Resolution 1-S17. Updating ACP Policy to Advocate Banning the Sale of Tobacco Products at All Retail Pharmacies

(Sponsor: Florida Chapters)

WHEREAS, it is well established that the use of tobacco is harmful; and

WHEREAS, the ACP already has established policy from 2010 for Tobacco Control and Prevention; and

WHEREAS, many leading medical organizations have called upon pharmacies to ban the sale of tobacco in their stores; and

WHEREAS, CVS was the first national chain to ban the sale and conducted a study on the effects of banning the sale of tobacco products which showed a decrease in the amount of tobacco purchased in the cities that were studied;

WHEREAS, several retail pharmacies, such as Walgreens, are still selling tobacco products; and

WHEREAS, the current ACP policy encourages steps be taken to reduce the use of tobacco as a means of promoting health prevention and wellness; therefore be it

RESOLVED, that the Board of Regents updates its policy to support the ban of the sale of tobacco products at all retail pharmacies; and be it further

RESOLVED, that the Board of Regents supports legislation that bans the sale of tobacco products at all retail pharmacies; and be it further

RESOLVED, that the Board of Regents joins with other medical organizations in an open letter to retail pharmacies that asks them to ban the sale of tobacco products at all retail pharmacies.

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1 https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/control_tobacco.pdf
Resolution 2-S17. Recognizing Hate Crimes as a Public Health Issue

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, the American College of Physicians does not have a current policy stance addressing hate crimes as a public health issue although the AMA recognizes hate crimes as a public health issue (1); and

WHEREAS, the resolution corresponds to the goal 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, according to FBI reports, there has been an increase in racially, ethnically, religiously and sexually-oriented related hate crime reports from 2014 to 2015 (2); and

WHEREAS, hate crimes do impact both the medical and mental health of individuals and groups (3); and

WHEREAS, ACP policy states that “All patients, regardless of race, ethnic origin, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion, deserve high-quality health care” [5]; and

WHEREAS, hate crimes lead to more physiological and psychological distress than other crimes (4); therefore be it

RESOLVED, that the Board of Regents publicly recognizes hate crimes as a public health issue; and be it further

RESOLVED, that the Board of Regents opposes all legislation with discriminatory effects upon patients based on their race, ethnic origin, ancestry, gender, nationality, primary language, socioeconomic status, sexual orientation, cultural background, age, disability, or religion.

References:
Resolution 3-S17. Supporting the Older Americans Act

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP has a long history of being supportive of efforts to improve the health care for the elderly (who are high-risk for the need for social services) as well as in general for other persons who are at-risk for the need for social services; and

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

WHEREAS, the Older Americans Act (OAA) \(^3\) \(^4\) provides funding for social services to at-risk elderly persons and is up for renewal in 2018; and

WHEREAS, such funding has not increased sufficiently to provide adequate assistance to individuals requiring significant need for social services (e.g., funding for the Older Americans Act has been essentially flat over the past decade though the population 65 and older has increased by over 25% in number in this period of time\(^5\); and

WHEREAS, individuals who cannot adequately care for themselves without supportive services suffer unnecessarily, spend substantial resources they often cannot afford, and have to rely upon medical care, which is often discontinuous and expensive, occurring in settings such as hospitals and nursing homes; therefore be it

RESOLVED, that the Board of Regents supports the Older Americans Act as official policy; and be it further

RESOLVED, that the Board of Regents will collaborate with other health care professional groups to lobby for the extension of the OAA beyond its current 2018 expiration date, lobby for increased funding for the OAA, and encourage the development of innovative, cost-effective models of care which combine medical and social services in general.

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\(^3\) https://www.congress.gov/bill/114th-congress/senate-bill/192/text


\(^5\) NEJM 375:5: 399-401.
Resolution 4-S17. Updating the ACP Gender Pay Gap Policy to Address Pay Disparities within Medicine among All Groups

(Sponsor: Florida Chapters)

WHEREAS, the diversity policy of the ACP allows for all physicians to be represented, regardless of race, gender, religion, sexual orientation and other classifications; and

WHEREAS, studies show there is a payment gap for many different groups [1]; and

WHEREAS, the ACP has already passed policy to address the pay gap based on gender; and

WHEREAS, we cannot discriminate as an organization; therefore be it

RESOLVED, that the Board of Regents updates the ACP gender pay gap policy to specifically address the pay disparities within medicine across all groups, including but not limited to race, gender, religion, nationality, sexual orientation, gender identity or type of practice; and be it further

RESOLVED, that the Board of Regents works to start a national dialogue and create a culture within medicine at large in which all physicians are paid equally and fairly; and be it further

RESOLVED, that the Board of Regents addresses the issue within the specific contexts of the lack of transparency of physician salaries, burnout and physician wellness, and resultant negative effects on the strength of our medical workforce.

[1] Differences in incomes of physicians in the United States by race and sex: observational study: BMJ 2016; 353 doi: http://dx.doi.org/10.1136/bmj.i2923 (Published 07 June 2016) Cite this as: BMI 2016;353:i2923
Resolution 5-S17. Updating ACP Policy on Narrow Networks

(Sponsor: Florida Chapters)

WHEREAS, the current policy of the college to ask for transparency from insurance companies regarding their networks is not sufficient to address the current insurance practice of arbitrarily limiting access to care; and

WHEREAS, several insurers are using discriminatory and arbitrary metrics to exclude providers from being in network, such as Blue Cross of Florida which did not allow some providers to join in a service area, claiming there were enough providers while at the same time patients could not get timely appointments, but allowed other providers with similar credentials to join the plan; and

WHEREAS, current insurance practices can cause an unfair restraint of trade; and

WHEREAS, more than 27 states, the majority of the country have enacted any willing provider (AWP) laws6; and

WHEREAS, the ACP must address the needs of both the patients and the membership; and

WHEREAS, limiting a network inherently limits access to care; and

WHEREAS, the experience in the states with AWP laws have not necessarily shown an increase in cost7; and

WHEREAS, the data that suggest increased cost is limited and in many cases over 20 years old; and

WHEREAS, in 2012, Michael Allgrunn, Pd. D., an assistant professor of economics at the University of South Dakota did an economic analysis of any willing provider laws and the effect it would have in South Dakota and his research and calculation study concluded a decrease in health care costs8; therefore be it

RESOLVED, that the Board of Regents updates ACP policy on narrow networks and supports legislation that prevents the arbitrary exclusion of physicians from an insurance network without clear and transparent guidelines for participation; and be it further

RESOLVED, that the Board of Regents studies the insurance premiums in states that have enacted Any Willing Provider laws to see if there is a cost increase and if that cost increase can be attributed to Any Willing Provider legislation; and be it further

RESOLVED, that the Board of Regents supports legislation that would allow any physician to join an insurance network, if they desire, so long as they meet the appropriate insurance credentialing guidelines set forth by the plan, while also maintaining quality of care metrics.

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6 http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx
7 http://www.sdpatientchoice.org/media/allgrunnreport.pdf
8 http://www.sdpatientchoice.org/media/allgrunnreport.pdf
Resolution 6-S17. Promoting Transparency in Conversion to Medicare Advantage Plans

(Sponsor: New York Chapters)

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) is permitting a process of "seamless conversion" wherein seniors are transitioned from their commercial insurance into the same company's Medicare Advantage plan when they turn 65 years old; and

WHEREAS, seniors who have signed up with traditional Medicare are enrolled in the Medicare Advantage programs without their knowledge and are not understanding the need to opt out of the seamless conversion to be enrolled in traditional Medicare; and

WHEREAS, many of the Medicare Advantage plans have select narrow provider panels which disrupt a patient's established doctor/patient relationship and adversely affect the patient's healthcare delivery and financial wellbeing; and

WHEREAS, this practice of seamless conversion is projected to augment for the January 2017 enrollment period, and will not be a transparent process available for review by seniors or their physicians; therefore be it

RESOLVED, that the Board of Regents advocates that the Center for Medicare and Medicaid Services (CMS) implement an immediate moratorium on seamless conversion. There is little time in the upcoming enrollment period to appropriately educate seniors on this less than honest business practice and assist them in making a choice between traditional Medicare and narrow network Medicare Advantage plans.
Resolution 7-S17. Advocating for a Uniform Filing Deadline for Medical Claims Submissions

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP has worked over the years to help physicians in their interactions with government and private health insurance companies; and

WHEREAS, a central mission of the ACP is to serve the professional needs of its membership; and

WHEREAS, the ACP endeavors to help medical practices deliver high-quality care to patients; and

WHEREAS, there is considerable variation in the period of time various insurance plans give medical practices for filing claims (e.g., Medicaid DC is one year, Medicare is 180 to 360 days depending upon specifics, Tricare is one year, Anthem is 180 days for participants and 365 days for non-participants while others such as United, Cigna and Aetna are as little as 90 days); and

WHEREAS, when insurance companies allow only 90 days for filing claims, this can result in financial hardship on medical practices due to denial of claims based on “untimely” claims submissions, and as a result, can adversely affect those practices’ ability to provide high quality care to patients; therefore be it

RESOLVED, that the Board of Regents will advocate that CMS, state governments, and organizations like America’s Health Insurance Plans (AHIP) and Blue Cross Blue Shield Association (BCBSA), as well as other relevant organizations adopt a uniform filing deadline of 365 days after date of service for medical claims submissions to Medicare, state Medicaid plans and commercial insurance plans in order to protect the financial stability of medical practices, particularly independent solo and small practices. Such financial stability can then help increase the efficiency of those practices and the ability to provide high quality patient care.
Resolution 8-S17. Advocating for the Integration of Artificial Intelligence Technology in Electronic Health Records

(Sponsor: New York Chapters)

WHEREAS, the mandated use of electronic health records is frequently cited as a major cause of physician burnout; and

WHEREAS, the design of electronic health records requires physicians to spend a great deal of time clicking on drop-down menus and documentation templates; and

WHEREAS, many physicians feel that they have had their training, skills, and judgment trivialized by relegating them to input data, perform coding tasks and clerical duties; and

WHEREAS, physicians report that most, if not all, electronic health records that they have utilized are constructed with poorly planned, often unrelated data fields that create obstacles to efficiency and comprehension rather than aid in identifying medical errors, enhancing differential diagnoses, and discovering trends across patient populations; and

WHEREAS, few if any electronic medical record systems currently in use provide meaningful “decision support” other than making relatively trivial comparisons of a few data fields; and

WHEREAS, artificial intelligence (AI) projects such as Google’s DeepMind and IBM’s Watson Health are ultimately capable of reducing or eliminating the need for a manual interface with an electronic health record interface by replacing field forms, drop-down menus, checkboxes and other manual interface functions with dictated free-form text from which AI may automatically extract diagnoses, perform coding functions, discern medical errors, and provide enhanced data analysis and decision support; therefore be it

RESOLVED, that the Board of Regents, in partnership with the Office of the National Coordinator for Health Information Technology, advocate for the integration of artificial intelligence technology into electronic health record technology.
Resolution 9-S17. Assisting ACP Members to Establish a Direct Primary Care Practice

(Sponsor: Florida Chapters)

WHEREAS, the overarching goals of the ACP are to ensure patients access to affordable and quality care, improve the delivery of healthcare and ensure physician satisfaction; and

WHEREAS, many different practice models exist to achieve this goal; and

WHEREAS, the ACP should be a leader in the field of guiding its members in different healthcare delivery models; and

WHEREAS, the current policy of the ACP allows for Direct Primary Care with certain guiding principles; and

WHEREAS, other primary care groups, such as the American Academy of Family Physicians, are using a model of Direct Primary Care that achieves the stated goals of the College; and

WHEREAS, a model can be created, that serves the need of patients who cannot afford health insurance or who have high deductible health plans that do not allow for effective coverage, which provides for a low cost contract between a patient and a doctor ensuring them access to primary care; and

WHEREAS, many states see this as a model to supplement a failing Medicaid system; and

WHEREAS, many physicians and patients express satisfaction with this practice model; therefore be it

RESOLVED, that the Board of Regents creates a resource to assist ACP members in establishing a direct primary care model that is in line with the ACP’s policy goals; and be it further

RESOLVED, that when developing this member resource the Board of Regents seeks input from other primary care organizations, such as AAFP, that have successfully created these models.
Resolution 10-S17. Exploring a Comprehensive ACP Educational Program in Behavioral Health and Substance Abuse

(Sponsor: New York Chapters)

WHEREAS, the practice of primary care includes the screening, diagnosis and management of a variety of behavioral health conditions; and

WHEREAS, the prevalence of mental health comorbidities in patients with chronic conditions such as diabetes, heart failure and COPD is large; and

WHEREAS, optimal management of chronic medical conditions requires attention to mental health comorbidities; and

WHEREAS, the care of major depression, anxiety disorders and substance abuse requires a specialized knowledge base and skill set; and

WHEREAS, many of the expanding alternative payment models require primary care physicians to manage behavioral health and substance abuse and report on these measures; and

WHEREAS, there is not a comprehensive, self-contained educational course on behavioral health and substance abuse, which currently requires internists to access this information in a piecemeal fashion; therefore be it

RESOLVED, that the Board of Regents explores the potential of developing a comprehensive online educational module in Behavioral Health and Substance Abuse, similar to the High Value Cost Conscious Care modules.
Resolution 11-S17. Accelerating High-Quality Research in Cost-Effectiveness, Comparative Effectiveness, and Safety of Non-Opioid Pain Treatments

(Sponsor: Illinois Chapters)

WHEREAS, an estimated 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses receive an opioid prescription; and 1

WHEREAS, more than 165,000 individuals died from opioid pain medication overdose in the United States between 1999 and 2014,2 and more than 420,000 emergency department visits were related to the misuse or abuse of narcotic pain relievers in 2011; and 3

WHEREAS, physician best practices for opioid prescribing, physician and patient education, and comprehensive drug monitoring programs are necessary but not sufficient to quell the rising epidemic of opioid-related morbidity and mortality; and 4

WHEREAS, many alternatives to opioids exist for both acute and chronic pain control 4,5,6 such as topical NSAIDs, 7 lidocaine patches, 8 adjuvant pain medications such as pregabalin 9 and duloxetine, 10 acupuncture, 11 biofeedback and cognitive behavioral therapy, 12 aquatic exercise training, 13 massage therapy, 14 Tai Chi, 15 etc.; and

WHEREAS, many of these pain management strategies are much more difficult to access than opioid medications because of lack of insurance coverage and the burden of the prior authorization process; and 4,5

WHEREAS, high-quality scientific evidence on the effectiveness, cost-effectiveness, comparative effectiveness, and safety is lacking for many non-opioid pain management strategies; therefore be it 8,10,11,12,14,15

RESOLVED, to accelerate the development of high-quality evidence for non-opioid pain treatments, that the Board of Regents:

- Advocates for PCORI- and AHRQ-funded research addressing safety, quality, comparative effectiveness, and cost effectiveness of non-opioid pain management strategies; and
- Advocates for large randomized controlled clinical trials whenever possible; and
- Encourages the incorporation of patient-centered and patient-reported outcomes in new research to appropriately characterize and assess potential benefits of these therapies; and be it further

RESOLVED, to facilitate improved access to non-opioid methods of pain control, that the Board of Regents advocates that CMS/Medicare reduce cost sharing and eliminate the need for prior authorization for non-opioid pain management strategies that are already covered, such as topical NSAIDs and adjuvant pain medications like duloxetine and pregabalin.

References


Resolution 12-S17. Clarifying ACP Policy/Opinion Regarding Generic Medications

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP takes a strong, proactive stand in favor of prescribing generic drugs in place of brand name drugs as outlined in a January 5, 2016 Annals of Internal Medicine article (1); and

WHEREAS, the Missions and Goals of the ACP include: advocating responsible positions on individual health care and public health policy regarding benefits to the public and our patients, as well as serving the professional needs of its membership; and

WHEREAS, the ACP’s current clinical guidelines (1) state it is generally true most generic drugs perform adequately, cost less than brand name versions, and should be prescribed whenever possible; it must not be assumed "Generic medicines are copies of brand-name medications" (2) and individual patient differences in bioavailability and tolerability are therapeutically unimportant; and

WHEREAS, blanket assurances from the ACP stating generic versions of a drug are identical to the brand name (and to other generic versions of the same drug) make it potentially more difficult for physicians to seek insurance overrides when a patient must continue a brand name or alternate generic drug; and

WHEREAS, valid reasons why a generic drug is not therapeutically similar to the brand name “equivalent” and to other generic versions of the same drug include:

1. Generics are not "identical" only "bioequivalent" to the comparable drug (usually brand-name) and have potential wide range of statistical variability to the comparable drug;
2. Generics are only bioequivalent to the active comparable molecule, and are not bioequivalence-tested for the “inactive” excipients used to manufacture and compound the drug;
3. Not all individuals react the same to a specific generic drug due to individual genetic variation causing different rates of absorption, metabolism and side effects; and
4. Differences, in generic drug composition, as noted above, may lead to variable efficacy, including different rates of metabolism and duration of half-life, and increased side effects; therefore be it

RESOLVED, that the Board of Regents supports ACP policy to continue to advocate for the prescription of generic drugs when appropriate for an individual patient, but that the written ACP policy makes it clear:

1. There are specific reasons why a given generic drug may not be best for an individual patient.
2. A generic drug is not "identical" to the brand name (or to other generic versions of the drug) as stated in the Summaries for Patients addendum to the Jan 5, 2016 Annals article (2).
3. ACP supports insurance company approval of a brand name or alternative generic drug when there are sufficient documented reasons for the physician to request the substitution without placing undue burden on the physician and/or their patients, including stringent pre-authorization requirements, nonadherence penalties for the physician, and significantly higher patient prescription costs.

REFERENCES
Resolution 13-S17. Assuring Chapter Input on National Award Nominations, Mastership Conferrals and Committee Appointments

(Sponsor: Florida Chapters)

WHEREAS, the strength of an organization is its membership; and

WHEREAS, the current system of advancement to fellowship requires review by the Governor; and

WHEREAS, the national awards and Mastership nominations can be done without chapter input; and

WHEREAS, the chapter is best suited to know the membership; and

WHEREAS, a discussion with the chapter can help to ensure all necessary information is provided to the Awards Committee; and

WHEREAS, a discussion with the chapter could reveal any potential problems or issues with the appointment or nomination; and

WHEREAS, the national committee may not have all necessary information to decide upon the candidate; therefore be it

RESOLVED, that the Board of Regents assures that the national Awards Committee seek chapter input and discuss all candidates for awards and Masterships from the respective chapter; and be it further

RESOLVED, that the Board of Regents assures that all appointments to a national committee be discussed with the respective Chapter before official appointment.
Resolution 14-S17. Increasing Chapter Funding Based on Per Capita/Membership

(Sponsor: Florida Chapters)

WHEREAS, discussion with different Governors throughout the chapters reveal that many chapters in the ACP struggle with financial issues; and

WHEREAS, medical student and resident education are critical to the preservation of the practice of medicine; and

WHEREAS, regardless of size, chapters need assistance in meeting the educational needs of the medical student and residents; and

WHEREAS, the current funding is based on a percentage of chapter expenses; and

WHEREAS, the chapters need a more consistent funding system to ensure proper educational activities; and

WHEREAS, discussion with Governors and executives from both small and large chapters show that a range of $2000 to $10,000 would meet many educational needs; and

WHEREAS, the average membership numbers coupled with average previous funding amounts would be met by a $10 per member contribution; therefore be it

RESOLVED, that the Board of Regents assures that every chapter will receive a minimum of $2000 with a maximum of $10,000, based on a per capita value $10 per every medical student and resident who are ACP members.