encounters for patients with whom they have an established physician-patient relationship.

6. Insurance companies must disclose any financial relationships with telehealth companies to prospective patients.

1. PREVIOUS RELATED RESOLUTIONS:

2-F14. Assuring that Expert Consensus, Evidence Based Medicine Principles, and Practice Guidelines (EEP) are Applied Appropriately to the Clinical Care of Individual Patients

RESOLVED, that the Board of Regents expresses its support for internists who take into consideration individual patient characteristics when applying Expert Consensus, Evidence Based Medicine Principles, and Practice Guidelines (EEPs) in the care of individual patients; and be it further

RESOLVED, that the Board of Regents strongly encourages institutions that rate, reward, and/or direct medical care according to EEPs to provide physicians with readily available means for providing justification for utilizing knowledge of patient specific characteristics in caring for individual patients when such care seems to conflict with EEPs.

At the September 2014 Business Meeting, the BOG recommended that the BOR adopt Resolution 2-F14 as a reaffirmation of College policy. At its November 2014 meeting, the BOR adopted Resolution 2-F14 as a reaffirmation of College policy.

1-S06. Evaluating Quality and Safety of “Minute Clinics”, RESOLVED, that the Board of Regents evaluate the quality and safety of the growing phenomenon of “minute clinics” or large retailer/chain pharmacy clinics opened to diagnose and treat “common family illnesses” and evaluate their impact on continuity of care; and be it further RESOLVED, that based on this evaluation, the Board of Regents provide
materials and/or other types of resources to assist individual chapters in ensuring that such clinics meet quality and safety standards.

At the April 2006 Business Meeting, the BOG recommended that the BOR adopt Resolution 11-S06 as amended. At their April 2006 Organizational Meeting, the BOR referred Resolution 11–S06 to the Health and Public Policy Committee (HPPC) for study and report back with recommendations.

The HPPC reviewed a staff background memo containing principles on retail health clinics at its meeting on September 2006. The HPPC recommended that the set of principles be approved and posted on the Governors’ Information Center (GIC) to guide ACP chapters in addressing state legislation and regulations concerning retail health clinics. Staff posted the full memo on the electronic information centers for Regent and Governor comment. A final draft reflecting comments received was approved with minor editing by the BOR in January 2007 and published in the ACP Policy Compendium.

2. DIVISION/DEPARTMENT BACKGROUND SUMMARY:

Health Policy and Regulatory Affairs
ACP’s 2008 position paper E-Health and Its Impact on Medical Practice offers limited guidance on direct-to-patient telemedicine. At the time of drafting, direct-to-patient telemedicine was still considered a novel service, although a handful of companies, such as Teladoc, were offering telephone consultations and other telehealth services on a small scale. Applicable policy from the 2008 paper includes:

ACP supports the expanded use of telemedicine for those patients with an established physician relationship, to achieve fully integrated, location-independent care processes supported by care teams that are not necessarily all present at a single location at the time of a patient encounter.

ACP supports reimbursement for appropriately structured online communications, whether synchronous or asynchronous and whether solely text-based, or supplemented with voice, video, or device feeds, as this form of communication may be a clinically appropriate comparable service alternative to a face-to-face encounter.

The Health and Public Policy Committee is currently reviewing a draft position paper that addresses the recent expansion of telemedicine, including into the direct-to-patient telemedicine setting.

3. FINANCIAL IMPACT ESTIMATE:

X None (0-$999)
_____ Minimal ($1,000-$14,999)
_____ Moderate ($15,000 - $50,000)
_____ Significant ($50,000 - $100,000)
_____ Substantial ($100,000 or more)

What percentage of these funds is unbudgeted? __100___ %