

## **Spring 2026 BOG Resolutions**

### **Resolution 1-S26. Educating ACP Members about Discharge Summaries from Skilled Nursing Facilities**

(Sponsor: New York Chapter)

### **Resolution 2-S26. Advocating for Partial Medicare Opt-Out for Physicians**

(Sponsor: Utah Chapter; Co-sponsors: Mississippi Chapter and BOG Class of 2029)

### **Resolution 3-S26. Updating the ACP's Tobacco Use Prevention and Control Policy Positions**

(Sponsor: New York Chapter)

### **Resolution 4-S26. Developing Evidence-Based Nutrition Policy and Establishing an ACP 'Nutrition and Food as Medicine' Hub**

(Sponsor: Vermont Chapter; Co-sponsors: Nevada, Ohio, and Washington Chapters)

### **Resolution 5-S26. Developing Policy to Support Permanent Standard Time**

(Sponsor: Washington Chapter; Co-sponsors: New Hampshire and Vermont Chapters)

### **Resolution 6-S26. Addressing the Environmental Burden Associated with ACP Publications**

(Sponsor: Vermont Chapter; Co-sponsor: Washington Chapter)

### **Resolution 7-S26. Phasing Out Industry Funding from ACP's Annual Internal Medicine Meeting**

(Sponsor: Washington Chapter)

## **Resolution 1-S26. Educating ACP Members about Discharge Summaries from Skilled Nursing Facilities**

(Sponsor: New York Chapter)

WHEREAS, it is well known that when patients transition between different settings, i.e. community to hospital, hospital to skilled nursing facility (SNF), and SNF to community, quality of care and patient safety can be compromised due to high rates of medication errors, incomplete/inaccurate information transfer, and lack of follow-up care (1,2,3,4,5,6); and

WHEREAS, there are published recommendations for optimization of transitions of care including a 2016 best practice consensus from SGIM-AMDA-AGS (7) [i.e., Society of General Internal Medicine, AMDA – The Society for Post-Acute and Long-Term Care Medicine, and the American Geriatrics Society] which includes a recommendation that SNFs transmit a formal discharge summary to the patient’s outpatient primary care physician (PCP) within 72 hours of patient discharge from SNF; and

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) has issued a policy regulation (8) in 2017 requiring SNFs to create a discharge summary that includes but is not limited to a recapitulation of the resident’s stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results, to improve follow-up care; therefore be it

**RESOLVED, that the Board of Regents educate their members as to CMS Policy (8) regarding SNF’s responsibility to create and timely deliver a comprehensive patient discharge summary to a patient’s outpatient primary care physician (PCP); and be it further**

**RESOLVED, that the Board of Regents advocate that CMS enforce its own policy regulation (8) regarding SNF’s responsibility to create and timely deliver a comprehensive patient discharge summary to a patient’s outpatient PCP.**

References:

1. Coleman EA, Min SJ, Chomiak A, Kramer AM. Posthospital care transitions: patterns, complications, and risk identification. Health Serv Res. 2004;39(5):1449–1465.
2. Grabowski DC, O’Malley AJ, Barhydt NR. The costs and potential savings associated with nursing home hospitalizations. Health Aff (Millwood). 2007;26(6):1753–1761.
3. Mor V, Intrator O, Feng Z, Grabowski DC. The revolving door of rehospitalization from skilled nursing facilities. Health Aff (Millwood). 2010;29(1):57–64.
4. van Walraven C, Seth R, Austin PC, Laupacis A. Effect of discharge summary availability during post-discharge visits on hospital readmission. J Gen Intern Med. 2002;17:186-192.
5. Moore C, Wisnevesky J, Williams S, McGinn T. Medical errors related to discontinuity of care from an inpatient to an outpatient setting. J Gen Intern Med. 2003; 18:646-651.
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## **Resolution 2-S26. Advocating for Partial Medicare Opt-Out for Physicians**

(Sponsor: Utah Chapter; Co-sponsors: Mississippi Chapter and BOG Class of 2029)

WHEREAS, despite ACP's efforts to advocate for Medicare payment reform, ongoing cuts are planned and many physicians are unable to sustain their private practices and may need to work in multiple settings; and

WHEREAS, in order to start a private practice or work in certain practice settings, physicians may desire to opt out of Medicare; and

WHEREAS, current federal Medicare regulations require physicians who opt out of Medicare to do so entirely, without the ability to selectively participate in certain practice settings, as Medicare billing is linked to a physician's National Provider Identifier (NPI) number; and

WHEREAS, this "all-in or all-out" policy prevents physicians who practice in different settings from billing Medicare for services provided in separate roles such as hospice, inpatient care, or locum tenens (outside of emergency care exceptions) without jeopardizing their opt-out status; and

WHEREAS, this restriction discourages physicians from opening innovative practice models that can improve access, reduce administrative burden, and enhance patient satisfaction; and

WHEREAS, the inability to partially opt out of Medicare can create physician shortages in high-need areas such as small practices, hospice, rural hospitals, and skilled nursing facilities, where part-time or moonlighting physicians could otherwise fill gaps; and

WHEREAS, ACP policy supports a physician's right to autonomy in participation in Medicare and Medicare reforms to decrease administrative burden; and

WHEREAS, this resolution builds on that position by advocating for a partial opt-out option, preserving patient access while protecting physician practice autonomy; therefore be it

**RESOLVED, that the Board of Regents advocate for federal legislation or regulatory changes to allow physicians to opt out of Medicare in one employment setting while maintaining the ability to bill Medicare for services provided in other practice settings (e.g., private practices, hospice, inpatient hospital care, or other defined roles); and be further**

**RESOLVED, that the Board of Regents join with AMA and other organizations to advocate for this change collectively on behalf of physicians and patients.**

### References:

1. Centers for Medicare & Medicaid Services. Manage your enrollment. Opt out of Medicare. Accessed Sept, 20, 2025. <https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/manage-your-enrollment#>
2. Eskew, P. Opted-Out Moonlighting. *Direct Primary Care Frontier*. Accessed Sept 20, 2025. <https://www.dpcfrontier.com/opted-out-moonlighting>.
3. Shay, D. Opting Out of Medicare: How to Get Out and Stay Out. *Fam Pract Manag*. 2017;24(6):17-20
4. Alex Cottrill, Nancy Ochieng, and Tricia Neuman. How Many Physicians Have Opted Out of the Medicare Program? Jan 17, 2025 <https://www.kff.org/medicare/how-many-physicians-have-opted-out-of-the-medicare-program/>

### **Resolution 3-S26. Updating ACP's Tobacco Use Prevention and Control Policy Positions**

(Sponsor: New York Chapter)

WHEREAS, most of the 6 official policy positions and recommendations from the ACP via its 2015 public policy paper "Electronic Nicotine Delivery Systems (ENDS): Executive Summary of a Policy Position Paper From the ACP" and current compendium should be updated to include current (2025) information and recommendations; and

WHEREAS, ACP's vision is to be recognized globally as the leader in promoting quality patient care, advocacy, education, and career fulfillment in internal medicine and its subspecialties; and

WHEREAS, tobacco use is considered the single most deadly legal consumer product ever made and its prevention and treatment are partially tied to the education of physicians and their advocacy for anti-tobacco actions (e.g., patient education/treatment, advocacy for legislative change, etc.) (1, 3); and

WHEREAS, the rate of legislation and the tobacco industries' actions towards attracting new customers (mainly young people) changes at a rapid pace, it becomes essential to stay up to date on the state of tobacco use and the most current recommendations for prevention and treatment (1-2); and

WHEREAS, ACP members may be missing valuable ENDS educational facts and advocating for effective anti-tobacco ENDS policies like banning the tobacco industry's price reduction strategies, zoning/licensing laws to limit tobacco retail density in vulnerable communities, laws on banning young people appealing designs/packaging of ENDS products, laws banning tobacco/ENDS point of sale marketing, increasing ENDS law enforcement (e.g., bestowing more rights to public health departments in trying to curtail the illegal sale of ENDS from retailers), increasing primary care physicians ENDS education and screening checks, etc. (1-3); therefore be it

**RESOLVED, that the Board of Regents update their tobacco use prevention and control policy positions to reflect current evidence.**

References:

1. <https://www.ncbi.nlm.nih.gov/books/NBK99237/>
2. <https://www.ncbi.nlm.nih.gov/books/NBK538680/>
3. <https://www.nature.com/articles/s41533-022-00277-9>

## **Resolution 4-S26. Developing Evidence-Based Nutrition Policy and Establishing an ACP ‘Nutrition and Food as Medicine’ Hub**

(Sponsor: Vermont Chapter; Co-sponsors: Nevada, Ohio, and Washington Chapters)

WHEREAS, the American College of Physicians (ACP) has longstanding policy supporting the role of physicians in promoting preventive health, high-value care, and health equity, including “*Strengthening Food and Nutrition Security to Promote Public Health in the United States*” (2022), which calls for improving medical education and clinical resources in nutrition and food security;<sup>1</sup> and

WHEREAS, a 2010 Health and Public Policy Committee report recommended that ACP consolidate diet-related disease information in a single location on its website and encouraged the ACP to create educational materials for physicians and patients;<sup>2</sup> however, such consolidated and freely accessible resources remain limited; and

WHEREAS, current ACP nutrition-related content, such as *Advancing Nutrition in Medicine* learning modules, exists primarily as fee-based continuing education packages, creating barriers for medical students, residents, and practicing physicians seeking high-quality, cost-free guidance on diet-related disease management; and

WHEREAS, diet-related diseases such as cardiovascular disease, diabetes, and cancer account for a substantial proportion of preventable morbidity and mortality,<sup>3</sup> and physicians consistently report limited training in evidence-based nutrition counseling,<sup>4</sup> representing an opportunity to further support ACP’s mission to promote prevention-focused, patient-centered care; and

WHEREAS, growing evidence supports the role of dietary patterns, including whole-food, plant-based diets, in the prevention and treatment of chronic diseases, yet ACP has not issued any recent clinical guidance evaluating such approaches; and

WHEREAS, movements such as *Make America Healthy Again (MAHA)* have mixed legitimate concerns about food and environmental exposures with unverified or misleading health claims, and research into “super-spreaders” on social media—individuals with large followings who regularly post nutrition content—found that 87% lacked medical or health-related credentials, yet their advice reached tens of millions and often contradicted established public health guidelines;<sup>5</sup> and

WHEREAS, the International Agency for Research on Cancer (IARC), a specialized agency of the World Health Organization (WHO), has classified processed meat as carcinogenic to humans (Group 1) and red meat as probably carcinogenic to humans (Group 2A)<sup>6</sup>, yet consumption of processed and red meat remains high in the United States, with a recent study demonstrating that red and processed meat account for 25.9% and 20.4% of protein-rich food sales, respectively, while poultry, seafood, eggs, other meats, and non-meat foods (beans, nuts, seeds, and meat alternatives) accounted for 25.8%, 5.9%, 12.6%, 1.3%, and 10.1% of sales, respectively;<sup>7</sup> and

WHEREAS, a report from the National Health and Nutrition Examination Survey found that the mean percentage of total calories consumed from ultra-processed foods among individuals aged one year and older was 55%<sup>8</sup>, despite evidence associating ultra-processed food consumption with increased risk of numerous health conditions and higher all-cause mortality<sup>9</sup>; and

WHEREAS, patients often encounter institutional and systemic barriers to healthy eating, including limited access to nutritious food options in hospitals, long-term care facilities, and community settings; therefore be it

**RESOLVED, that the Board of Regents review and summarize the current evidence on the role of diet in the prevention and treatment of disease and publish updated practice guidelines; and be it further**

**RESOLVED, that the Board of Regents support the creation of a centralized nutrition hub on the ACP website with content addressing the role of nutrition and ‘food as medicine’ in the prevention and treatment of diet-related disease. Materials may include evidence based clinical nutrition resources, patient education tools, and counseling frameworks and should be free for all ACP members including medical students and residents; and be it further**

**RESOLVED, that the Board of Regents advocate for healthier food options in hospitals, long-term care facilities, and other health care settings by encouraging the adoption of institutional nutrition standards and menu policies consistent with evidence-based dietary recommendations.**

#### References:

1. American College of Physicians. *Strengthening Food and Nutrition Security to Promote Public Health in the United States: A Position Paper from the American College of Physicians*. *Ann Intern Med*. 2022;175(8):1150-1154.
2. Final Report from ACP resolution 18-F09 Promoting Education, Developing Policy, and Supporting Legislation that Addresses the Prevention, Diagnosis and Treatment of Diet-related Disease and Makes a Healthy Diet Available and Affordable for the U.S. Population, 11/12/2010.
3. Murphy SL, Kochanek KD, Xu J, Arias E. *Mortality in the United States, 2020*. *NCHS Data Brief*. 2021;(427):1-8.
4. Harkin N, Johnston E, Mathews T, Guo Y, Schwartzbard A, Berger J, Gianos E. *Physicians' Dietary Knowledge, Attitudes, and Counseling Practices: The Experience of a Single Health Care Center at Changing the Landscape for Dietary Education*. *Am J Lifestyle Med*. 2018 Nov 23;13(3):292-300.
5. Rooted Research Collective & Freedom Food Alliance. *Nutrition Misinformation in the Digital Age: Nutrition Misinformation Super-Spreaders on Social Media*. 2024-2025. As reported via DISA: “Social Media Dissemination of Nutrition Misinformation Poses Significant Public Health Risk.”
6. International Agency for Research on Cancer (IARC). *IARC Monographs Volume 114: Red Meat and Processed Meat*. Lyon, France: World Health Organization, 2018. Press release No. 240, October 26, 2015. Available at: [https://www.iarc.who.int/wp-content/uploads/2018/07/pr240\\_E.pdf](https://www.iarc.who.int/wp-content/uploads/2018/07/pr240_E.pdf).
7. Semba RD, Ramsing R, Thorne-Lyman AL, Rahman N, Altema-Johnson D, Chang KB, Young R, Nussbaumer E, Bloem MW, Love D. Retail Purchases of Red and Processed Meat by State in the United States. *Nutr Cancer*. 2023;75(1):247-255. doi: 10.1080/01635581.2022.2108072. Epub 2022 Aug 9. PMID: 35942589.
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## **Resolution 5-S26. Developing Policy to Support Permanent Standard Time**

(Sponsor: Washington Chapter; Co-sponsors: New Hampshire and Vermont Chapters)

WHEREAS, ACP does not currently have policy regarding Daylight Savings Time; and

WHEREAS, [ACP goals](#) include advocacy for “responsible positions on individual health and on public policy related to health care for the benefit of the public, patients, the medical profession, and our members”<sup>1</sup>; and

WHEREAS, evidence suggests that permanent Standard Time could improve multiple outcomes including [myocardial infarction](#)<sup>2</sup>, [obesity](#)<sup>3</sup>, [motor vehicle fatalities](#)<sup>4</sup>, and [medical errors](#)<sup>5</sup>; and

WHEREAS, internal medicine physicians in training are at increased risk for sleep disruption, especially during changes to and from Daylight Savings Time; and

WHEREAS, other organizations including the [American Medical Association](#)<sup>6</sup> and the [American Academy of Sleep Medicine](#)<sup>7</sup> already advocate for permanent Standard Time; and

WHEREAS, Daylight Savings Time is regulated by both state and Federal law, and updating ACP policy would allow individual ACP Chapters to advocate for change in state legislatures; therefore be it

**RESOLVED, that the Board of Regents develop policy in support of permanent Standard Time.**

### References:

1. American College of Physicians, “Mission, Vision, Goals & Core Values”, accessed online 9/30/2025 at <https://www.acponline.org/about-acp/who-we-are-what-we-do/mission-vision-goals-core-values>
2. Janszky I, Ljung R. Shifts to and from Daylight Saving Time and Incidence of Myocardial Infarction. N Engl J Med 2008;359:1966–8. <https://doi.org/10.1056/nejmc0807104>.
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4. Fritz J, VoPham T, Wright KP, Vetter C. A Chronobiological Evaluation of the Acute Effects of Daylight Saving Time on Traffic Accident Risk. Curr Biol 2020;30:729-735.e2. <https://doi.org/10.1016/j.cub.2019.12.045>.
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6. American Medical Association, “AMA calls for permanent standard time”, accessed on 9/30/2025 at <https://www.ama-assn.org/press-center/ama-press-releases/ama-calls-permanent-standard-time>
7. Rishi MA, Cheng JY, Strang AR, Sexton-Radek K, Ganguly G, Licitis A, et al. Permanent standard time is the optimal choice for health and safety: an American Academy of Sleep Medicine position statement. J Clin Sleep Med 2024;20:121–5. <https://doi.org/10.5664/jcsm.10898>.

## **Resolution 6-S26. Addressing the Environmental Burden Associated with ACP Publications**

(Sponsor: Vermont Chapter; Co-sponsor: Washington Chapter)

WHEREAS, climate change, air and water pollution and other environmental impacts of human activity are widely considered by public health authorities and professional medical societies to be the leading contemporary and future threat to human health; and

WHEREAS, the ACP has acknowledged the central importance of comprehensively addressing environmental health in two position papers on the subject, calling for “immediate action” to limit global temperature rise to 1.5 degrees Celsius; and

WHEREAS, the present default provision of *Annals* and other publications to ACP members in the United States and around the world comes at a significant environmental cost, via the procurement of raw materials and the expenditure of energy and resources for the production and transportation of materials; and

WHEREAS, the readership of the *Annals of Internal Medicine* and other ACP publications is comprised of healthcare professionals invested in the health of the individuals and communities they serve, including the broader global community; and

WHEREAS, online-only access to ACP publications cannot currently be selected by members without direct contact with an ACP representative, despite being preferred over print by 22% of recently polled readers; therefore be it

**RESOLVED, that the Board of Regents address the environmental burden of printed publications, and diverse preferences of the ACP readership, by providing a simplified pathway to select online-only access to publications via the ACP web portal and upon registering for ACP membership.**

### References:

1. Crowley R, Mathew S, Hilden D. Environmental Health: A Position Paper From the American College of Physicians. *Ann Intern Med.* 2022 Nov;175(11):1591-1593. doi: 10.7326/M22-1864. Epub 2022 Oct 25. PMID: 36279541.
2. Crowley RA; Health and Public Policy Committee of the American College of Physicians. Climate Change and Health: A Position Paper of the American College of Physicians. *Ann Intern Med.* 2016 May 3;164(9):608-10. doi: 10.7326/M15-2766. Epub 2016 Apr 19. PMID: 27089232.
3. Atwoli L et al. Call for Emergency Action to Limit Global Temperature Increases, Restore Biodiversity, and Protect Health. *N Engl J Med.* 2021 Sep 16;385(12):1134-1137. doi: 10.1056/NEJMe2113200. Epub 2021 Sep 5. PMID: 34491006.
4. <https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health>

## **Resolution 7-S26. Phasing Out Industry Funding from ACP's Annual Internal Medicine Meeting**

(Sponsor: Washington Chapter)

WHEREAS, ACP's [mission](#) is to foster "professionalism in the practice of medicine" and its vision is to be recognized as a leader in promoting quality patient care and advocacy<sup>1</sup>; and

WHEREAS, ACP's [position paper pertaining to physician-industry relations](#) recommends that "medical education providers and medical professional societies should avoid all industry interactions that might diminish, or appear to others to diminish, their objectivity or concern for patients' best interests", or risk endangering the organization's integrity and public confidence;<sup>2</sup> and

WHEREAS, prior [studies of physician behavior have shown](#) that industry payments to physicians influence prescribing and increase costs of health care<sup>3</sup>; and

WHEREAS, "corporate capture of medical information" by pharmaceutical and healthcare industries is an argument used in the [Make America Healthy Again report](#) to undermine the credibility of physicians, physician organizations, and the advice we give<sup>4</sup>; and

WHEREAS, despite these concerns, ACP [solicits payments](#) from industry as exhibitors and symposia sponsors for its annual Internal Medicine Meeting, including promoting exposure to "6,500+ physicians" for "3 hours of unopposed exhibit time daily" and "unlimited networking opportunities"<sup>5</sup>; and

WHEREAS, ACP "drives traffic into the Hall" by co-locating industry exhibitors with important meeting content, including the ACP Resource Center, Career & Professional Development Center, Coffee Breaks, Boxed Lunches, and Attendee Lounges<sup>5</sup>; and

WHEREAS, the 5% of meeting attendees who choose not to visit the exhibit hall are still subject to industry advertising in the form of posters, banners, and brand placement in the ACP Meeting App and elsewhere; therefore be it

**RESOLVED, that the Board of Regents eliminate advertising outside the exhibit hall by [ACCME-defined ineligible companies](#)<sup>6</sup> effective no later than Internal Medicine Meeting 2030; and be it further**

**RESOLVED, that the Board of Regents develop and implement a plan to eliminate funding for IMM by ineligible companies effective no later than Internal Medicine Meeting 2035.**

References:

1. American College of Physicians, "Who We Are and What We Do", accessed online 9/30/2025 at: <https://www.acponline.org/about-acp/who-we-are-what-we-do>
2. Coyle SL. Physician-industry relations. Part 2: organizational issues. Ann Intern Med. 2002; 136:403-6. PMID: 11874315.
3. Newham M, Valente M. The cost of influence: How gifts to physicians shape prescriptions and drug costs. J Heal Econ 2024; 95:102887. PMID: 38723461.
4. Whitehouse.gov, "The MAHA report", accessed online 9/30/2025 at: <https://www.whitehouse.gov/wp-content/uploads/2025/05/MAHA-Report-The-White-House.pdf>
5. ACP IMM 2026 Exhibitor Prospectus, accessed online 9/30/2025 at: <https://annualmeeting.acponline.org/sites/default/files/documents/exhibitors-sponsors/2026-exhibitor-prospectus.pdf>
6. Accreditation Council for Continuing Medical Education, "Definition: Ineligible Companies", accessed online 9/30/2025 at: <https://accme.org/resource/definition-ineligible-company/>