Resolution 1-F17. Redoubling Efforts to Achieve RVU Reimbursement for Currently Uncompensated Physician EHR Work

[ACCEPTED AS REAFFIRMATION]

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP has publicly emphasized that the time spent by physicians is a key resource in health care delivery; and

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

WHEREAS, practicing physicians who provide medical care are a key constituency of the ACP; and

WHEREAS, fee for service payments are intended to reflect resources (RVUs) used before, during and after clinical encounters associated with face-to-face ambulatory care visits; and

WHEREAS, in the age of electronic health records, questions have been raised about whether the reports underlying the RVU estimates are representative of physician effort in providing patient care services; and

WHEREAS, a recent study from Health Affairs (36:4 page 655, 2017) used data on physician's time allocation and found that physicians logged an average of 3.08 hours on office visits and 3.17 hours on desk top medicine each day; and

WHEREAS, much of the work generated via the electronic health record (EHR) is not directly associated with a face-to-face visit and thus not compensated; and

WHEREAS, previous efforts by ACP to have uncompensated physician EHR work be compensated have been unsuccessful; therefore be it

RESOLVED, that the Board of Regents will redouble its efforts in lobbying to achieve RVU reimbursement for currently uncompensated physician EHR work which will take into account the increased time for physician EHR work, including joining other medical organizations in such efforts and lobbying for federal legislation if necessary.

Resolution 2-F17. Updating ACP Policy to Oppose Fail First or Step Therapy Policies

(Sponsor: Florida Chapter)

WHEREAS, fail first or step therapy will be defined as an insurance company requiring a patient to be on certain medications and fail in a particular order before trying other medications; and

WHEREAS, the treating physician possesses the most knowledge about their patient and is the best judge for that patient's treatment plan; and

WHEREAS, there are many examples and information regarding issues with step therapy: http://csro.info/advocacy/state-advocacy/step-therapy.aspx, https://failfirsthurts.org/ffh/, http://www.columbiatribune.com/8dd02562-c287-543b-84ad-b5d59c52d3b1.html, http://files.ctctcdn.com/9d08e137201/651b0856-299c-482c-8654-32e5270a7f78.pdf; and

WHEREAS, insurance companies do not always use purely medical decisions to choose medications; and

WHEREAS, fail first or step therapy creates an undue burden on both practices and patient care; and

WHEREAS, patients before paperwork policies seek to minimize unnecessary burdens; and

WHEREAS, switching a patient's medication can possibly cause a deterioration in the patients' health; and

WHEREAS, ACP policy on Drug Formularies and Pharmacy Benefit Managers supports an exception or override process to allow patients and physicians to use medications outside a formulary when medically justifiable; and

WHEREAS, current ACP policy does not specifically address fail first or step therapy protocols; and

WHEREAS, current ACP policy supports drug choice based on effectiveness, safety, and ease of administration and not solely on cost; and

WHEREAS, many states are attempting to address this issue by preventing fail first or step therapy protocols; and

WHEREAS, Medicare and other federal insurance programs should also be held accountable for fail first or step therapy protocols; therefore be it

RESOLVED, that the Board of Regents updates its policy to specifically oppose step therapy and fail first policies that do not allow for formulary exemptions that are medically justifiable; and be it further

RESOLVED, that the Board of Regents will support legislation that opposes step therapy and fail first policies that do not allow for formulary exemptions that are medically justifiable.

Resolution 3-F17. Updating ACP Policy on Drug Formularies and Pharmacy Benefit Managers to Increase Transparency of Drug Cost and Rebate Incentives

(Sponsor: Florida Chapter)

WHEREAS, the role of pharmacy benefit managers (PBMs) has evolved from mere administrator to highly involved middleman acting as an intermediary between insurers, manufacturers, employers, government programs and pharmacies; and

WHEREAS, PBMs have significant influence over pharmaceutical drug costs and patient access to effective and affordable treatment; and

WHEREAS, PBMs receive discounts off the Wholesale Acquisition Cost (WAC) from the manufacturers as well as subsequent retroactive rebates from the manufacturers to the PBMs in exchange for favorable placement on their formularies, which may motivate PBMs to structure formularies that maximize potential profit and result in unnecessary formulary restrictions and denial of coverage for some patients; and

WHEREAS, deductibles, co-pays, coinsurance and other costs for prescription drugs are calculated based on the undiscounted, inflated manufacturers' list price and not the actual net price that takes into account manufacturer rebates, thereby greatly increasing out-of-pocket costs for the many patients with cost-sharing obligations; and

WHEREAS, step therapy, prior authorization, non-medical switching and other utilization management requirements, which can delay patient access to effective and appropriate treatment, largely stem from the formulary restrictions caused by the discount and rebate system; and

WHEREAS, ACP policy on Drug Formularies and PBM supports transparency, patient protection and certain limitations on pharmacy benefit managers but does not specifically address the rebate system or advocate for legislative change; therefore be it

RESOLVED, that the Board of Regents updates ACP policy on drug formularies and pharmacy benefit managers (PBM) and supports legislative and regulatory measures that would increase transparency for PBMs by requiring them to periodically disclose at least once a year as well as when there is a price increase in the wholesale acquisition cost, the aggregate amount of rebates and discounts they receive from manufacturers; and be it further

RESOLVED, that the Board of Regents advocates for legislation that would require coinsurance, deductibles, and other cost-sharing requirements to be calculated based off of a drug's actual net price, inclusive of rebates and other discounts, and not the inflated list price.

Resolution 4-F17. Updating ACP Policy to Oppose Non-Medical Switching of Medications by Insurance Companies and Pharmacy Benefit Managers

(Sponsor: Florida Chapter)

WHEREAS, non-medical switching is defined as insurance plans or pharmacy benefit managers changing a medication for reasons other than medical necessity or patient benefit, such as financial concerns and cost of medications; and

WHEREAS, current ACP policy on Drug Formularies and Pharmacy Benefit Managers support notification of patients when formularies change; and

WHEREAS, current policy does not address specific solutions to non-medical switching; and

WHEREAS, many states are seeking legislation to prevent non-medical switching with requirements for insurance companies and pharmacy benefit managers to maintain coverage of a patients medication through the next year; and

WHEREAS, patients with chronic medical conditions require ongoing treatment; and

WHEREAS, patients may require several different medications to find a proper treatment; and

WHEREAS, changing medications unnecessarily can lead to worsening patient outcomes; and

WHEREAS, many insurance companies will use financial reasons to define their medication formulary; and

WHEREAS, patients may need to change insurance companies in the middle of a treatment as a result of situations beyond their control, such as an employer changing health insurance plans; and

WHEREAS, data suggests that non-medical switching can increase the overall cost of patient care while also worsen patient outcomes (http://allianceforpatientaccess.org/wp-content/uploads/2016/10/IfPA_Cost-Motivated-Treatment-Changes_October-2016.pdf); and

WHEREAS, many states have experienced this issue leading to the formation of many advocacy groups (http://csro.info/advocacy/state-advocacy/non-medical-switching.aspx, https://www.50statenetwork.org/issues/non-medical-switching/); and

WHEREAS, patients should be able to have a grace period in order to properly change their medication in a controlled fashion; and

WHEREAS, insurance companies should honor a patient's current medications for the following year; therefore be it

RESOLVED, that the Board of Regents will update policy to oppose non-medical switching of medications by insurance companies and pharmacy benefit managers which will also allow coverage of a patient's medication through the next year; and be it further

RESOLVED, that Board of Regents will support legislation that prevents non-medical switching of medications by insurance companies and pharmacy benefit managers which will also allow coverage of a patient's medication through the next year.

Resolution 5-F17. Advocating to Remove Falls from the List of Hospital-Acquired Conditions (HACs) with Financial Penalties to Promote Mobility

(Sponsor: New York Chapter)

WHEREAS, unintended consequences can result from performance measures (e.g. time to antibiotics for pneumonia); and

WHEREAS, geriatric patients become deconditioned rapidly upon admission to the hospital, and restricting mobility contributes to the "post-hospital syndrome" of physiologic derangement and increased risk of readmission; and

WHEREAS, hospitals and health systems focus on quality metrics coupled to financial penalties, which includes hospital-acquired conditions (HACs) such as falls; and

WHEREAS, enhanced attention to mobility during hospitalization results in better transitions of care (increased chance of being discharged to home); therefore be it

RESOLVED, that the Board of Regents urges CMS to remove falls from the list of hospital-acquired conditions (HACs) with financial penalties; and be it further

RESOLVED, that the Board of Regents asks that early mobility be considered as a performance measure to be tested and validated.

Resolution 6-F17. Advocating for Appropriate Training/Expertise for Disability Claim Reviewers

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP has been a strong proponent of reducing barriers to medical care and promoting access to needed and appropriate medical care; and

WHEREAS, one of the missions of the ACP has been to advocate responsible positions on health care for the benefit of the public in general and for our own patients in particular; and

WHEREAS, private disability insurers appear to deny benefits for many patients with legitimate disability claims[1]; and

WHEREAS, many of these denials are based on opinions rendered by physicians employed by or hired as "independent reviewers" by the disability insurers potentially compromising their ability to render impartial opinions; and

WHEREAS, it appears that many of the physicians' opinions favor denying or significantly limiting benefits to claimants (even when there is medical evidence supporting such claims); and

WHEREAS, many of these physician reviewers have no formal training or expertise relevant to the medical conditions they are reviewing (i.e., an orthopedist rendering an opinion regarding a claimant with a neurologic condition); therefore be it

RESOLVED, that the Board of Regents will advocate that physicians reviewing disability claims have the appropriate training/expertise relevant to the claimant's medical condition; and be it further

RESOLVED, that the Board of Regents will advocate that claimants be allowed to verify the credentials of the physicians reviewing their claims and that reviewers be provided a means for sharing concerns with regulatory authorities for any pressure placed on them to render biased opinions (i.e., a "whistleblower" type of protection).

[1] Disability insurer UnumProvident was fined $15 million and ordered to re-open 115,000 claims in a multi-state regulatory settlement in 2006.

Resolution 7-F17. Eliminating Mandatory Additional Training to Prescribe Buprenorphine

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, there has been a well-documented rise in opioid abuse among patients in the United States (1); and

WHEREAS, opioid replacement therapy with buprenorphine-naloxone (Suboxone) is an evidence-based pharmacologic strategy to treat opioid abuse disorder that can be prescribed in a primary care physician's office, unlike methadone, with a negligible risk of adverse effects; and (1)

WHEREAS, a major barrier to physician prescription of buprenorphine is a required 8-hour training to obtain a specific DEA license to prescribe it, limiting the number of physicians that can 1) prescribe buprenorphine-naloxone, and 2) precept physicians-in-training who wish to learn to prescribe it (1, 2, 3); and

WHEREAS, federal caps limit the number of patients that a physician can be actively treating with buprenorphine-naloxone; and

WHEREAS, there is no similar training required to prescribe the vast majority of other medications, including controlled substances such as opioids; therefore be it

RESOLVED, that the Board of Regents advocates to eliminate mandatory additional training to prescribe buprenorphine.

1. http://annals.org/aim/article/2613555/health-public-policy-facilitate-effective-prevention-treatment-substance-use-disorders
2. http://www.asam.org/education/live-online-cme/buprenorphine-course
3. https://www.washingtonpost.com/national/health-science/im-a-doctor-who-wants-to-treat-addiction-but-the-rules-wont-let-me/2017/01/13/faaa6ee4-d2b0-11e6-9cb0-54ab630851e8_story.html?utm_term=.c250528eefe8

Resolution 8-F17. Addressing the Impact of and Establishing Guidelines for Changing Patient – Physician Communication Methods

(Sponsor: BOG Class of 2021)

WHEREAS, patient – physician communication is necessary for effective healthcare and outcomes; and

WHEREAS, patient – physician communication methods in health care rapidly change to now include unsecure channels of communication such as personal cell phones, texts, emails, and social media; and

WHEREAS, changing communication methods between patient and physician could lead to poor or missed notification/documentation and negatively impact quality of care and patient outcomes; and

WHEREAS, changing communication methods can confuse patients and families on how to reach out to the care team; and

WHEREAS, a possible unintended consequence of changing communication methods may be that physician work time extends to 24 hours a day; and

WHEREAS, 24 / 7 access to physicians may contribute to decreased patient-physician boundaries adding to stress and burnout; and

WHEREAS, this is new territory in communication and will likely be an increasing, not a decreasing problem; and

WHEREAS, communication guidelines, boundaries and appropriateness criteria for contact need to be developed to determine proper triage of various medical issues; therefore be it

RESOLVED, that the Board of Regents initiates an evaluation of the extent and impact of changing communication methods on patient care, access, privacy, quality and physician burnout; and be it further

RESOLVED, that the Board of Regents creates "reasonable expectation" guidelines for patient-physician communication that can be a basis for patients, physicians, and institutions to reference; and be it further

RESOLVED, that the Board of Regents develops and makes available to ACP members a "patient guide to communication with your health care team" that can be distributed to patients and their families by their physician offices.

Resolution 9-F17. Developing a Means of Publicly Recognizing Excellence in American Health Care as a Component of Combating Physician Burnout

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP has developed policies and programs to help reduce the incidence and consequences of physician burnout; and

WHEREAS, a Mission of the ACP is to serve the professional needs of its membership and support healthy lives for physicians; and

WHEREAS, ACP, as an institution, regularly highlights failings in American medical care and publicly supports other organizations in their criticism of medical care in the United States without similarly and publicly recognizing the excellence of the medical care provided by many of its own physicians; and

WHEREAS, such lack of public recognition of many of its own members' contributions to the wellbeing of their patients may contribute to the public's increasingly negative perceptions of physicians by allowing negative media coverage to overwhelm recognition of the positive work that many of its own physicians do; and

WHEREAS, one of the key components of burnout is that physicians feel they are not appreciated for the medical care they provide; therefore be it

RESOLVED, that the Board of Regents works with ACP staff and committees to develop a means of publicly recognizing the value and excellence of medical care provided by most of its members (individually and as a group) and by many American medical institutions as a component of combating physician burnout without reducing its efforts to support appropriate programs aiming to improve access to high quality medical care for more Americans.

Resolution 10-F17. Developing ACP Policy on Physician Impairment and Rehabilitation Towards Re-integration

(Sponsor: Council of Early Career Physicians; Co-Sponsor: Southern California Region I))

WHEREAS, physician impairment is the inability or impending inability of a physician to practice his or her health profession that conforms to acceptable standards of practice; this resolution focuses on physician impairment attributable to substance abuse, chemical dependency, or mental illness [Baldisseri 2007]; and

WHEREAS, (1) 15.3% of physicians meet criteria for alcohol overuse or dependence [Oreskovich 2015], (2) as many as 10-15% of physicians experience a substance abuse disorder at some time in their careers [Brewster 1986, Flaherty 1993], and (3) physicians have a high rate of self-treatment with controlled medications, which could increase their risk of drug misuse and dependence [Oreskovich 2015, Hughes 1992]; and

WHEREAS, physician impairment is on the spectrum of physician burnout, for example, where burnout has been associated with risky alcohol use [Pederson 2016] and can lead to physician impairment; and the prevention and management of burnout is one of the American College of Physicians' 2017-2018 priority initiatives; and

WHEREAS, the current physician work culture is not supportive of impaired physicians or physicians at-risk of impairment through a "conspiracy of silence," in which physicians might be reluctant to recognize or talk openly about psychological problems due to stigma or undesirable consequences for their careers [Arnetz]; and

WHEREAS, existing state medical board policies are non-standard and vary in their provision of physician health programs intended to facilitate rehabilitation and re-integration into the workforce, with some state boards using punitive, disciplinary, or even coercive approaches to treat impaired physicians [Boyd 2015]; therefore be it

RESOLVED, that the Board of Regents develops a policy statement that endorses the rehabilitation and "safe reintegration of the recovering physician back into the workforce" as recommended by the Federation of State Medical Boards Policy on Physician Impairment [FSMB 2011], considering also opportunities to partner with other professional organizations representing physicians to develop such a policy statement [AMA 2016]; and be it further

RESOLVED, that the Board of Regents includes in such a policy statement that state physician health programs must meet a minimum set of standards that facilitate (1) the appropriate referral of impaired physicians to confidential treatment programs, (2) non-punitive and clearly protected approaches to treating impaired physicians (including physicians voluntarily seeking confidential assistance and/or therapy), and (3) the retention of medical licensing after compassionate rehabilitation and re-integration into the physician workforce; and thereby provide clear and specific guidance that necessarily expands upon existing ethical guidance on physician impairment [ACP 2012, AMA 2016]; **and be it further**

RESOLVED, that the Board of Regents also includes in such a policy statement the need for a strategy to promote education for the medical community, healthcare organizations, the general public, and

state policymakers, in alignment with efforts to promote physician health and wellness, on physician impairment towards a more holistic and compassionate perspective that supports rehabilitation towards re-integration of our affected physician colleagues.

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Resolution 11-F17. Reviewing ACP's Position on Physician Aid in Dying from a Legal and Health Policy Standpoint

(Sponsor: Oregon Chapter)

WHEREAS, at least 15 ACP Chapters/Regions are located in states or countries where Physician Aid in Dying (PAD) is currently legal (16) and

WHEREAS, the majority of US and Canadian voters are in favor of legalizing PAD for adults within strict limits and guidelines (2, 3) leading to recent introduction of proposed legislation to allow PAD for adults in multiple state legislatures (1, 3, 4, 20, 21) and

WHEREAS, ACP needs to represent all our members, other physicians, and most importantly, patients, in chapters where PAD is legal; and

WHEREAS, a neutral policy stance by ACP does not imply support for or require advocacy for PAD, and

WHEREAS, there is a distinct difference between euthanasia and PAD in practice and in intent, both ethically and legally (6, 7, 15), and

WHEREAS, 20 years of experience in Oregon and the accumulated experience in other places where PAD is legal do not bear out the concern of a slippery slope leading from PAD to euthanasia, or the concern that legalizing PAD will lead to large numbers of patients or physicians participating in PAD (5, 7, 9, 10), nor do they bear out concerns regarding a disproportionate use for those who live with physical or mental disabilities, for minorities, or for those with fewer resources or who are less educated (5, 7, 9, 10) and

WHEREAS, to the contrary, in those locations with legal PAD, the growth in palliative, hospice and other compassionate end of life care has by far exceeded the growth in practice of PAD (8, 9, 5, 11, 12) and

WHEREAS, in Oregon, the US state with the longest experience with legal PAD, the medical community, partnering with patients, has worked diligently since 1997 on these issues and was recently shown to have superior palliative, hospice and end of life care (11, 12) and

WHEREAS, no current or proposed law allowing PAD has ever required a physician or other provider to practice PAD or to refer for PAD (18) and

WHEREAS, in Canada and at least two US states law regarding (not necessarily legalising) PAD has come through the courts without the benefit of prior legislative development and review, and

WHEREAS, the existing US and Canadian laws allowing PAD include significant protections for patients to prevent the practice of euthanasia and the abuse of or inappropriate use of PAD (12, 13, 14, 16, 18, 19), but legalization through court action may not, and,

WHEREAS, the existing US and Canadian laws allowing PAD include legal guidelines and protections for physicians who choose not to participate in PAD or who choose to ease dying with or without PAD (12, 13, 14, 16, 18, 19); therefore be it

RESOLVED, that the Board of Regents review ACP's position on Physician Aid in Dying (PAD) from a legal and health policy standpoint and change ACP's position from opposing PAD to a neutral stance; and be it further

RESOLVED, that the Board of Regents develop policy and legal guidelines on legislation in order to ensure that the best legal protections for all patients and physicians are made part of such legislation; and be it further

RESOLVED, that the Board of Regents, in addition, advocates for better education about, coverage of, and payment for advanced care planning, palliative care and hospice care, as well as developing guidelines for improving advanced care planning, provision of palliative care and of compassionate patient oriented end of life care.

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2. https://www.compassionandchoices.org/wp-content/uploads/2016/07/FS-Medical-Aid-in-Dying-Survey-Results-FINAL-7.21.16-Approved-for-Public-Distribution.pdf
3. http://www.tucsonweekly.com/TheRange/archives/2015/09/02/bisbee-becomes-first-city-inarizona-to-approve-an-aid-in-dying-resolution
4. https://ww2.kqed.org/lowdown/2015/10/06/california-becomes-fifth-state-to-legalizephysician-assisted-suicide-interactive-map/?share=email&nb=1
5. http://www.jlgh.org/Past-Issues/Volume-10---Issue-2/Editor-s-Desk---Physician-Assisted-Dying.aspx
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7. http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/AID-brief-may2016.pdf
8. http://www.bbc.com/news/world-34445715
9. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf
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11. Lessons from Oregon in Embracing Complexity in End-of-Life Care, NEJM 376;11, l.p.1078-1082, nejm.org March 16, 2017 http://www.nejm.org/doi/pdf/10.1056/NEJMsb1612511
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18. https://www.cpsbc.ca/files/pdf/PSG-Medical-Assistance-in-Dying-FAQ.pdf
19. https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#a1
20. https://www.thestar.com/news/canada/2015/02/13/most-canadians-support-assisted-death-ruling-poll-shows.html
21. http://www.nejm.org/doi/full/10.1056/NEJMp1502442?af=R&rss=currentIssue - t=article

Resolution 12-F17. Amending ACP Policy for a National Medical Tort System Based on 1975 MICRA of California and 2003 MMTRA of Texas

(Sponsor: District of Columbia Chapter)

WHEREAS, primary missions of the ACP include advocating for the professional needs of the membership, as well as advocating responsible positions on public policy relating to heath care for the benefit of the public and our patients; and,

WHEREAS, California and Texas have model medical tort systems centered on a $250,000 cap on non-economic damages in medical tort cases; and

WHEREAS, over 30 states have some type of cap on non-economic damages in such cases; and

WHEREAS, medical malpractice insurance premiums have stabilized at lower rates in California and Texas relative to such premiums without caps on non-economic damages; and

WHEREAS, prior to 1975 in California and prior to 2003 in Texas, physicians were leaving those states to practice elsewhere, or closing/limiting their practices, or raising fees charged to patients, all of which negatively affected access to care in those states; and

WHEREAS, there is some evidence that medical tort reform can reduce overall healthcare costs by reducing "defensive medicine"; and

WHEREAS, it will be easier to achieve high-quality evidence-based medical care by reducing "defensive medicine"; and

WHEREAS, the DC ACP Chapter acknowledges ACP policy supporting tort reform centered on the $250,000 cap on noneconomic damages, the DC chapter believes that such policy should be modified to more closely reflect the above-mentioned California and Texas laws and to add to them; therefore be it

RESOLVED, that the Board of Regents amends ACP policy for a national medical tort system based on 1975 Medical Injury Compensation Reform Act (MICRA) of California and 2003 Medical Malpractice Tort Reform Act (MMTRA) of Texas; and be it further

RESOLVED, that the Board of Regents will lobby for a national medical tort reform law that limits non-economic damages to $250,000 without allowing for adjustment for inflation but allows for unlimited economic and punitive damages, restricts contingency fees charged by attorneys, and in cases deemed frivolous, holds the plaintiff responsible for legal expenses incurred by the defendant.

Resolution 13-F17. Invoking Patent Law to Make Direct Acting Antivirals Accessible to Medicaid Populations

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, Hepatitis C (HCV) is the most common blood-borne infection in the United States, with an estimated 2.7 to 3.9 million individuals chronically infected[i], rates of new infections tripling since 2010[ii], mostly among young white persons in non-urban areas in Appalachian, Midwestern, and New England regions, most commonly contracted through illicit drug use[iii]; and

WHEREAS new direct-acting antivirals, which can achieve sustained virologic response (SVR) in 90 – 95% of patients, make up some of the most expensive medications on the Medicare formulary, with Ledipasivir/Sofosbuvir (Harvoni) given to 75,000 beneficiaries in 2015 at a cost of approximately 7 billion[iv]; and

WHEREAS only five (5) state Medicaid agencies treat HCV, unrestricted by level of fibrosis (CT, FL, MA, NY, WY), and almost half of state agencies (23)[v], citing the cost of medications, have extended HCV treatment only to Medicaid recipients with moderate to advanced fibrosis[vi] despite the Center for Medicaid and Medicare Services (CMS)'s 2015 warning state agencies that such restrictions are contrary to longstanding US law restricting access to medications,[vii] leading to suits against some agencies accused of violating these laws[viii]; and

WHEREAS, the National Academies, in coordination with the CDC, AASLD, and IDSA, in March 2017 recommended "a voluntary transaction between the government and companies producing direct-acting antivirals,"[ix] and public health researchers,[x] in response to the secretary of health for Louisiana's request[xi] for additional avenues to address the cost crisis[xii] recommend "HHS should invoke 28 U.S.C. (§)1498, which provides for the government use of patented products including pharmaceuticals, and authorize a company to make available a highly effective treatment at a fraction of current market cost"[xiii]; therefore be it

RESOLVED, that the Board of Regents should advocate for the U.S. Department of Health and Human Services to take urgent steps to lower the price of medications for low-income populations, including invoking 28. U.S.C. (§)1498 to obtain direct acting antivirals to treat HCV at a cost which will make them accessible to the Medicaid populations.

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[i] https://www.cdc.gov/hepatitis/statistics/
[ii] https://www.cdc.gov/hepatitis/statistics/2015surveillance/commentary.htm#Ref20
[iii] CDC. Hepatitis C virus infection among adolescents and young adults: Massachusetts, 2002-2009. MMWR. 2011;60(17):537-41
[iv] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/2015-Medicare-Drug- Spending/medicare-drug-spending-dashboard-2015-data.html
[v] http://www.chlpi.org/wp-content/uploads/2013/12/HCV-Report-Card-National-Summary_FINAL.pdf?
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[viii] http://www.bizjournals.com/boston/blog/health-care/2016/02/harvard-law-decries-medicaid-drug-practices-spurs.html?
[ix] http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2017/hepatitis-report/Hep-report-highlights.pdf
[x] https://kaiserhealthnews.files.wordpress.com/2017/04/gee-letter-4_12_17.pdf?
[xi] https://www.ssa.gov/OP_Home/ssact/title18/1860D-11.htm?

[xii] https://www.washingtonpost.com/national/health-science/louisiana-proposes-tapping-a-century-old-patent-law-to-cut-hepatitis-c-drug- prices/2017/05/02/fc611990-2f76-11e7-9534-00e4656c22aa_story.html?utm_term=.3827408746fc?
[xiii] http://ldh.la.gov/assets/docs/HepatitisC/ResponsememotoSecretaryGeeHCV.pdf

Resolution 14-F17. Adopting ACP Policy Protecting Access to Essential Reproductive Health Services including Abortion

(Sponsor: New Mexico Chapter)

WHEREAS, the World Health Organization states that the term *Reproductive Health* "implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so [i]"; and

WHEREAS, an amicus brief in 2013 submitted to the Supreme Court of the United States in the case of Whole Woman's Health, et al., v. Kirk Cole, M.D., et al., was submitted jointly by the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Family Physicians, and the American Osteopathic Association; and

WHEREAS, the aforementioned amicus brief began with, "Reproductive healthcare is essential to a woman's overall health, and access to abortion is an important component of reproductive healthcare [ii]"; and

WHEREAS, the aforementioned amicus brief continued, "When state legislatures enact laws that restrict access to abortion without any valid medical justification, they jeopardize women's health [iii]"; and

WHEREAS, legislative efforts to restrict access to abortion are commonplace, take many forms, and directly impact access to essential health care; and

WHEREAS, ACP has existing policy against legislation that interferes with patient-physician communication on reproductive health; therefore be it

RESOLVED, that the Board of Regents adopt specific policy stating that access to comprehensive reproductive health services (including abortion) is essential to overall health; and be it further

RESOLVED, that the Board of Regents adopt specific policy stating that legislation restricting access to reproductive health services (including abortion) without valid medical justification jeopardizes health.

[i] http://www.who.int/topics/reproductive_health/en/
[ii] https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Whole-Womans-Health-v-Cole-Amicus-ACOG-et-al%20cert.%20amicus%20brief.pdf
[iii] https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Whole-Womans-Health-v-Cole-Amicus-ACOG-et-al%20cert.%20amicus%20brief.pdf

Resolution 15-F17. Advocating for LCME Policy Regarding Parental Leave for Medical Students

(Sponsor: Council of Student Members)

WHEREAS, ACP has historically advocated for medical school parental leave policies for faculty[1,2]; and

WHEREAS, policies established in the 1993 Family and Medical Leave Act (FMLA) do not apply to students as they do for employees; and

WHEREAS, medical student options for taking parental leave require them to utilize time dedicated to vacation, elective study, and residency interviews or take a medical leave of absence; and

WHEREAS, current policies can place undo strain on medical students by restricting time for vacation, elective study, and residency interviews or by extending duration of medical school curriculum, thus exacerbating financial burdens of medical school; and

WHEREAS, medical schools cite graduation requirements imposed by the Liaison Committee for Medical Education (LCME) as justification for these policies; and

WHEREAS, current LCME policy does not address the topic of parental leave for medical students; and

WHEREAS, current LCME policy encourages that "medical curriculum includes self-directed learning experiences and time for independent study to allow medical students to develop the skills of lifelong learning"; and

WHEREAS, parenting and childbirth provides intimate knowledge for medical students on topics at the foundation of clinical rotations in Obstetrics and Gynecology and Pediatric medicine; and

WHEREAS, parental leave has been shown to have significant benefits for the health and development of children[3-5]; therefore be it

RESOLVED, that the Board of Regents advocates that the LCME establish policy regarding parental leave and explore independent study alternatives for medical students that allow students to complete graduation requirements during parental leave.

1. Grisso J, Hansen L, Zelling I, Bickel J, Eisenberg JM. Parental leave policies for faculty in U.S. medical schools. *Annals of Internal Medicine.* 1991;114(1):43-45.
2. Carr PL, Ash AS, Friedman RH, et al. Relation of family responsibilities and gender to the productivity and career satisfaction of medical faculty. *Annals of Internal Medicine.* 1998;129(7):532-538.
3. Rossin M. The effects of maternity leave on children's birth and infant health outcomes in the United States. *Journal of health Economics.* 2011;30(2):221-239.
4. Adema W, Clarke C, Frey V. Paid parental leave and other supports for parents with young children: The United States in international comparison. *International Social Security Review.* 2016;69(2):29-51.
5. Danzer N, Lavy V. Paid parental leave and children's schooling outcomes. *The Economic Journal.* 2017.

Resolution 16-F17. Updating the 2015 ACP Policy Recommendation Regarding Immunization Laws and Quickly Implementing a Public Education Campaign

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP has an excellent policy recommendation that there should be no exemptions allowed under state laws for required immunizations except for medical reasons[1]; and

WHEREAS, the ACP has a 2017-2018 strategic goal to advocate reasonable positions that benefit the public partly through a strategic initiative to deliver evidence-based information and education; and

WHEREAS, there is an alarming rise in support for bad science, wherein poor quality data is used to justify predetermined conclusions and any contradictory data is simply ignored or deemed to be wrong, with a concomitant decrease in support for traditional scientific institutions and traditional, evidence-based science; and

WHEREAS, some prominent "anti-vaccine" advocates are in positions of power and influence, giving them real opportunities to affect vaccine related legislation and policy; and

WHEREAS, the "anti-vaccine" movement has proven to have serious deleterious effects on patient safety (i.e. the California Disneyland measles outbreak); and

WHEREAS, the current ACP immunization policy statement does not specifically address the "anti-vaccine" movement nor the misinformation which advises non-adherence to well recognized and supported immunization recommendations; and

WHEREAS, the ACP is about to implement a public education campaign regarding "anti-vaccine" misinformation; therefore be it

RESOLVED, that the Board of Regents will update its 2015 policy recommendation regarding immunization laws to specifically state that the ACP supports strong, scientific, evidence-based medical care regarding immunizations and specifically, that "anti-vaccine" studies and positions based on unscientific, non-evidenced-based data and reasoning should be labeled as such with their potential harm to patients being emphasized; and be it further

RESOLVED, that the Board of Regents will *quickly* implement a strong public education campaign showing why recommended vaccines are safe and effective and why the "anti-vaccine" movement is based on bad science that can harm public safety.

[1]July 29, 2015 Statement of the American College of Physicians, adopted by BOR, summer 2015.

Resolution 17-F17. Advocating for Medical Licensure Process Reform to Lessen Fears of Stigma Regarding Mental Health Disclosures

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, studies have shown that physicians experience higher rates of mental illness, substance abuse, and suicide compared to the general population [1]; and

WHEREAS, most state medical boards require disclosure of mental health diagnoses and/or treatment on physician licensing applications, and it is not clear which diagnoses require reporting; and

WHEREAS, the mandatory disclosure of mental health diagnoses and treatment among physicians has been shown to increase stigma and prevent help-seeking behavior [2,3], as one study found that only six percent of physicians with a mental health diagnosis reported it to their state medical board as most felt their condition did not functionally impair their ability to work as a physician [2]; and

WHEREAS, there is a discrepancy in state requirements between what most state medical boards ask about physical medical conditions and mental health conditions, specifically regarding the effect on the individual physician's ability to practice medicine; and

WHEREAS, many hospitals use a different approach than state licensing boards when deciding whether to extend credentials to a physician, usually requiring an endorsement(s) from a physician's peers or supervisors based on performance; and

WHEREAS, few studies have evaluated the effect of non-substance mental health issues on physician performance, and there is no policy that demonstrates ACP's support for the full disclosure of mental health diagnoses in physicians without fear of professional consequences; therefore be it

RESOLVED, that the Board of Regents advocates for reform in the medical licensure process that does not isolate prior or current mental health condition(s) from other medical condition(s) in the reporting process; and be it further

RESOLVED, that the Board of Regents supports research and provides policy specifically addressing the barriers to truthful reporting of mental health diagnoses on state licensing applications in order to lessen fears of stigma and career repercussions; and be it further

RESOLVED, that the Board of Regents advocates for a modernization of state licensure practices that focuses more on the functional impact of mental health diagnoses in physicians and limits additional administrative requirements.

1. A. Wilson, A. Rosen, P. Randal et al., "Psychiatrically impaired medical practitioners: an overview with special reference to impaired psychiatrists," Australasian Psychiatry, vol. 17, no. 1, pp. 6–10, 2009.
2. K. Gold, L. Andrew, E. Goldman, T. Schwenk. "I would never want to have a mental health diagnosis on my record": A survey of female physician on mental health diagnosis, treatment, and reporting. General Hospital Psychiatry 43(2016):51-57.
3. A. Hill. "Breaking the Stigma—A Physician's Perspective on Self-Care and Recovery." NEJM 2017;376:1103-1105. http://www.nejm.org/doi/full/10.1056/NEJMp1615974#t=article.

Additional resources:
AMA Policy: https://wire.ama-assn.org/life-career/beating-burnout-confidential-access-health-services-trainees
https://www.hindawi.com/journals/psychiatry/2016/9850473/#B26

Resolution 18-F17. Updating ACP Policy to Oppose Purchasing of Tobacco Products by Individuals under the Age of 21

(Sponsor: Florida Chapter)

WHEREAS, tobacco is serious public health threat; and

WHEREAS, many states are enacting legislation to raise the current legal purchasing age to 21; and

WHEREAS, an elevated purchasing age can help to curtail the number of individuals purchasing tobacco; and

WHEREAS, precedent has been set with other substances, such as alcohol, to have a higher purchasing age; and

WHEREAS, it is well documented that most smokers start before age 25 and tobacco companies target minors to encourage them to smoke at earlier ages; and

WHEREAS, it has been shown that raising the purchasing age can dramatically reduce the number of new smokers; and

WHEREAS, the Institute of Medicine reviewed the literature and calculated the impact of raising the age to 21, which showed a substantial decrease in incidence of smokers (http://nationalacademies.org/hmd/~/media/Files/Report%20Files/2015/TobaccoMinAge/tobacco_minimum_age_report_brief.pdf); therefore be it

RESOLVED, that the Board of Regents will update its policy to oppose purchasing of tobacco products, including electronic cigarettes, by individuals under the age of 21; and be it further

RESOLVED, that the Board of Regents will support legislation to raise the legal age to purchase tobacco products, including electronic cigarettes, to 21.

Resolution 19-F17. Requesting an Investigation of Possible Fraudulent Activities Related to Misuse of Mental Health and Substance Abuse Treatment Policies

(Sponsor: Florida Chapter)

WHEREAS, coverage for mental health and substance abuse is important; and

WHEREAS, ACP policy supports mental health parity and substance abuse treatment; and

WHEREAS, drug addiction is a serious public health issue; and

WHEREAS, the parity for mental health treatment has unintended consequence; and

WHEREAS, the law has potentially given rise to a system with the potential for financial abuse and illegal activities including fraudulent billing and patient brokering (http://www.mypalmbeachpost.com/news/county-billion-gold-rush-addiction-treatment-draws-fbi/JT3MyQwWckFyEZaSfQnoTN/ , https://www.justice.gov/usao-sdfl/pr/owner-sentenced-more-27-years-prison-multi-million-dollar-health-care-fraud-and-money); and

WHEREAS, the Florida States Attorney has created a taskforce to evaluate the problem (http://www.sa15.state.fl.us/stateattorney/SoberHomes/_content/Minutes/7-14Minutes.pdf); and

WHEREAS, a report from the state of Florida on sober houses outlines many of the problems created under the new laws (http://www.dcf.state.fl.us/programs/samh/docs/SoberHomesPR/DCFProvisoRpt-SoberHomes.pdf); and

WHEREAS, many states are seeing a cycle of continued drug abuse and addiction perpetuated, in part, by the over marketing of sober houses, lab companies, drug rehab facilities and advertisers; therefore be it

RESOLVED, that the Board of Regents will send a letter to Congress, and any other agency deemed appropriate, asking them to investigate possible fraudulent activities related to addiction treatment and misuse of laws for mental health parity and substance abuse treatment, including but not limited to patient brokering, unnecessary testing, and inappropriate marketing.