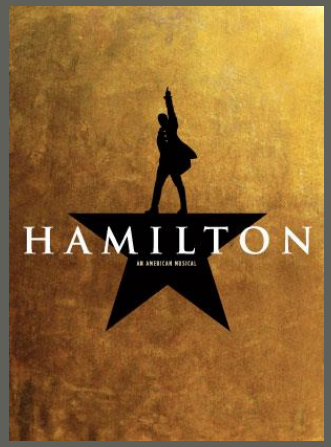
Want to be "*in the room where it happens*"? It starts with standing for *something.*

ACP Northern California Chapter
October 12, 2019



American College of Physicians
Leading Internal Medicine, Improving Lives

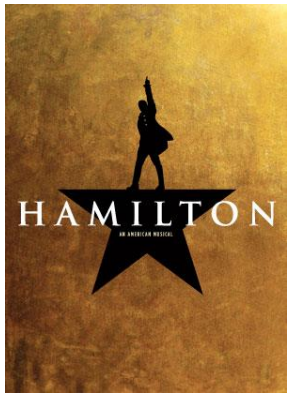
Bob Doherty, SVP, Governmental Affairs and Public Policy

The room where it happens.

The scene:

Alexander Hamilton, Thomas Jefferson and James Madison meet over dinner in NYC, and emerge with an agreement to locate the nation's capital (to Virginia) and Hamilton's plan for a central banking system.

Aaron Burr is not invited.



The room where it happens

Burr:]
Two Virginians and an immigrant walk
into a room
[Burr and Ensemble:]
Diametric'ly opposed, foes
[Burr:]
They emerge with a compromise, having
opened doors that were
[Burr and Ensemble:]
Previously closed
[Ensemble:]
Bros
[Burr:]
The immigrant emerges with unprecedented
financial power
A system he can shape however he wants
The Virginians emerge with the nation's capital

And here's the pièce de résistance:
No one else was in
The room where it happened
The room where it happened
The room where it happened
No one else was in
The room where it happened (The room where it happened)
The room where it happened
The room where it happened (The room where it happened)
No one really knows how the game is played (Game is played)
The art of the trade
How the sausage gets made (How the sausage gets made)
We just assume that it happens (Assume that it happens)
But no one else is in
The room where it happens (The room where it happens)

But what did Burr stand for?

HAMILTON/JEFFERSON/MADISON/WASHINGTON:

What do you want, Burr?
What do you want, Burr?

If you stand for nothing
Burr, then what do you fall for?

What can *Hamilton* teach us about advocacy?

If you stand for nothing, what do you fall for?

What does ACP stand for?

What do we stand for?

The following statements are not official ACP policy, as approved by the Board of Regents. They characterize (*in my own words*) what the College stands for, based on approved policies.

1. **That advocacy must always put the interests of patients above all else.**
2. **That *everyone* should have coverage for the care they need, at a cost they, and the country, can afford.**

What do we stand for?

3. That physicians have a responsibility to advocate for policies to lower costs without compromising care; to practice high-value, cost-effective care themselves, and be accountable for it.
4. That physicians and patients must be freed of unnecessary administrative tasks that take time away from patient care, contribute to professional burn-out, and impose enormous system- and practice-level costs.

What do we stand for?

5. That technology should support patient care and not detract from it.
6. That a well-trained internist will be shown to be the best value in American medicine.
7. That public policy must support the training, retention, and well-being of internists, and the overall primary care physician workforce, as being essential to good outcomes of care and lower costs.

What do we stand for?

8. That practices and delivery systems must center on what is best for patients and families, and be supportive of internists and other clinicians within those systems.
9. That patients and physicians benefit from having a choice of practice models, from large groups to small independent practices, and those choices should be supported.
10. That internists must be compensated for their services at a level commensurate with their value.

What do we stand for?

11. That the medical profession has a responsibility to advocate for policies to address social determinants of health, the environment, discrimination, tobacco and substance use, public health, inequality, gun violence, immigration and other societal issues affecting the health of patients and the public.
12. That all persons, without regard to where they live or work; their sex or sexual orientation; gender or gender identity; race, ethnicity, faith, or country of origin; must have equitable access to high quality medical care, and must not be discriminated against based on such characteristics.

We stand for policies to:

- Lower the High Cost of Prescription Drugs
- Address the Epidemic of Firearms-Related Injury and Death
- Expand Coverage and Stabilize the Insurance Market
- Fund Federal Workforce, Medical and Health Services Research, Public Health Initiatives
- Protect patients from surprise bills
- Improve Physician Payment under Medicare
- Reduce Unnecessary Administrative Tasks on Physicians and Patients
- Support Healthy Women and Families
- Support Medical Education and Reduce Student Debt

We stand for policies to reduce injuries and deaths from firearms.

- ACP advocacy is driving the national debate
- Spawning the #ThisIsOurLane movement.

What does ACP recommend to curb injuries and deaths from firearms?

POSITION PAPER

Annals of Internal Medicine

Reducing Firearm Injuries and Deaths in the United States: A Position Paper From the American College of Physicians

Renee Butkus, BA; Robert Doherty, BA; and Sue S. Bornstein, MD; for the Health and Public Policy Committee of the American College of Physicians*

For more than 20 years, the American College of Physicians (ACP) has advocated for the need to address firearm-related injuries and deaths in the United States. Yet, firearm violence continues to be a public health crisis that requires the nation's immediate attention. The policy recommendations in this paper build on, strengthen, and expand current ACP policies approved by the Board of Regents in April 2014, based on analysis of approaches that the evidence suggests will be effective in reducing deaths and injuries from firearm-related violence.

Ann Intern Med. 2018;169:704-707. doi:10.7326/M18-1530 Annals.org
For author affiliations, see end of text.
This article was published at Annals.org on 30 October 2018.

For more than 20 years, the American College of Physicians (ACP) has advocated for the need to address firearm-related injuries and deaths in the United States. In 2014, the ACP published a comprehensive set of recommendations (1). In 2015, it joined the American College of Surgeons, American College of Obstetricians and Gynecologists, American Public Health Association, American Psychiatric Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, and American Bar Association in a call to action to address gun violence as a public health threat, which was subsequently endorsed by 52 organizations that included clinician organizations, consumer organizations, organizations representing families of gun violence victims, research organizations, public health organizations, and other health advocacy organizations (2). Yet, firearm violence remains a problem–firearm-related mortality rates in the United States are still the highest among high-income countries (3).

Firearm violence continues to be a public health crisis in the United States that requires the nation's immediate attention. The ACP is concerned about not only the alarming number of mass shootings in the United States but also the daily toll of firearm violence in neighborhoods, homes, workplaces, and public and private places across the country. The policy recommendations in this paper build on, strengthen, and expand current ACP policies approved by the Board of Regents in April 2014 (1) and are based on an analysis of approaches that the evidence suggests will be effective in reducing deaths and injuries from firearm-related violence. The ACP has long advocated for policies to reduce the rate of firearm injuries and deaths in the United States and once again calls on its members, nonmember physicians, nonphysician clinicians, policymakers, and the public to take action on this important issue.

See also:
Related article 734
Editorial comments 723, 725

Methods

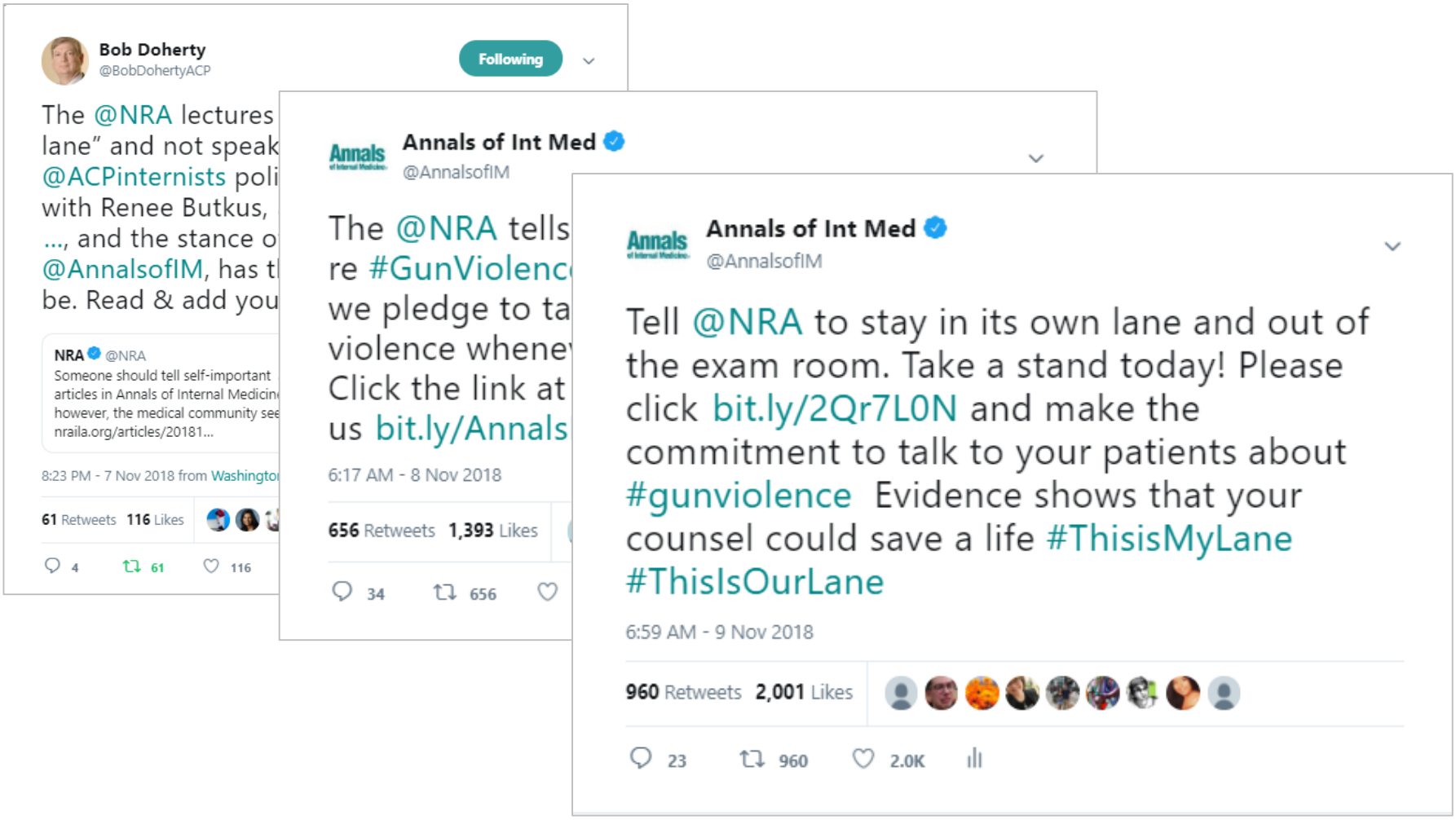
This policy paper was drafted by the Health and Public Policy Committee of the ACP, which is charged with addressing issues that affect the health care of the U.S. public and the practice of internal medicine and its subspecialties. The paper builds on, strengthens, and expands current ACP policies approved by the Board of Regents in April 2014 (1). The authors determined that many positions were still relevant and did not revisit those positions or the evidence supporting them. They identified gaps in policy and existing positions that needed to be strengthened, clarified, or expanded on the basis of emerging research and new initiatives on which the ACP did not have clear policy. The authors focused solely on evidence related to the new or modified recommendations and reviewed available studies, reports, and surveys related to firearm violence from PubMed, Google Scholar, relevant news articles, policy documents, Web sites, and other sources. Recommendations were based on reviewed literature and input from the ACP's Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies. The policy paper and related recommendations were reviewed and approved by the ACP Board of Regents on 21 July

- New policy paper updates 2015 policy paper.
- The paper does *not* threaten the 2nd amendment right to own firearms for personal defense or recreation. Rather, we seek to:
  - To keep guns out of the hands of felons, *all* convicted domestic violence abusers (whether against a person within their house or outside of it), those with temporary as well as permanent restraining orders, and persons at imminent risk of harm to themselves or others
    - Background checks for all sales.
    - Close domestic violence loopholes.
    - Extreme risk protection laws
  - To require safe storage of guns and ammunition
  - To prohibit sales only of “assault” rifles and large capacity magazines.
  - To study causes and solutions to reduce injuries and deaths.

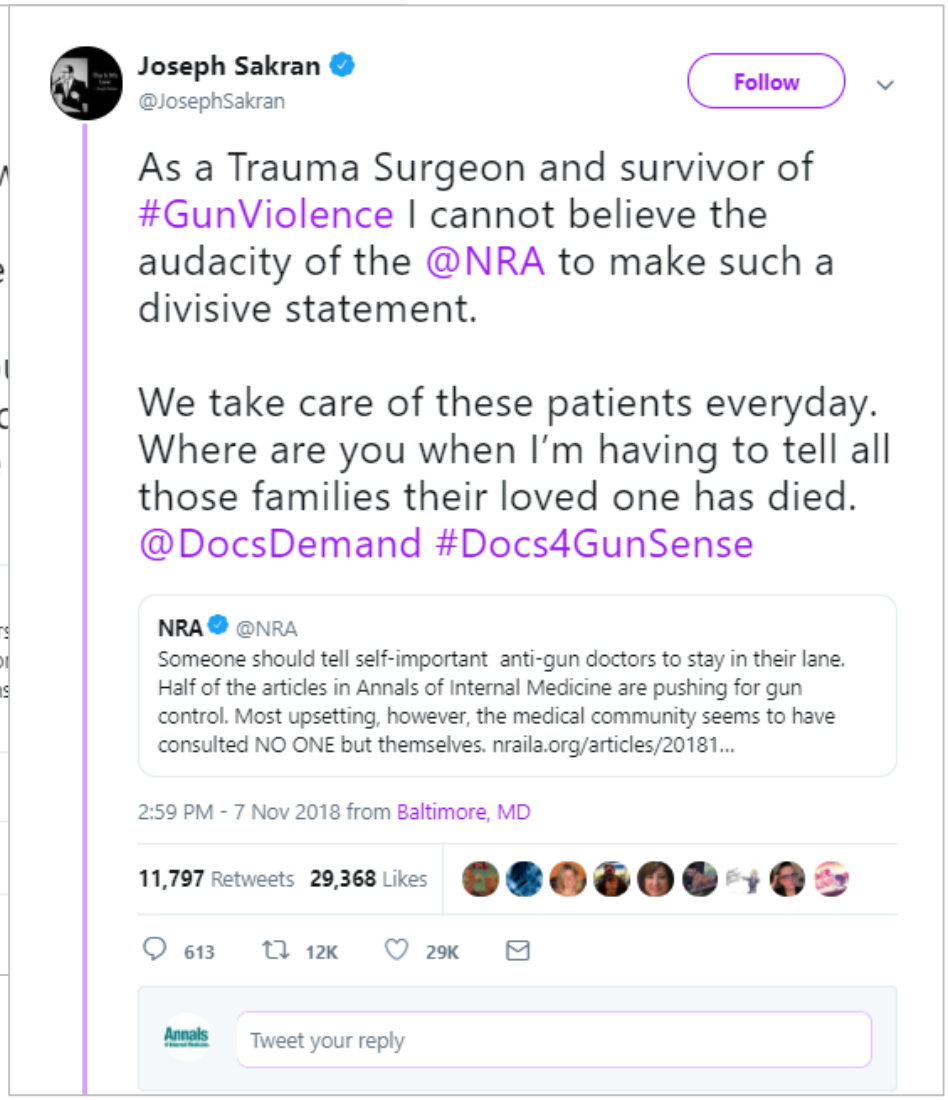
NRA Response to new ACP Policy Paper sparked *This is Our Lane* movement

- In response to the most recent ACP policy recommendations on reducing firearm-related injuries and deaths published In *Annals,* the NRA tweeted saying physicians should “stay in their lane.”
- Physicians were quick to respond…

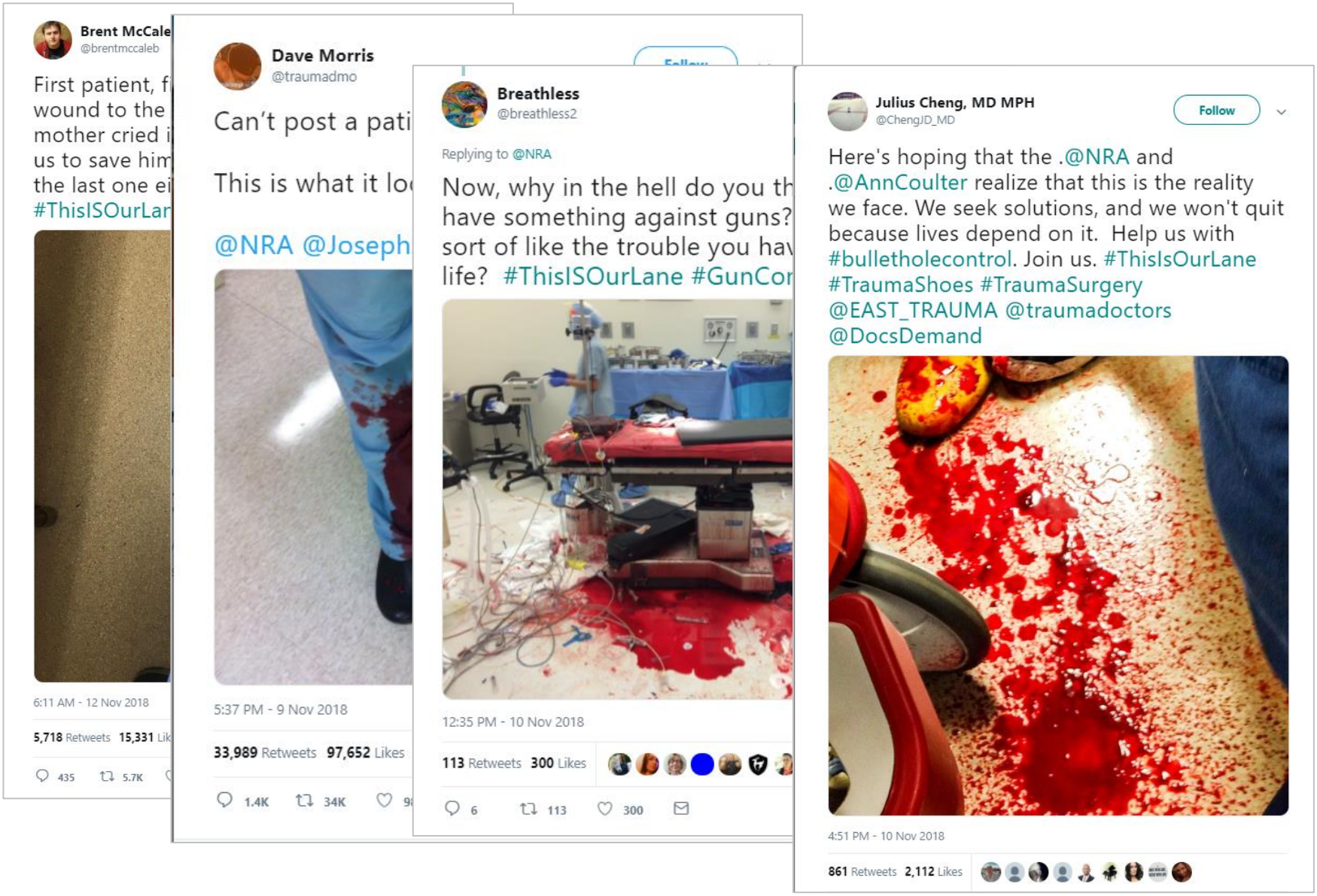
Our Response



Public Response

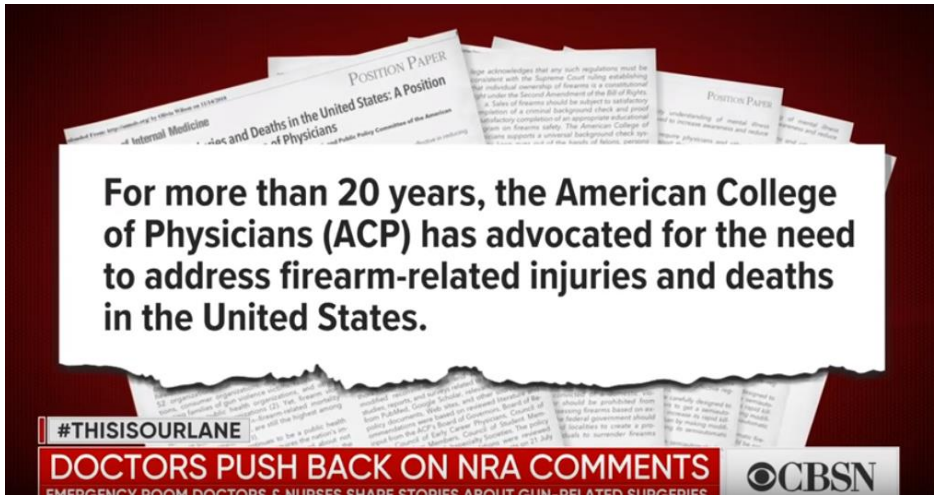


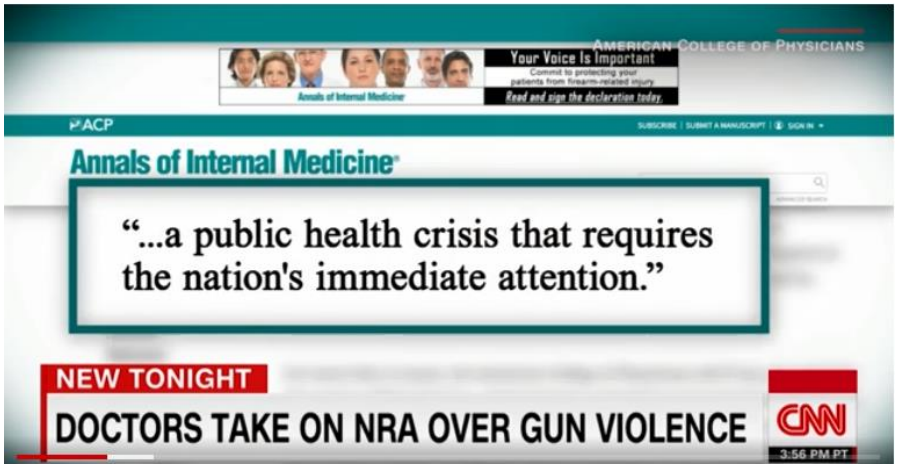
#ThisIsOurLane



Firearms Position Paper Response

ACP's position paper on reducing firearm-related injuries and deaths published In *Annals* has received extensive coverage in light of the NRA tweet saying physicians should "stay in their lane." ACP, and the position paper, was mentioned in several top-tier media outlets, including CNN and CBS.





Firearms Position Paper Response: Top-Tier Media Coverage

Reduce injuries and deaths from firearms.

- New *Call to Action* from ACP, American Academy of Family Physicians, American Academy of Pediatrics, American College of Surgeons, American Medical Association, and the American Public Health Association, published August 7, 2019, Annals of Internal Medicine.

Annals of Internal Medicine

SPECIAL ARTICLE

Firearm-Related Injury and Death in the United States: A Call to Action From the Nation's Leading Physician and Public Health Professional Organizations

Robert M. McLean, MD; Patrice Harris, MD; John Cullen, MD; Ronald V. Maier, MD; Kyle E. Yasuda, MD; Bruce J. Schwartz, MD; and Georges C. Benjamin, MD

Shortly after the November 2018 publication of the American College of Physicians' policy position paper on reducing firearm injury and death (1), the National Rifle Association tweeted:

> Someone should tell self-important anti-gun doctors to stay in their lane. Half of the articles in Annals of Internal Medicine are pushing for gun control. Most upsetting, however, the medical community seems to have consulted NO ONE but themselves.

Within hours, thousands of physicians responded, many using the hashtags #ThisIsOurLane and #ThisIsMyLane, and shared the many reasons why firearm injury and death is most certainly in our lane. Across the United States, physicians have daily, first-hand experience with the devastating consequences of firearm-related injury, disability, and death. We witness the impact of these events not only on our patients, but also on their families and communities. As physicians, we have a special responsibility and obligation to our patients to speak out on prevention of firearm-related injuries and deaths, just as we have spoken out on other critical public health issues. As a country, we must all work together to develop practical solutions to prevent injuries and save lives.

In 2015, several of our organizations joined the American Bar Association in a call to action to address firearm injury as a public health threat. This effort was subsequently endorsed by 52 organizations representing clinicians, consumers, families of firearm injury victims, researchers, public health professionals, and other health advocates (2). Four years later, firearm-related injury remains a problem of epidemic proportions in the United States, demanding immediate and sustained intervention. Since the 2015 call to action, there have been 18 firearm-related mass murders with 4 or more deaths in the United States, claiming a total of 288 lives and injuring 703 more (3).

With nearly 40 000 firearm-related deaths in 2017, the United States has reached a 20-year high according to the Centers for Disease Control and Prevention (CDC) (4). We, the leadership of 6 of the nation's largest physician professional societies, whose memberships include 731 000 U.S. physicians, reiterate our commitment to finding solutions and call for policies to reduce firearm injuries and deaths. The authors represent the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American College of Surgeons, American Medical Association, and American Psychiatric Association. The American Public Health Association, which is committed to improving the health of the population, joins these 6 physician organizations to articulate the principles and recommendations summarized herein. These recommendations stem largely from the individual positions previously approved by our organizations and ongoing collaborative discussion among our leaders (1, 5–10).

Background

In 2017, a total of 39 773 people died in the United States as a result of firearm-related injury–23 854 (59.98%) were suicides, 14 542 (36.56%) were homicides, 553 (1.39%) were the result of legal intervention, 486 (1.22%) were subsequent to unintentional discharge of a firearm, and 338 (0.85%) were of undetermined origin. The population-adjusted rates of these deaths are among the highest worldwide and are by far the highest among high-income countries (11, 12). Firearm-related deaths now exceed motor vehicle–related deaths in the United States (13, 14). Further, estimates show that the number of nonfatal firearm injuries treated in emergency departments is almost double the number of deaths (15). Firearm-related injury and death also present substantial economic costs to our nation, with total societal cost estimated to be $229 billion in 2015 (16).

While mass shootings account for a small proportion of the nearly 109 firearm-related deaths that occur daily in the United States (11), the escalating frequency of mass shootings and their toll on individuals, families, communities, and society make them a hot spot in this public health crisis. Mass shootings create a sense of vulnerability for everyone, that nowhere–no place of worship, no school, no store, no home, no public gathering place, no place of employment–is safe from becoming the venue of a mass shooting. Mass shootings have mental health consequences not only for victims, but for all in affected communities (17), including emergency responders. Studies also show that mass shootings are associated with increased fear and decreased perceptions of safety in indirectly exposed populations (18, 19). Preventing the toll of mass firearm violence on the well-being of people in U.S. cities and towns demands the full resources of our health care community and our governments.

This article was published at Annals.org on 7 August 2019.

Universal background checks

Funding for research

Intimate Partner Violence

Safe Storage

Access to Mental Health treatment

Extreme Risk Protection Laws

Physician counseling and "Gag Laws"

Firearms with Features designed to increase their rapid and extended killing capacity

You need to stand for something to be in the room where it happens. *But that's not enough.*

You also have to know "how the sausage is made"

Believing in something is essential.
But you also have to know "how the sausage is made"

Burr:

No one really knows how the game is played (Game is played)
The art of the trade
How the sausage gets made (How the sausage gets made)

We just assume that it happens

But no one else is in the room where it happens

ACP knows “how the sausage is made”

- Coalition-building (Group of 6): ACP, AAFP, AAP, APA, AOA, ACOG: represents over 560,00 physician and medical student members!
- Lobbying: congressional and regulatory branches
- Judicial branch: lawsuits and amicus briefs
- Grass roots (AIMn and Leadership Day)
- Earned and social media
- And of course, evidence-based policy positions

We do it all. We do it well.

We’re in the room where it happens

- The White House, HHS, and Congress regularly consult with us on a wide range of issues, from opioids, to Medicare payment policies, to immigration, to GME and workforce, to regulatory relief, to coverage, to public health, to gun violence—the list goes on and on.
- Even when we disagree, we are invited because ACP is viewed as a respected, credible, and evidence-based organization that stands for policies to improve the lives of patients, and daily work of our physicians.

We're in the room where it happens

ACP President Robert McLean,
On Capitol Hill with the Group of 6

ACP's Shari Erickson discusses Medicare payment policy with CMS administrator Seema Verma

LD attendees with Rep. Ami Bera, D-CA

Case study of *being in the room where it happens:* improving payments for internists' cognitive care

- Major wins in the proposed Medicare physician rule! If finalized:
  - ✓ Reverses CMS proposal to collapse E/M code payments and de-value complex cognitive care
  - ✓ Accepts RUC recommendations to improve RVUs and payments for office visit codes (ACP lead the multi-specialty efforts to survey physicians and make the case for higher payments)
  - ✓ Reduces documentation of E/M services
  - ✓ Improves payments for care management services

Background

- In November 2018, CMS released the 2019 Medicare Physician Payment Schedule Final Rule outlining a new E/M payment structure proposal—including blended payment rates for office-based/outpatient E/M visit levels 2 through 4 and separate payment for level 5 office visits

In the room where it happens

ACP leaders and staff meet With CMS Administrator Seema Verma to discuss E/M payments and documentation, Patients Before Paperwork,
And EHR interoperability. June 2018

Proposed Medicare Fee Schedule

Proposed changes in Medicare payments to physicians would recognize the value of cognitive services in providing quality patient care. Improvements include:

- Increased payments for evaluation and management (E/M) services
- Retained separate payment levels for E/M codes
- Improved documentation for E/M services
- Improved accuracy in tracking time spent
- Payment for managing opioid use disorder
- Additional add-on codes

Previous CMS Proposal:

		Current (2018) Payment Amount	Revised Payment Amount***				
	Complexity Level under CPT	Visit Code Alone*	Visit Code Alone Payment	Visit Code With Either Primary or specialized care add-on code**	Visit Code with New Extended Services Code (Minutes Required to Bill)	Visit with Both Add-on and Extended Services Code Added**	Current Prolonged Code Added (Minutes Required to Bill)*
New Patient	Level 2	$76	$130	$143	$197 (at 38 minutes)	$210	
	Level 3	$110					
	Level 4	$167					
	Level 5	$211	$211				$344 (at 90 minutes)
Established Patient	Level 2	$45	$90	$103	$157 (at 34 minutes)	$170	
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				$281 (at 70 minutes)

Need for E/M Proposal Changes

- ACP was a leader, along with several other specialty societies, in creating a coalition to push to improve payments for the historically undervalued E/M services, by retaining separate payment levels for each of the E/M codes, and revising the code definitions.
- ACP's representative to the RUC, Dr. Bill Fox (also, chair-elect, Board of Governors) presented the coalition's recommendations, *which were accepted by the RUC, and now CMS!*

In the room where it happens

ACP's Dr. Bill Fox at RVS Update Committee, April 26, 2019 (2nd from right)

CMS's Proposed Changes E/M

CMS proposes to assign separate payment rather than a blended rate, to each of the office/outpatient E/M visit codes (except CPT code 99201, which will be deleted)

Payment for a new prolonged visit add-on CPT code (CPT code 99XXX).

Proposed E/M wRVU Changes

CPT Code	Descriptor	Current Work RVU	New Work RVU	Work RVU Increase	Total Time
99202	New Pt, straightforward medical decision making, 15-29 min day of visit	0.93	0.93	0%	22 minutes
99203	New Pt, low level medical decision making, 30-44 min day of visit	1.42	1.60	13%	40 minutes
99204	New Pt, moderate level medical decision making, 45-59 min day of visit	2.43	2.60	7%	60 minutes
99205	New Pt, high level medical decision making, 60-74 min day of visit	3.17	3.50	10%	85 minutes
99211	Est Pt, Supervision	0.18	0.18	0%	7 minutes
99212	Est Pt, straightforward medical decision making, 10-19 min day of visit	0.48	0.70	46%	18 minutes
99213	Est Pt, low level medical decision making, 20-29 min day of visit	0.97	1.30	34%	30 minutes
99214	Est Pt, moderate level medical decision making, 30-39 min day of visit	1.50	1.92	28%	49 minutes
99215	Est Pt, high level medical decision making, 40-54 min day of visit	2.11	2.80	32.8%	70 minutes
99XXX	Prolonged visit new/est pt, add'l 15 min		0.61	New	15 minutes

Documentation Changes

- History and Exam would no longer be used for code selection; but are performed and documented as medically appropriate.
- **Medical Decision Making (MDM) *or* Total Time on the Date of the Encounter may be used for code selection**
  - (without regard to whether counseling and coordination of care dominate the service).

Care Management Services

- Prolonged services: add-on code was created. A minimum of 15 minutes is required for each unit of this code.
- Complex Chronic Care Management (CCCM)
  - The agency propose to adopt two G codes for complex chronic care management services in place of the two existing CPT codes.
  - Revising what must be included in the comprehensive care plan.
- Principle Care Management
  - CMS proposes to create two new payable codes for Principle Care Management (PCM) services, which would entail providing care management services to patients with a single serious, high-risk condition.

To recap:

- Advocacy requires that *you be in the room where it happens* whenever decisions are made.
- To be *in the room where it happens*, you have to know *what you stand for*.
- You need to *know how the sausage is made*: coalition-building, grass roots, traditional and social media, evidence-based policy, lobbying, engaging with regulatory agencies—and relationships and trust built over many years.

- ACP is in the room where it happens
  - Because we know what we stand for.
  - And know how the sausage is made.