**Resolution 1-S18. Waiving of CMS Two-Midnight Rule for Skilled Nursing Facility Eligibility**

(Sponsor: New York Chapter)

WHEREAS, the Center for Medicaid and Medicare Services (CMS), for Medicare patients, has defined an inpatient admission to a hospital as a stay that exceeds two midnights; and

WHEREAS, CMS also mandates that Medicare eligibility for Skilled Nursing Facility (SNF) short term admission with initial coverage must have a hospital stay of at least three days; and

WHEREAS, patients evaluated in an Emergency Department who in the opinion of the evaluating physician would be more appropriately cared for in a Skilled Nursing Facility (e.g. for a physical debility) rather than an inpatient service cannot be directed to a SNF but rather must be admitted to the acute care hospital to fulfill Medicare's requirements; and

WHEREAS, these needless hospitalizations increase the patient's risk for hospital acquired infections and adverse events; and

WHEREAS**,** these admissions are costly without any medical benefit; therefore be it

**RESOLVED, that the Board of Regents lobbies CMS to waive the two midnight SNF coverage rule for Emergency Department patients deemed appropriate by the evaluating physician for admission to a Skilled Nursing Facility (SNF); and be it further**

**RESOLVED, that the Board of Regents lobbies CMS to suspend the requirement for a three-day hospitalization before the patient is eligible for coverage for a Skilled Nursing Facility admission.**

**Resolution 2-S18. Defining Human Trafficking as a Separate Diagnosis Code and Billable Medical Condition under ICD-11**

(Sponsor: District of Columbia Chapter)

WHEREAS, "Victim of Human Trafficking" is currently not an ICD-10 Diagnosis Code and billable medical condition and may not always be included under Z91.410, ICD-10-CM 2017/2018 "Personal History of Physical and Sexual Abuse," even though victims of human trafficking suffer similar emotional and physical burdens as a result of force, fraud, or coercion; and

WHEREAS, "Human Trafficking," a form of modern slavery, occurs in every state and the District of Columbia, and subjects its victims to involuntary servitude, peonage, debt bondage, and physical, emotional and sexual abuse, and

WHEREAS, "Human Trafficking" presents a significant public health issue, the harms of which are multifold; and impacts multiple disciplines of medicine, including emergency medicine, internal medicine, obstetrics/gynecology, infectious disease, pediatrics, and psychiatry; and

WHEREAS, the Sixth Edition of the ACP Ethics Manual, under Obligations of the Physician to Society, states, "Physicians have obligations to society that in many ways parallel their obligations to individual patients. … This includes caring for vulnerable populations, such as the uninsured and victims of violence or human rights abuses"; therefore be it

**RESOLVED, that the Board of Regents supports including 'Victim of Human Trafficking' as an official Diagnosis Code and billable medical condition in the World Health Organization's 11th International Classification of Diseases (ICD-11); and be it further**

**RESOLVED, that the Board of Regents supports the development of educational materials to provide physicians and other health care providers with appropriate continuing education to prepare them to identify, treat and assist "Victims of Human Trafficking" as part of clinical practice.**

Reference: ICD-10 data set

**Resolution 3-S18. Advocating for an Annual Review of Payments for Ambulatory CPT Codes for Non-Procedural Services**

(Sponsor: New York Chapter)

WHEREAS, the economic viability of small ambulatory primary care practices is threatened by unfunded mandates including, but not limited to, compliance, infection control and OSHA, increased costs of maintaining electronic health records, rising personnel costs, increasing requirements to track and report clinical data, and other factors that command the resources of physicians and their staffs; and

WHEREAS, the current structure of reimbursement for professional services makes it essentially impossible for physicians to pass on increased costs to consumers of healthcare as other business entities would; and

WHEREAS, health insurance companies factor increased administrative and labor costs into their premiums allowing them to be made whole for such costs; therefore be it

**RESOLVED, that the Board of Regents advocates at the national level for annual review of payments for ambulatory CPT codes for non-procedural services and adjust reimbursement for annual administrative cost increases based on the specific costs of ambulatory medical practice rather than less relevant economic indices.**

**Resolution 4-S18. Opposing Health Insurance Companies from Requiring NDC's (National Drug Codes) on Vaccine Claim Submissions**

(Sponsor: Florida Chapter)

WHEREAS, it has been well established that vaccines are essential for the prevention of disease; and

WHEREAS, ACP already has strong standing policy on promoting the use of vaccines; and

WHEREAS, ACP advocates for patients before paperwork; and

WHEREAS, being able to get properly reimbursed for vaccines is essential for physicians to be able to afford to provide these necessary and lifesaving vaccines; and

WHEREAS, insurance companies are attempting to make this process more difficult by requiring more information than is reasonable for billing; and

WHEREAS, ACP has policy on managed care practices at https://www.acponline.org/acp_policy/policies/managed_care_compendium_2012.pdf; and

WHEREAS, Medicare does not require a National Drug Code (NDC) code for vaccine billing; and

WHEREAS, the NDC is a 10 digit universal product identifier for all prescription and non-prescription medications; and

WHEREAS, NDC can be burdensome to find for vaccines as multiple codes exist for the vaccines in a multidose vial versus a prefilled syringe or other formulation; and

WHEREAS, NDC can change from year to year; and

WHEREAS, the only information that should be specifically required is the appropriate ICD-10 and CPT code; and

WHEREAS, the mandate by United and other insurers to use NDC has led to delays in payments and denials of vaccine reimbursement; and

WHEREAS, if this process continues, it can lead to a barrier to vaccination; therefore be it

**RESOLVED, that the Board of Regents sends a letter to all the major insurances carries opposing NDC's (National Drug Codes) on vaccine claim submissions and demanding that the only requirement for vaccine billing and claims submission is the appropriate ICD-10 and CPT code, and not the NDC code; and be it further**

**RESOLVED, that the Board of Regents advocates to CMS and other appropriate agencies that only appropriate ICD-10 and CPT, and not NDC, codes be required for proper billing.**

**Resolution 5-S18. Advocating for Standardization of DME Requests with a Single DME Form Embedded in Existing Electronic Medical Records**

(Sponsor: Mississippi Chapter; Co-Sponsor: Connecticut Chapter)

WHEREAS, as highlighted by the American College of Physicians (ACP) Patients Before Paperwork framework, the use of durable medical equipment (DME) is increasing because of direct-to-consumer advertising, unsolicited requests by DME companies, and general public awareness (1); and

WHEREAS, the vision of the ACP is to be the recognized leader in quality patient care and in enhancing career satisfaction for internal medicine and its subspecialties; and

WHEREAS, there have been many well-documented instances of fraud originating with DME suppliers during the DME procurement process, with limited ability of the physician to control the process (2); and

WHEREAS, the ACP stated in 2006 that it supports efforts to prevent, investigate, and eliminate fraud and abuse associated with the supply of DME, provided that such increased enforcement activities do not result in increased hassles for internists (3); and

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) issued guidance in 2008 for DME suppliers stating, "For DME to be covered by Medicare, the medical records must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items claimed (4);" and

WHEREAS, the CMS guidance also stated, "A supplier should obtain as much documentation from the patient's medical record as it determines is needed to ensure that coverage criteria for an item have been met (4);" and

WHEREAS, the aforementioned guidance and the lack of standardized documentation required from different DME companies has led to significant variance in the amount and type of documentation requested and subsequently submitted to support the provision of DME, including clinical documentation unrelated to the need for DME; and

WHEREAS, a secure electronic request system is not utilized for DME requests, which also results in the potential release of health information unrelated to the need for DME; and

WHEREAS, the Privacy Rule in Title II of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 states, "When using or disclosing protected health information (PHI) or when requesting PHI from another covered entity or business associate, a covered entity or business associate must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request (5);" and

WHEREAS, much of the paperwork requested by vendors is tedious, causing delays in meeting patient needs and resulting in dissatisfaction among patients and clinicians; and

WHEREAS, when placed into the ACP's Patients Before Paperwork framework, DME requests inconsistently improve quality of care, do not typically lead to both timely and appropriate care, often question physician judgment, and have an unknown financial effect, making these requests burdensome; therefore be it

**RESOLVED, that the Board of Regents advocates for implementation of a single standard DME form within existing electronic medical records in order to reduce fraud, comply with the HIPAA Privacy Rule, and reduce the burdensome nature of DME requests.**

1. Erickson SM et al. Putting patients first by reducing administrative tasks in health care: A position paper of the American College of Physicians. *Ann Intern Med*. 2017;166:659-661.
2. https://www.justice.gov/opa/pr/former-owner-durable-medical-equipment-company-pleads-guilty-5-million-health-care-fraud
3. ACP Policy Compendium, Home Health Services subsection, pages 105-106.
4. http://compliance.com/publications/durable-medical-equipment-dme-documentation-required-for-medicare-payment/#footnote-20
5. https://www.gpo.gov/fdsys/pkg/CFR-2007-title45-vol1/pdf/CFR-2007-title45-vol1-part164-subpartE.pdf

**Resolution 6-S18. Studying the Coordination of Care of Complex Patients and the Reimbursement Thereof**

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP has previously backed policy to improve the coordination of care of complex patients; and

WHEREAS, a goal of the ACP is to advocate for responsible positions on public policy relating to health care for the benefit of the public and our patients; and

WHEREAS, complicated patients (especially complicated elderly patients with multiple medical problems and multiple subspecialists providing subspecialty care) can benefit from comprehensive coordination of their medical care by internists; and

WHEREAS, internists' current efforts to promote coordination of medical care through medical homes and additional coordination of care codes seem to be proving inadequate to fully allow internists to realistically provide true comprehensive coordination of care; therefore be it

**RESOLVED, that the Board of Regents study and recommend additional means where internists can coordinate care of complicated patients and also be adequately compensated by payments from commercial insurance, Medicare and Medicaid.**

Reference:
PCMH data from ACOs

**Resolution 7-S18. Improving Access to Care for the Uninsured by Making Hospital Charges More Equitable**

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP has previously published policy on the behalf of patients seeking needed medical care; and

WHEREAS, it is a goal of the ACP to advocate responsible positions on public policy relating to healthcare for the benefit of the public and our patients; and

WHEREAS, it is a well-recognized fact that uninsured patients are charged full rates for emergency room and hospital fees relative to the negotiated rates that private insurance plans, Medicare, and Medicaid pay; and

WHEREAS, it is unfair that such patients should have to pay such charges relative to other patients (especially since they are often the individuals with the most difficulty in paying such charges); and

WHEREAS, California has had a "fair pricing" law in existence since 2006, which has been effective according to a 2012 Health Affairs study; and

WHEREAS, the ACP strongly supports improving access to care for all patients; therefore be it

**RESOLVED, that the Board of Regents improve access to care for the uninsured by making hospital charges more equitable by encouraging and supporting state chapters to advocate for state legislation modeled on the 2006 California fair pricing law, lobbying the U.S. Congress to pass national legislation based on the California law and asking JCAHO to mandate a fair pricing policy as part of the criteria for hospital accreditation; and be it further**

**RESOLVED, if these efforts prove unsuccessful or prohibitively expensive, that the Board of Regents will recommend that the ACP lobby the American Hospital Association and other hospital organizations to create policies asking hospitals to voluntarily restrict charges to individuals without insurance to a level of charges equal to the average insurance payment for that charge (plus 10% to help cover losses from the uninsured patients).**

Reference: Hospital pricing data

**Resolution 8-S18. Opposing Insurance Company's Termination without Cause Policy**

(Sponsor: Florida Chapter)

WHEREAS, access to care is of paramount importance to the mission of the College; and

WHEREAS, the College has as policy that insurance companies should have reasonable and transparent processes for their networks; and

WHEREAS, insurance companies can terminate without cause; and

WHEREAS, such a termination can arbitrarily determine the access to care in a community; and

WHEREAS, this termination does not have to be based on any quality metrics, care data or objective findings; and

WHEREAS, physicians may stand to lose significant percentages of their patient population; and

WHEREAS, a loss of physicians in an area can cause a significant disruption in the care of the community; and

WHEREAS, ACP currently has policy opposing termination without cause at https://www.acponline.org/acp_policy/policies/promoting_transparency_and_alignment_in_medicare_advantage_2017.pdf and https://www.acponline.org/acp_policy/policies/managed_care_compendium_2012.pdf; therefore be it

**RESOLVED, that the Board of Regents sends a letter to major insurance companies and their respective trade organizations urging them to remove termination without cause from all physician contracts.**

**Resolution 9-S18. Updating Policy to Support Private Contracting with Medicare Beneficiaries**

(Sponsor: Florida Chapter)

WHEREAS, the College has already passed policy for fair reimbursement; and

WHEREAS, appropriate compensation for services has a direct impact on patient care; and

WHEREAS, studies have shown that systems with lower reimbursement rates have led to less physician involvement with that system; and

WHEREAS, the United States operates under a free market system; and

WHEREAS, individuals have a right to purchase services, within legal boundaries; and

WHEREAS, current Medicare and insurance models do not always provide for coverage of all services; and

WHEREAS, patients should have the right to choose how they spend their finances; and

WHEREAS, current insurance plans do not always allow for physicians to join in an area and thereby lead to decreased access to care; and

WHEREAS, patients may want to see physicians outside of a current network; and

WHEREAS, private contracting will be defined as a financial agreement for medical services mutually agreed upon between a physician and a patient; and

WHEREAS, current ACP policy supports the right of patients to have choice in their health care at https://www.acponline.org/acp_policy/policies/snapshot_sgr_repeal_bill_2014.pdfhttps://www.acp and online.org/acp_policy/policies/managed_care_compendium_2012.pdf ; therefore be it

**RESOLVED, that the Board of Regents updates its current policy to support private contracting with Medicare beneficiaries with physicians as long as it does not create an underserved area or decrease access to care.**

**Resolution 10-S18. Recognizing Health Care as a Human Right**

(Sponsor: Rhode Island Chapter; Co-Sponsors: Arkansas, Arizona, Oklahoma, Missouri, Massachusetts, North Carolina, Nevada, and New York, Chapters)

WHEREAS, there is strong evidence that lack of access to health care results in poorer health and earlier death (https://www.acponline.org/acp_policy/policies/no_health_insurance_scientific_research_linking_lack_of_health_coverage_to_poor_health_1999.pdf); and

WHEREAS, College policy advocates for the provision of "universal health insurance coverage to ensure that all people within the United States have equitable access to appropriate health care without unreasonable financial barriers" (ACP Policy Compendium 2017, p. 71); and

WHEREAS, while ACP policy states that "[H]ealth and human rights are interrelated," the College does not have policy recognizing access to care as a human right, as opposed to a privilege (ACP Policy Compendium, p. 223); and

WHEREAS, the World Health Organization and many nations recognize medical care as a human right, while the United States does not (http://www.who.int/mediacentre/factsheets/fs323/en/); and

WHEREAS, recognizing medical care as a human right would strengthen efforts to achieve universal coverage; therefore be it

**RESOLVED, that the Board of Regents recognize that equitable access to appropriate health care is a fundamental human right; and be it further**

**RESOLVED, that the Board of Regents advocate for legislative and/or constitutional recognition of equitable access to appropriate health care as a fundamental human right.**

**Resolution 11-S18. Evaluating MIPS Effect on Quality of Care and Developing an Alternative if the Effect is Proven to be Negative**

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP is a proponent of evidence based approaches to improving medical care; and

WHEREAS, goals of the ACP include serving the professional needs of its membership and advocating responsible positions on public policy relating to health care of the public and our patients; and

WHEREAS, it is unclear exactly how the Merit-based Incentive Payment System (MIPS) will be evaluated for its effectiveness in improving quality of medical care (which is its presumed primary function); therefore be it

**RESOLVED, that the Board of Regents will call upon CMS to perform an evaluation of MIPS and provide data demonstrating that MIPS is improving the quality of care provided by physicians; and be it further**

**RESOLVED, that the Board of Regents will choose an appropriate national committee to oversee a study of the CMS evaluation and if quality of care is proven to be lacking then advocate for the development of an alternative system to replace MIPS that actually does improve quality of care without introducing an unnecessary level of paperwork/hassle for practicing physicians.**

Reference:

1. MACRA

**Resolution 12-S18. Evaluating the Processes for ACP Representation in the American Medical Association**

(Sponsor: Arkansas Chapter)

WHEREAS, the American College of Physicians in the largest specialty organization represented in the American Medical Association (AMA) House of Delegates (HOD) – AMA's policy making body; and

WHEREAS, one of the goals of ACP is to advocate 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, ACP strives to attain that goal through its influence on AMA policies by virtue of its delegates, besides other avenues; and

WHEREAS, ACP delegation will become the largest specialty delegation starting 2018; and

WHEREAS, it is important that ACP's AMA delegation besides promoting ACP policies also represents the current views of its membership as expressed in the BOG and BOR meetings; and

WHEREAS, ACP BOR approved 'Operating Rules' for the ACP Delegation to the AMA on November 5, 2016, which addresses many but not all issues involving the delegation; therefore be it

**RESOLVED, that the Board of Regents evaluates the processes for nomination, selection, composition, appointment of delegates and its officers to achieve optimal alignment with ACP policy, engagement by Regents, Governors and Officers, mentoring and development of candidates for AMA office, experience, diversity and inclusion in the delegation composition; and be it further**

**RESOLVED, that the Board of Regents amends the "Operating Rules" for the ACP delegation to assure that no delegate shall serve more than eight years as an AMA delegate, unless elected or appointed to AMA BOT or a Council, in which case the delegate shall remain a delegate through the term of that office.**

**Resolution 13-S18. Calling for the United States to Embrace the Treaty on the Prohibition of Nuclear Weapons**

(Sponsor: Massachusetts Chapter; Co-sponsor: Rhode Island Chapter)

WHEREAS, since the height of the Cold War, the United States and Russia have dismantled more than 50,000 nuclear warheads, but 15,000 of these weapons still exist and pose an intolerable risk to human survival; and

WHEREAS, 95 percent of these weapons are in the hands of the United States and Russia and the rest are held by seven other countries: China, France, Israel, India, North Korea, Pakistan, and the United Kingdom[1]; and

WHEREAS, the use of even a tiny fraction of these weapons would cause worldwide climate disruption and global famine; to wit, as few as 100 Hiroshima sized bombs, small by modern standards, would put at least 5 million tons of soot into the upper atmosphere and cause climate disruption across the planet, cutting food production and putting 2 billion people at risk of starvation[2]; and

WHEREAS, a large scale nuclear war would kill hundreds of millions of people directly and cause unimaginable environmental damage[3] and catastrophic climate disruption dropping temperatures across the planet to levels not seen since the last ice age; under these conditions the vast majority of the human race would starve and it is possible we would become extinct as a species[4]; and

WHEREAS, despite assurances that these arsenals exist solely to guarantee that they are never used, there have been many occasions when nuclear armed states have prepared to use these weapons, and war has been averted only at the last minute[5]; and

WHEREAS, nuclear weapons do not possess some magical quality that prevents their use; and

WHEREAS, former Defense Secretary Robert McNamara said, speaking about the Cuban Missile Crisis, "It was luck that prevented nuclear war," yet our nuclear policy cannot be the hope that luck will continue; and

WHEREAS, the effects of climate change place increased stress on communities around the world and intensify the likelihood of conflict, the danger of nuclear war will grow[6]; and

WHEREAS, the planned expenditure of more than $1 trillion to enhance our nuclear arsenal will not only increase the risk of nuclear disaster but fuel a global arms race and divert crucial resources needed to assure the well-being of the American people and people all over the world[7]; and

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[1] https://fas.org/issues/nuclear-weapons/status-world-nuclear-forces/

[2] http://www.psr.org/assets/pdfs/two-billion-at-risk.pdf

[3] http://www.psr.org/assets/pdfs/projected-us-casualties-and-destruction.pdf

[4] http://climate.envsci.rutgers.edu/pdf/RobockNW2006JD008235.pdf

[5] http://www.ucsusa.org/sites/default/files/attach/2015/04/Close%20Calls%20with%20Nuclear%20Weapons.pdf

[6] https://www.scientificamerican.com/article/once-again-climate-change-cited-as-trigger-for-war/

[7] https://www.armscontrol.org/factsheets/USNuclearModernization

WHEREAS, there is an alternative to this march to nuclear war: in July 2017, 122 nations called for the elimination of all nuclear weapons by adopting the Treaty on the Prohibition of Nuclear Weapons[8]; and.

WHEREAS, ACP supports the elimination by all nations of nuclear weapons and other weapons of mass and indiscriminate destruction. The College urges that this policy be widely disseminated, including dissemination through the World Health Organization and other forums. (ACP AMA Del I-96; reaffirmed BOR 06); and

WHEREAS, ACP recognizes the threat of nuclear weapons to the health of the people of the world and supports worldwide diplomatic efforts to limit, reduce and ultimately eliminate these weapons. (HOD 89; reaffirmed BOR 04; reaffirmed BOR 16); therefore be it

**RESOLVED, that the Board of Regents calls upon our federal leaders and our nation to embrace the Treaty on the Prohibition of Nuclear Weapons[9] and make nuclear disarmament the centerpiece of our national security policy; and be it further**

**RESOLVED, that the Board of Regents calls upon our federal leaders and our nation to spearhead a global effort to prevent nuclear war by:**

- renouncing the option of using nuclear weapons first;
- ending the president's sole, unchecked authority to launch a nuclear attack;
- taking US nuclear weapons off hair-trigger alert;
- canceling the plan to replace its entire nuclear arsenal with enhanced weapons; and
- actively pursuing a verifiable agreement among nuclear armed states to eliminate their nuclear arsenals.

[8] http://www.icanw.org/treaty-on-the-prohibition-of-nuclear-weapons/

[9] http://www.icanw.org/treaty-on-the-prohibition-of-nuclear-weapons/

**Resolution 14-S18. Establishing Policy on the Appropriate Use of Point of Care Ultrasound**

(Sponsor: Florida Chapter)

WHEREAS, point of care ultrasound (POCUS) is increasingly used by clinicians of many backgrounds (physicians, physician assistants, emergency medical technicians, and nurse practitioners)[1] to extend their clinical skills; and

WHEREAS, guidelines for the use of POCUS in the care of patients and/or training have been published by many specialties including emergency medicine[2], critical care[3], cardiology[4], rheumatology[5], family medicine[6], and pediatrics[7]; and

WHEREAS, over half of all schools of medicine in the U.S.[8] and medical schools in Canada now expose and educate students in the skills of POCUS, and over one quarter have formal ultrasound curricula[9]; and

WHEREAS, at least one quarter of U.S. internal medicine GME programs have formal ultrasound curricula training residents to use POCUS to enhance patient care[10,11], and the Canadian Internal Medicine Ultrasound Group has published consensus recommendations for residency programs[12 13]; and

WHEREAS, ACP has sponsored courses in ultrasound at its annual national and chapter meetings for a decade and has co-sponsored faculty and physician development workshops across the U.S.; and

WHEREAS, there is no current ACP policy statement on the role of POCUS use in the care of Internal Medicine patients; therefore be it

**RESOLVED, that the Board of Regents establishes policy addressing the appropriate use of point of care ultrasound by internists; and be it further**

**RESOLVED, that the Board of Regents establishes point of care ultrasound educational resources for internists that are consistent with ACP policy.**

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**Resolution 15-S18. Advocating for a Streamlined Credentialing Process**

(Sponsor: Florida Chapter)

WHEREAS, the ACP supports patients before paperwork; and

WHEREAS, the re-credentialing process at hospitals, insurances companies and other organizations can become onerous and redundant; and

WHEREAS, a streamlined process can more accurately reflect the status of the physicians credentials; and

WHEREAS, much information does not change in the credentialing period; and

WHEREAS, credentialing can often be a redundant and burdensome process; and

WHEREAS, the Joint Commission has input on the credentialing process; and

WHEREAS, representatives from the ACP sit on the Board of Commissioners for the Joint Commission; therefore be it

**RESOLVED, that the Board of Regents communicates the onerous re-credentialing process with the Joint Commission and asks them to allow for a streamlined and reasonable process.**

**Resolution 16-S18. Updating ACP Policy regarding ABIM Certification and MOC**

(Sponsor: Arkansas Chapter)

WHEREAS, the ACP helped create ABIM in 1936 to "enhance the quality of health care by certifying internists and subspecialists who demonstrate the knowledge and skills essential for excellent patient care"; and

WHEREAS, ABIM appears to have, by and large, fulfilled that goal; and

WHEREAS, ABIM proceeded to add "maintenance of certification" (MOC) to its charter starting in 1991, as "professionally determined standard that attests that an internist is staying current in knowledge and practice throughout his/her career"; and

WHEREAS, development of an ACP alternative MOC pathway with ABIM remains uncertain despite ongoing efforts by ACP; and

WHEREAS, ACP remains the leader in providing highly relevant continuing medical education to internists to help maintain competency and excellent patient care; and

WHEREAS, ACP is the leading voice and medical home of internists; therefore be it

**RESOLVED, that the Board of Regents formulates a policy for ACP to assume responsibility of certification of continuing medical education of internists commensurate with their specific patient care responsibilities to help them maintain lifelong learning and competency, while continuing to rely on ABIM for the initial certification.**

**Resolution 17-S18. Lobbying ABIM to Offer MOC Exams That are More Representative of Diplomates' Practice Environments and Creating ACP's Own Alternate MOC Exams to Do the Same**

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP considers itself the professional home for all internists; and

WHEREAS, the ACP is widely considered a premier source of educational resources for internists; and

WHEREAS, internists are increasingly being employed in narrow practice environments, i.e., mostly or 100% outpatient, and mostly or 100% inpatient settings; and

WHEREAS, ABIM has extensive internal data regarding Diplomates' practices through mandatory self-reported practice profiles; and

WHEREAS, ABIM already offers an optional Focused Practice in Hospital Medicine (FPHM) pathway with a Hospital Medicine MOC exam for hospitalists but not an outpatient-specific MOC exam for internists who only practice in an outpatient setting; and

WHEREAS, ABIM has already agreed to allow ACP to create an alternate MOC exam pathway for ABIM Diplomates; therefore be it

**RESOLVED, that the Board of Regents will lobby ABIM to offer three types of Internal Medicine MOC exam pathways and will also create its own MKSAP-based MOC exams to be more representative of Diplomates' practice environments:**

1. The current Focused Practice in Hospital Medicine (FPHM) MOC exam pathway would continue to be available to hospitalists as currently defined by ABIM profile criteria with either a single 10-year Hospital Medicine MOC exam or five 2-year Knowledge Check-In's. All exams and knowledge check-in's would consist of inpatient-specific questions.
2. A new Focused Practice in Outpatient Medicine (FPOM) MOC exam pathway with either a single 10-year Outpatient Medicine MOC exam or five 2-year Knowledge Check-In's would be made available to internists who meet ABIM profile criteria for outpatient-based practice. All exams and knowledge check-in's would consist of outpatient-specific questions.
3. The current MOC exam pathway of either five 2-year Knowledge Check-In's or a single 10-year MOC exam would continue to be available to any Diplomate who wishes to take this pathway to fulfill Internal Medicine MOC exam requirements. All exams and Knowledge Check-In's would continue to consist of mixed inpatient/outpatient questions.
4. ACP will develop three exam pathways when it creates its own MKSAP-based alternate MOC exams: a hospital-specific exam pathway available to hospitalists, an outpatient-specific exam pathway available to outpatient-based internists and a mixed inpatient/outpatient exam pathway available to any internist.
5. The current requirement of obtaining 100 MOC points every 5 years would be unchanged regardless of which one of the above MOC exam pathways a Diplomate chooses and such points can continue to come from any source meeting ABIM's criteria for MOC points eligibility.

Reference:
1. ACP website
2. ABIM website

**Resolution 18-S18. Updating Policy on MOC and Licensure Requirements**

(Sponsor: Florida Chapter)

WHEREAS, the maintenance of certification process has become onerous and not always reflective of a true assessment of physician knowledge; and

WHEREAS, the goal of maintenance of certification should be lifelong learning and not lifelong testing; and

WHEREAS, strong evidence does not exist to substantiate that maintenance of certification leads to better quality outcomes; and

WHEREAS, many physicians are faced with regulations and requirements that can negatively affect their ability to practice medicine and provide access of care to patients; and

WHEREAS, many physicians are being faced with hospitals and insurances companies mandating maintenance of certification as a condition of licensure; and

WHEREAS, state medical boards are also facing an issue of mandating MOC as a condition of licensure; and

WHEREAS, nothing in this resolution is to devalue the concept of lifelong learning, initial certification or maintaining quality and appropriate care; and

WHEREAS, the ACP should continue to work with ABIM to ensure a quality and meaningful MOC product; and

WHEREAS, the current ACP policy states that MOC should not be the sole determinant for licensure at https://www.acponline.org/acp_policy/policies/state_regulation_of_credentialing_2017.pdf; and

WHEREAS, leaving any possibility of having MOC as a condition of licensure can allow for physicians to be unfairly removed from medical staff, insurance and other organizations; and

WHEREAS, the current policy does not firmly and decisively protect the interests of internal medicine physicians; and

WHEREAS, the ACP should be more forceful and supportive of the membership; and

WHEREAS, ambiguous language as stated in the current policy can still allow for organizations to use MOC as a requirement for licensure; therefore be it

**RESOLVED, that the Board of Regents updates it MOC policy to specifically state that MOC should not be a condition of licensure.**

**Resolution 19-S18. Promoting Wellness, Community Outreach, and Chapter Excellence through an ACP "Day of Service"**

(Sponsor: BOG Class of 2021)

WHEREAS, participation in community service has been linked to improved physician wellness, a reduction in "burnout,' and overall return of joy to the practice of medicine for many physicians (1); and

WHEREAS, physician wellness is a major area of focus for the American College of Physicians (ACP); and

WHEREAS, community service is a major driver in the engagement of the millennial generation (2); and

WHEREAS, the Chapters play a critical role in facilitating a connection with ACP members at the local level; and

WHEREAS, the ACP is currently undergoing a restructuring of the Chapter Excellence Criteria; therefore be it

**RESOLVED, that the Board of Regents promotes wellness, community outreach, and chapter excellence through an ACP "Day of Service," which would honor and encourage a commitment of time and effort by the Chapters to people in need; and be it further**

**RESOLVED, that the Board of Regents highlights the purpose and impact of the "Day of Service" at IM 2020 and each successive year thereafter.**


1. Physicians' Perceptions of Volunteer Service at Safety-Net Clinics.
   Mcgeehan L, Takehara MA, Daroszewski E.
   Perm J. 2017;21. pii: 16-003. doi: 10.7812/TPP/16-003

2. Gilman, H.R. and Stokes, E. (2014). The Civic and Political Participation of Millennials. New America. Retrieved from https://www.newamerica.org/downloads/The_Civic_and_Political_Participation_of_Millennials.pdf

**Resolution 20-S18. Exploring the Feasibility of Creating an ACP Foundation to Support Physicians and Patients during Natural and Manmade Catastrophes**

(Sponsor: Florida Chapter)

WHEREAS, charitable contributions are inherently of value; and

WHEREAS, recent years have shown an increase in both natural and manmade disasters that impact patient care and the practice of medicine; and

WHEREAS, College resources have been limited to listing other organizations for charitable giving; and

WHEREAS, many charities only have to use 10% of funds for charity and can use contributions for administration and overhead; and

WHEREAS, not all charities provide enough support to the groups they claim to help; and

WHEREAS, ACP should take a more active role in underserved areas; and

WHEREAS, medical organizations, such as the Florida Medical Association and others, have created charitable foundations to help membership with patient care and other needs in times of crisis, and

WHEREAS, the ACP does not currently have a charitable foundation; therefore be it

**RESOLVED, that the Board of Regents explores the feasibility of creating a charitable foundation, or other mechanism, for the purpose of supporting physicians and patients in areas of need during natural and manmade catastrophes; and be it further**

**RESOLVED, that if such a foundation or mechanism can be created, the Board of Regents does so.**

**Resolution 21-S18. Allowing ACP Chapters to Seek Vendor Support without Restrictions**

(Sponsor: Florida Chapter)

WHEREAS, every chapter needs to have independent source of funding; and

WHEREAS, the College allows for industry support of chapter activities; and

WHEREAS, the funds can be used to support and stabilize the financial needs of the chapter; and

WHEREAS, national ACP uses industry support for its own finances; and

WHEREAS, industry support may overlap with national and local efforts; and

WHEREAS, a situation can occur where a specific service may exist at the chapter level that conflicts with a corresponding national service, for example an insurance company could offer educational resources that may conflict with educational resources provided for by national ACP in which case ACP national will prohibit obtaining support under those conditions (i.e. a vendor offers products/services that directly compete with those from ACP national); and

WHEREAS, many chapters have a separate entity from ACP national's such as a C6 division for member benefits; therefore be it

**RESOLVED, that the Board of Regents unconditionally and without restriction allows a chapter the liberty to seek industry and vendor support from the same sources that national uses; and be it further**

**RESOLVED, that the Board of Regents cannot disallow a chapter from industry support solely on the basis that national has a similar service or vendor that may be in competition with a national contract**.

**Resolution 22-S18. Increasing Efforts to Attract Physicians Involved in Direct Patient Care by Supporting Their Efforts in Providing Such Care**

(Sponsor: District of Columbia Chapter)

WHEREAS, ACP has made efforts in recent years to attract a broader variety of internists to become members of the ACP; and

WHEREAS, goals of the ACP include serving the professional needs of its membership as well as unify the many voices of internal medicine; and

WHEREAS, the ACP has been unable to attract as members many internists whose careers are oriented primarily towards providing medical care directly to patients; and

WHEREAS, many practicing internists do not feel adequately represented by "organized medicine" such as AMA and ACP; therefore be it

**RESOLVED, that the Board of Regents increase efforts at attracting and maintaining as members practicing internists (especially but not only in "private practice") by encouraging ACP chapters to submit resolutions to the BOG of potential benefit especially to practicing physicians and by advertising the resolution process to members and nonmembers alike, emphasizing that the resolution process is a critical way for members to influence national ACP policies that directly impact their own practices; and be it further**

**RESOLVED, that the Board of Regents will be more sensitive to how its policies affect the well-being (personally and professionally) of practicing internists and to change such policies, if necessary, so that practicing internists feel adequately represented by the ACP in their effort to provide optimal care to their patients.**

References: Membership Data

**Resolution 23-S18. Making LeaderNet Commentator's Conflict of Interest Clearly Accessible**

(Sponsor: Florida Chapter)

WHEREAS, it is essential for the function of an organization to have clear and open dialogue; and

WHEREAS, transparency is essential to that dialogue; and

WHEREAS, declaration of conflict of interest is required for service on chapter committees and governance structures; and

WHEREAS, the ACP has policy on accountability at https://www.acponline.org/acp_policy/policies/acp_professional_accountability_principles_2015.pdf; and

WHEREAS, that information is not always readily available during discussion of resolutions; and

WHEREAS, the context of commentary can be better understood when knowing what conflicts may exist; and

WHEREAS, discussions can involve issues with insurance, pharmaceutical and other industries that can lead to a clear conflict of interest; and

WHEREAS, discussions on LeaderNet already display title of the individual and role in the College; therefore be it

**RESOLVED, that the Board of Regents makes commentator's title and possible conflict clearly accessible on LeaderNet, in a manner created with staff input, for easy identification and reference (i.e. employment by pharmaceutical company, insurance company or institution et.al.) for any posted discussions.**