Resolution 1-S15. Educating ACP Chapters on How to Engage National ACP in Local/State Issues that Impact the Patient-Physician Relationship

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP already has a "Statement of Principles on the Role of Governments in the Patient-Physician Relationship", enacted in July, 2012; and

WHEREAS, ACP's Mission and Goals include advocating for 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, the very basis of the confidential doctor-patient relationship is to protect and promote patient safety and care; and

WHEREAS, any legal imposition of physician speech has historically been to promote patient safety and care, such as informed consent laws, and not as a response to various political lobbying efforts; and

WHEREAS, state laws already exist which require physicians to give a type of speech (nominally for patient safety but of questionable significance and mostly due to anti-abortion lobbying efforts) to patients; and

WHEREAS, in 2011, the state of Florida passed the Firearms Owners' Privacy Act, which bars physicians from discussing firearms safety with their patients not out of a concern for patient safety but due to lobbying efforts of gun rights; and

WHEREAS, this law has been recently upheld by a federal appeals court in July 2014, which may embolden more states to pass laws based on political lobbying efforts to prohibit OR require certain types of speech given by physicians to patients; and

WHEREAS, many laws related to the doctor-patient relationship are state laws rather than federal laws; and

WHEREAS, it is national ACP's practice not to involve itself in state legislation unless specifically requested to do so by the state's ACP chapter and only when ACP has existing policy relevant to the state legislation in question, despite the fact that it is a national ACP policy to promote the sanctity of the doctor-patient relationship and the communication involved in this relationship; therefore be it

RESOLVED, that the Board of Regents educates ACP chapters on how to engage national ACP in local/state issues that impact the patient-physician relationship. This education should include resource material detailing what types of help are potentially available from national ACP and accepted procedures for chapters to contact appropriate national staff.

Resolution 2-S15. Approving Chapter Dues Collection at Time of Member Application

(Sponsor: New York Chapter)

WHEREAS, the American College of Physicians does not collect chapter dues at the time new and/or reinstated members are processed; and

WHEREAS, promoting the advantages of both national and chapter membership strengthens the College and enhances the reasons to join by adding the value of Chapter benefits; and

WHEREAS, new members must pay dues at the time of application, therefore adding chapter dues at the time of application will reinforce the value of both national and chapter membership and will eliminate what currently appears to be a dues increase in year two of their membership when chapter dues are billed; and

WHEREAS, currently membership in the Chapter is afforded to new members without the benefit of dues to support the activities for that member within his/her Chapter; therefore be it

RESOLVED, that the Board of Regents approves the collection of Chapter dues at initial and reinstated membership application.

Resolution 3-S15. Stopping Unnecessary Distracted Driving Deaths – Especially Newly Licensed Youth (SUDDDENLY)

(Sponsor: Idaho Chapter)

WHEREAS, ACP supports investing in the nation's public health infrastructure and promoting critical public health objectives[1] and has clearly written policy regarding accident prevention and injury via bicycle helmets and drunk drivers of motor vehicles; and

WHEREAS, internists have the opportunity to educate adult drivers, young and old, regarding distracted driving or texting and driving; and

WHEREAS, internists likely have the opportunity to educate parents of newly licensed youth and young adults regarding the risks of distracted driving; and

WHEREAS, distracted driving from cell phone use is a major cause of morbidity and mortality, 78% of teenagers and young adults have read or sent a text message while driving[2]; and

WHEREAS, a report from the Centers for Disease Control and Prevention claim each day, more than nine people are killed and 1,060 more are injured in crashes that involve a distracted driver[3]. "In 2011, 3,331 people were killed in crashes involving a distracted driver, and 421,000 people were injured in 2012 in motor vehicle crashes involving a distracted driver"[4]; and

WHEREAS, only 14 states prohibit all cell phone use while driving[5]; and drivers can claim they were dialing the phone and not texting in states where cell phone use while driving is still legal[6]; therefore be it

RESOLVED, that the Board of Regents develops a strategy for comprehensive education for members to advocate responsible positions on individual health, particularly to young adults and parents of newly licensed youth, regarding distracted driving mortality and provide educational resources.

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[1] American College of Physicians. (2012). Policy Compendium, Winter 2012 – 2013, p 201- 202. Retrieved July 7, 2014 from http://www.acponline.org/advocacy/acp_policy_compendium_winter_2012-13_1.pdf

[2] National Highway Traffic Safety Administration. (n.d.) Distracted Driving. Retrieved November 7, 2014 from http://www.distraction.gov/

[3] Center for Disease Control and Prevention. (2013). Distracted Driving in the United States and Europe. Retrieved July 7, 2014 from http://www.cdc.gov/Features/dsDistractedDriving/

[4] Center for Disease Control and Prevention. (2013). Distracted Driving in the United States and Europe. Retrieved July 7, 2014 from http://www.cdc.gov/Features/dsDistractedDriving/

[5] Governor's Highway Safety Association. (2014). Distracted Driving Laws. Retrieved July 7, 2014 from http://www.ghsa.org/html/stateinfo/laws/cellphone_laws.html

[6] Hult, J. (2014). Enforcement Tries to Curb Temptation to Text and Drive. *Argus Leader*. Retrieved July 7, 2014 from http://www.argusleader.com/story/news/crime/2014/07/06/enforcement-tries-curb-temptation-text-drive/12261115/

Resolution 4-S15. Advocating for Federal Approval of Environmentally Safe Controlled Substance Waste Disposal

(Sponsor: New York Chapter)

WHEREAS, current hospital practice for discarding unusable controlled substance waste varies and includes flushing down the toilet or pouring into the sink; and

WHEREAS, drugs flushed down the toilet pass unaltered through wastewater treatment plants into water tables, rivers, and lakes; and

WHEREAS, nationwide studies have found low levels of many drugs in our country's rivers and streams; and

WHEREAS, studies have found that fish and other aquatic wildlife are adversely affected by exposure to low levels of medications demonstrating reduced fertility, sexual affects and abnormal spawning[1]; and

WHEREAS, the Environmental Protection Agency recommends destroying unused medications by mixing them in undesirable substances like coffee grounds or kitty litter; and

WHEREAS, companies that the Bureau of Narcotics has approved for disposal of controlled substances from hospitals can only accept intact medications, and not "waste" which includes partial doses and open pills; and

WHEREAS, there is no accepted method for disposal of controlled substance waste besides flushing or pouring down the drain; and

WHEREAS, there are controlled substance drug disposal devices and systems that incinerate the waste commercially available for hospitals but are not approved by various federal entities; therefore be it

RESOLVED, that the Board of Regents advocates for federal approval of controlled substance drug disposal systems specifically designed to provide a safe and responsible method for disposing of unusable discarded controlled substance waste.

[1] http://www.dec.ny.gov/chemical/45083.html

Resolution 5-S15. Limiting the Use of the Pain Scale to Support a Move Away from Excessive Narcotic Prescribing

(Sponsor: Maine Chapter)

WHEREAS, there is an epidemic of narcotic abuse in the USA; and

WHEREAS, the rate of death from drug overdoses has more than doubled in the last 15 years; and

WHEREAS, narcotics are of questionable benefit for chronic non-cancer pain and frequently lead to addiction; and

WHEREAS, the pain scale was created when the dangers of drug addiction were less well appreciated; and

WHEREAS, a higher number on the pain scale can often be misinterpreted by patients, clinicians and insurers as a mandate for increased intensity of opiate prescribing; and

WHEREAS, it is better to focus patients with chronic non-cancer pain on improving functional status rather than on pain and limitations; and

WHEREAS, the Board of Regents supports a national standard of rational use of opioid narcotics and that the decision to prescribe narcotics should be evidence-based and remain that of the practitioner after complete assessment of the patient. (04 F11); therefore be it

RESOLVED, that the Board of Regents will work toward limiting the use of pain scales in outpatient medicine except in post-operative settings and hospice care; and be it further

RESOLVED, that the Board of Regents discuss the pain scale issue with the Joint Commission and the Centers for Medicaid and Medicare Services (CMS) and encourage them to base chronic non-cancer pain treatment on maximizing function.

Resolution 6-S15. Advocating for Health Research and Services Administration Designation of Individuals with Intellectual and Developmental Disabilities as a Medically Underserved Population

(Sponsor: Texas Chapter; Co-Sponsor: Oregon Chapter)

WHEREAS, the American College of Physicians is committed to advocating for increased access to quality health care for all, regardless of race, ethnicity, socioeconomic status or other factors[1]; and

WHEREAS, intellectual and developmental disabilities affect up to 3% of people in the United States[2]; and

WHEREAS, persons with intellectual and developmental disabilities are less likely to receive adequate medical care than the general population despite their increased burden of chronic health problems and shortened life expectancy[3]; and

WHEREAS, the federal government defines "medically underserved populations" according to a formula that weighs a population's lack of primary care providers, its experience with poverty and increased infant mortality and its percentage of people age 65 and older and then applies that result to a population within a defined geographic area[4] [5]; and

WHEREAS, persons with intellectual and developmental disabilities are not limited to particular geographic areas; and

WHEREAS, few physicians have had formal training regarding the specific needs of this population or may not possess the comfort level required to treat people with intellectual and developmental disabilities and only 25% of medical schools include content regarding people with such disabilities in their curricula[6]; and

WHEREAS, training and increased familiarity with individuals with disabilities leads to favorable outcomes of greater confidence and willingness to provide care; therefore be it

RESOLVED, that the Board of Regents advocates for HRSA to include persons with intellectual and developmental disabilities as medically underserved populations; and be it further

RESOLVED, that the Board of Regents encourages medical schools and graduate medical education programs to include disability-related competencies and objectives in their curricula.

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[1] Racial and ethnic disparities in health care: a summary of a position paper approved by the American College of Physicians Board of Regents April, 2010.
[2] The ARC: Intellectual Disability. Retrieved from: http://www.thearc.org/page.aspx?pid=2448
[3] U.S. Surveillance of Health of People with Intellectual Disabilities: A White Paper; Centers for Disease Control and Prevention/National Center on Birth Defects and Developmental Disabilities Health Surveillance Work Group. September, 2009.
[4] Autistic Self Advocacy Network Policy Brief: The case for designation of people with intellectual and developmental disabilities as a medically underserved population. April 2014.
[5] Section 330 of the Public Health Service Act. 42 USC § 254b(b)(3)(A)2010.
[6] Woodward L et al. An innovative clerkship module focused on patients with disabilities. Academic Medicine, Vol. 87, No. 4. April 2012.

Additional references:

Intellectual Disability (Intellectual Developmental Disorder)

Intellectual disability involves impairment of general mental abilities that impact adaptive function in three domains. These domains determine how well an individual copes with everyday tasks.

- Conceptual domain includes skills in language, reading, writing, math, reasoning, knowledge and memory
- Social domain refers to empathy, social judgement, interpersonal communication, ability to make and retain friendships
- Practical domain centers on self-management in areas such as personal care, job responsibilities, money management, recreation, organizing school and work tasks.

Symptoms begin during the developmental period and are diagnosed based on severity of deficits in adaptive function.

Source: American Psychiatric Association

Developmental Disability

The current definition under the DD Act defines "developmental disability" as a severe, chronic disability of an individual that:

(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(ii) is manifested before the individual attains age 22;
(iii) is likely to continue indefinitely;
(iv) results in substantial functional limitations in 3 or more of the following areas of major life activity:
  (I) Self-care.
  (II) Receptive and expressive language.
  (III) Learning.
  (IV) Mobility.
  (V) Self-direction.
  (VI) Capacity for independent living.
  (VII) Economic self-sufficiency; and
(v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Source: Title 42 U.S. Code § 15001 Section 102 (8).

American Medical Association House of Delegates Policy H-90.968 Medical care of persons with developmental disabilities.

American Medical Association CMS Report 3-I-11. Designation of the intellectually disabled as a medically underserved population.

Resolution 7-S15. Studying the Economic Viability of Rural Sole Community Hospitals

(Sponsor: New Mexico Chapter)

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) has developed a complex definition for a hospital to be designated as a Sole Community Hospital (SCH)[1], primarily applicable to small rural hospitals that are located at least 25 miles from any similar facility; and

WHEREAS, SCHs have their own payment schedule under CMS[1,2], including occupancy based adjustments that are theoretically designed to help maintain the economic viability of SCHs; and

WHEREAS, some hospitals that were formerly classified as Essential Access Community Hospitals have now been re-designated for payment purposes as SCHs; and

WHEREAS, many rural hospitals designated as SCHs have had to reduce the services they offer because of reduced funding and increased costs; and

WHEREAS, failures of Congress and CMS to enact laws and regulations that would provide increased financial stability and predictability have led to great concern about the possibility of further decreases in funding while costs continue to increase, and have greatly compromised the ability of SCHs to make rational planning decisions; and

WHEREAS, the loss of services provided by SCHs will likely prove devastating to the health care systems and the patients served by these facilities in many states but most especially in poor rural states; therefore be it

RESOLVED, that the Board of Regents advocates that MedPAC or a similar federal entity studies the complex economic factors that threaten the viability of Sole Community Hospitals.

References:

[1] Sole Community Hospital, Rural Health Fact Sheet Series, Department of Health and Human Services, Centers for Medicare & Medicaid Services, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SoleCommHospfctsht508-09.pdf

[2] Summary of Medicare's special payment provisions for rural providers and criteria for qualification, MEDPAC, http://www.medpac.gov/publications/congressional_reports/Jun01 AppB.pdf

Resolution 8-S15. Eliminating CMS Penalties for Not Using Certified Electronic Medical Records (EMRs)

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP is committed to supporting internists in providing high quality and compassionate medical care to their patients; and

WHEREAS, ACP's Mission and Goals include serving the professional needs of the membership, supporting healthy lives for physicians, and advancing internal medicine as a career which means helping clinicians be successful in maintaining their medical practices; and

WHEREAS, there is little (if any) high quality research or other evidence associating the use of currently available certified EMRs to higher quality more cost effective medical care (a goal of the ACP); and

WHEREAS, the cost of implementing and maintaining certified EMRs is a significant burden for internists in small and medium sized practices; and

WHEREAS, CMS is beginning to penalize internists not using certified EMRs; and

WHEREAS, CMS is planning to prohibit internists not using certified EMRs from receiving the new Chronic Care Management payments even when these internists provide high quality chronic care management to their patients; and

WHEREAS, these actions by CMS will make it increasingly difficult for internists in small and medium sized practices to maintain their practices and provide care for their Medicare patients; therefore be it

RESOLVED, that the Board of Regents calls upon CMS to indefinitely eliminate penalties on internists not using certified EMRs until there is strong research based evidence demonstrating that the use of certified EMRs results in superior quality and cost effectiveness in clinical care; and be it further

RESOLVED, that the Board of Regents calls upon CMS to award Chronic Care Management payments to internists who provide chronic care management regardless of whether or not they are using certified EMRs.

Resolution 9-S15. Introducing Legislation to Ensure Immunity from Federal Prosecution for Marijuana-Prescribing Physicians

(Sponsor: New York Chapter)

WHEREAS, as of July 2014 more than 20 states have enacted some form of law permitting medical marijuana. The NY law, also known as the Compassionate Care Act, is carefully crafted and allows only doctors who have completed a special course and have registered with the health department to prescribe marijuana for patients who have any of a list of "Serious Conditions" or complications of one of the aforementioned "Serious Conditions."; and

WHEREAS, although prescribing medical marijuana may be legal in a given state, marijuana remains illegal under the federal Controlled Substances Act; and

WHEREAS, the United States Department of Justice ("USDOJ") has issued sometimes conflicting guidance on state laws allowing medical marijuana; and

WHEREAS, such guidance from USDOJ as the 2013 notification to attorneys indicated that enforcement of state law by state and local law enforcement and regulatory bodies should remain the primary (but not sole) means of addressing marijuana-related activity; and

WHEREAS, the USDOJ could change its position at any point in the future; and

WHEREAS, notwithstanding any position taken by the USDOJ, the status of marijuana under federal law is determined by Congress and not the USDOJ; and

WHEREAS, physicians who prescribe or dispense marijuana pursuant to their state's law may nonetheless be subject to criminal prosecution under federal law; therefore be it

RESOLVED, that the Board of Regents introduces legislation ensuring or providing immunity against federal prosecution for physicians who prescribe marijuana in accordance with their state's laws.

Resolution 10-S15. Raising Awareness about the Transition of Care from Pediatric to Adult Health Care through ACP Educational Sessions, Electronic Publications, and Chapter Outreach

(Sponsor: District of Columbia Chapter)

WHEREAS, ACP, in position papers such as "The Health Care Needs of the Adolescent" (*Annals of Internal Medicine*, 1989) and in its coauthoring of the "Transition Clinical Report, Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home" (2011) has expressed support for efforts to improve health care provided to adolescents and young adults; and

WHEREAS, ACP's Mission and Goals include being the premier provider of education and information for internists and their health care team; and

WHEREAS, there is an estimated 18 million adolescents (ages 18-21), of whom one quarter have chronic illness and disabilities, and many millions of young adults (ages 21-26) who must transition from pediatric to adult-centered care; and

WHEREAS, the majority of youth/young adults are ill-prepared for this change and gaps in care are common resulting in poorer outcomes, increased costs, and dissatisfaction with care; and

WHEREAS, surveys of health care professionals consistently show that health care professionals lack a systematic approach to support youth, families and young adults in this transition from pediatric to adult-centered care including integration of young adults to adult health care; therefore be it

RESOLVED, that the Board of Regents works to raise awareness about pediatric to adult health care transition by arranging for educational sessions at national ACP meetings, publishing articles in the *ACP Internist* and creating/promoting the presence of a section on the ACP website containing information to help internists in this transition process (including links to other helpful websites such as the "Got Transition: Center for Health Care Transition Improvement" website); and be it further

RESOLVED, that the Board of Regents calls upon ACP chapters to reach out to their American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP) state chapters to improve this transition process through methods such as holding joint meetings around transition information and education and by encouraging quality improvement initiatives on transition.

Resolution 11-S15. Adopting Principles for Appropriate Use of Direct-to-Patient Telehealth

(Sponsor: Virginia Chapter)

WHEREAS, telehealth is a rapidly evolving medical technology, and The American College of Physicians has not updated its position paper on telehealth since 2008[1]; and

WHEREAS, numerous private telehealth companies now offer medical diagnosis and treatment via the internet (Direct-to-Patient Primary and Urgent Care Telehealth)[2]; and

WHEREAS, third party payers have now begun to reimburse patients when utilizing these private companies; and

WHEREAS, there are limited data regarding the safety and efficacy of diagnosing and treating human disease without performing a physical examination and such practice is not considered current standard of care in most cases; and

WHEREAS, there is limited regulation and legislation regarding the use of Direct-to-Patient teleheath; therefore be it

RESOLVED, that the Board of Regents adopts the following principles for the appropriate use of direct-to-patient telehealth:

1. **Direct-to-Patient telehealth should primarily be reserved as an adjunct for physicians/providers and patients with an established relationship.**
2. **A physician-patient relationship can only be established via telemedicine if the encounter a) provides information equivalent to an in-person exam, b) conforms to the standard of care expected of in-person care (for example, if a component of a physical examination is generally the considered standard of care in diagnosing and treating a particular condition, then such a physical examination must also be performed), including through the use of peripheral devices appropriate to the patient's condition, and c) incorporates appropriate diagnostic tests sufficient to provide an accurate diagnosis (for example, if a diagnostic test is required for an accurate diagnosis of streptococcal pharyngitis then such diagnostic test should be performed).**
3. **A physician-patient relationship may be established via telehealth if there is a duly licensed telepresenter (such as a nurse, NP, or PA) with the patient.**
4. **Only physicians or other licensed health care providers, using their professionalism, can determine if any given patient encounter is appropriate for telehealth.**
5. **Physicians should receive appropriate reimbursement for telehealth encounters for patients with whom they have an established physician-patient relationship.**
6. **Insurance companies must disclose any financial relationships with telehealth companies to prospective patients**.

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[1] ACP paper: E-Health and its impact on Medical Practice: http://www.acponline.org/acp_policy/policies/ehealth_impact_medical_practices_2008.pdf

[2] An example of an insurance company offering telehealth serviceshttp://members.optimahealth.com/federaldocs/Options%20for%20Care.pdf