Resolution 1-F16. Developing Policy to Address the Gender Pay Gap within the Field of Medicine

(Sponsor: Council of Resident/Fellow Members)

WHEREAS, there has been a well-documented history of and persistence of salary disparities between men and women, particularly among women in academic medicine, who report earning less than 70% of their male colleagues when adjusted for work performed [1] [2]; and

WHEREAS, this considerable pay inequity between male and female physicians, along with other sociocultural circumstances, contributes to higher rates of burnout in women vs. their male colleagues [3] [4]; and

WHEREAS, inherent institutional barriers to the professional and financial advancement of women in medicine have been cited as a number one reason for attrition of women in academic leadership [5], and, when barriers are actively addressed, departments have shown improved advancement and equity of qualified female medical leaders compared to men [6]; and

WHEREAS, there is no policy requiring salary transparency across the spectrum of medical specialties; therefore be it

RESOLVED, that the Board of Regents develops policy specifically addressing the gender pay gap within medicine; 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 men and women physicians are paid equally and fairly; and be it further

RESOLVED, that the Board of Regents addresses the issue within the specific contexts of (1) the lack of transparency of physician salaries, (2) burnout and physician wellness, and (3) resultant negative effects on the strength of our medical workforce.

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Resolution 2-F16. Opposing Rising Out-of-Pocket Patient Spending

(Sponsor: New York Chapter)

WHEREAS, out-of-pocket costs for patients are rising more rapidly than any other component of the health care system; and

WHEREAS, the imposition of such costs is cited by payers as a mechanism to reduce wasteful spending and to make patients choose to sign up with narrow provider networks; and

WHEREAS, many studies have shown that high out-of-pocket costs often result in patients eschewing needed medical care; and

WHEREAS, the patients with health plans that require large out-of-pocket costs are often the most financially vulnerable; therefore be it

RESOLVED, that the Board of Regents adopts as a matter of principle its opposition to rising out-of-pocket patient spending that is fostered by health plans, whether public or private; and be it further

RESOLVED, that the Board of Regents makes public statements addressing the deleterious effects of rising out-of-pocket patient spending on health access and outcomes.

Resolution 3-F16. Modifying HCAHPS Questions and Eliminating Associated Financial Incentives to Improve the Safety of Opioid Prescribing

(Sponsor: Alaska Chapter; Co-Sponsors: Texas Chapter, New York Chapter, and Class of 2017)

WHEREAS, ACP policy supports a patient-centered approach to patient care with appropriate use of guidelines, attention to clinical context and patient safety; and

WHEREAS, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a survey instrument used at hospital discharge to measure patients' perceptions of their providers' and a facility's quality of care; and

WHEREAS, the HCAHPS survey includes the following questions:

- During this hospital stay, did you need medicine for pain?
- During this hospital stay, how often was your pain well-controlled?
- During this hospital stay, how often did hospital staff do everything they could to help you with your pain?; and

WHEREAS, patients experience varied types of pain, with various goals of management, depending on features of the clinical situation, such as: underlying diagnosis, acute vs. chronic nature of the pain, life expectancy, prior narcotic use, dependence, and/or abuse history, and other factors which must be taken into account by the prescribing clinician; and

WHEREAS, opioid pain relievers are often incorrectly perceived to be the only means to achieve optimal pain relief[1-2]; and

WHEREAS, patient experience, as assessed by the HCAHPS survey, is now tied by the Centers for Medicare and Medicaid Services (CMS) to hospital payments; and

WHEREAS, some hospitals tie compensation of providers and executives to HCAHPS scores, creating an incentive for hospitals to achieve the highest scores possible; and

WHEREAS, from 1999-2014, over 165,000 persons died in the United States from overdose of opioid pain medications, with 19,000 deaths occurring in 2014 alone[2,3]; and

WHEREAS, the rates of death due to overdose of opioid pain medications in the United States increased roughly four-fold between 2000 and 2014;[4] therefore be it:

RESOLVED, that the Board of Regents advocates to revise pain-related questions on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to better reflect the appropriateness of pain management interventions, with particular attention to the differences between acute and chronic pain and also attention to the goals and risks of the clinical situation; and be it further

RESOLVED, that the Board of Regents advocates to remove financial incentives based on the HCAHPS that could inadvertently incentivize inappropriate opioid administration and prescribing.

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3. Califf RM, Woodcock J, Ostroff S. A proactive response to prescription opioid abuse. *N Engl J Med* 2016; electronic publication ahead of print, available at: http://www.nejm.org/doi/pdf/10.1056/NEJMra1511480
4. Compton WM, Jones CM, Baldwin GT. Relationship between nonmedical prescription-opioid use and heroin use. *N Engl J Med* 2016; 374:154-163

Resolution 4-F16. Petitioning CMS to Adopt a Single Code for Initial and Ongoing Physician Care Regardless of Patient Status

(Sponsor: New York Chapter)

WHEREAS, Medicare and other payers define "observation" as "outpatient care in a hospital bed"; and

WHEREAS, the patient's status (observation vs. inpatient) may change during the episode of care in response to clinical changes; and

WHEREAS, the distinction between observation and inpatient is essentially fiscal, while physicians perceive the patient's care as a single continuous episode of care; and

WHEREAS, observation is the only Medicare payment classification that requires prospective determination of the services to be rendered to a patient; and

WHEREAS, a complete history and physical identical in scope and content to one required for a hospital admission is required when a patient is assigned to observation status; and

WHEREAS, the CPT code for an observation history and physical is different from that of an inpatient admission; and

WHEREAS, it is difficult for the hospital and physicians to know exactly what the patient's status is at all times; and

WHEREAS, if the hospital's bill for services and physicians' do not reflect the same type of service (inpatient or outpatient/observation) Medicare will deny payment and may even conduct an audit; and

WHEREAS, physicians and hospitals are just trying to take care of the patient; and

WHEREAS, the College approved the following policy statement in November 2012:

The College supports the position that the decision to admit a patient into an inpatient hospital setting is a complex medical judgment which can be made only after the physician has considered a number of factors. In light of this position, the College recommends that:

- *Inpatient admission review criteria used by all payers, including Medicare, should be clear and transparent.*
- *Whenever possible, these criteria should be evidence-based.*
- *A physician's decision to admit a patient to an inpatient hospital setting should only be denied by a payer through a process which includes a review and confirmation by a physician and is supported by clearly documented, evidenced-based reasons.*
- *All payers should have easily accessible and clearly stated reconsideration/appeals processes to review denied inpatient admissions*; therefore be it

RESOLVED, that the Board of Regents petitions the Centers for Medicare and Medicaid Services (CMS) to adopt a single code for initial and ongoing physician care that is payable regardless of whether the patient is in an observation or inpatient status.

Resolution 5-F16. Studying Various Practice Models Known as "Direct Primary Care" and Updating Previous ACP Policy

(Sponsor: Florida Chapter)

WHEREAS, new practice models are constantly being sought for better healthcare delivery; and

WHEREAS, many non-traditional models currently exist that are valid and beneficial to patient care; and

WHEREAS, "Assessing the Patient Care Implications of 'Concierge' and Other Direct Patient Contracting Practices: A Policy Position Paper from the American College of Physicians" does not adequately differentiate the various types of patient care models by narrowly defining them as direct patient contracting practice (DPCP) instead of addressing each model on its own; and

WHEREAS, the ACP policy on diversity specifically believes that diversity is essential to the strength of the organization and welcomes and encourages all internists, including private practice, to participate; and

WHEREAS, the responsibility of the ACP, also outlined in the policy on diversity, is to represent all its membership, regardless of professional activity; and

WHEREAS, more information and study is needed to properly assess Direct Primary Care; therefore be it

RESOLVED, that the Board of Regents properly studies the varied and different practice models known as direct primary care with a goal of revising the previous policy statement, "Assessing the Patient Care Implications of 'Concierge' and Other Direct Patient Contracting Practices: A Policy Position Paper from the American College of Physicians," to be consistent with the ACP policy on Diversity and properly represent its diverse membership, with a report back to the Board of Governors.

Resolution 6-F16. Advocating for Formal Infrastructure to Support Expansion and Sustainability of Wellness Initiatives

(Sponsor: Council of Early Career Physicians)

WHEREAS, physician burnout and satisfaction with work-life balance worsened significantly from 2011 to 2014, with more than half of practicing physicians experiencing professional burnout, and with internal medicine physicians being among those with the highest point prevalence of burnout and correspondingly low satisfaction with work-life balance (1, 2); and

WHEREAS, burnout negatively affects patient care and health outcomes, lowers patient satisfaction, and increases costs (3); and

WHEREAS, burnout affects physicians' health including an increased risk for depression and suicide (4), and physicians prematurely leaving the workforce compounding a growing physician shortage (5); and

WHEREAS, burnout symptoms, substance abuse, and other negative outcomes have been reported in medical students, residents, and fellows (6, 7); and

WHEREAS, ACP has a demonstrated track record of success in sustainable efforts with the development of the Center for Patient Partnership in Healthcare and the Volunteerism Committee, along with collaborative efforts with other organizations to develop educational products such as the AAIM-ACP High Value Care Curriculum; and

WHEREAS, ACP has an existing Wellness Champions Initiative; and

WHEREAS, one of the identified priority initiatives for 2016-2017 by the Board of Regents is to help ACP members experience greater professional satisfaction and fulfillment by promoting resilience and practice efficiencies while advocating for change in the underlying causes of dissatisfaction (8); therefore be it

RESOLVED, that the Board of Regents creates and supports a formal infrastructure, such as a Center for Physician Wellness, that will allow for expansion and sustainability of its current and future wellness initiatives for physicians and physicians-in-training; and be it further

RESOLVED, that the ACP Board of Regents becomes a leading voice in addressing areas such as burnout prevention, physician wellness, and professional satisfaction and collaborate with like-minded organizations and entities in these areas.

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8. ACP Strategic Priorities:
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Resolution 7-F16. Modifying the ACP BOG Resolutions Process

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP Board of Governors (BOG) Resolutions Process is recognized to be a major conduit for membership to voice its wishes to ACP; and

WHEREAS, it is a mission/goal of the ACP to serve the professional needs of the membership; and

WHEREAS, the ACP BOG Resolutions Process can be exceedingly slow in terms of the time it takes for resolutions to progress from discussion at the chapter level to policy actions taken on a national ACP level; and

WHEREAS, currently the ACP BOG Resolutions Process states that "at least four months prior to each Board of Governors meeting, resolutions approved at the chapter or committee level are submitted to ACP headquarters." The non-specific "at least" in this rule has resulted in significantly longer intervals of time being required by national ACP at times (e.g., 5 months in the case of the most recent Board of Governors meeting); therefore be it

RESOLVED, that the Board of Regents modify the current ACP BOG Resolutions Process so that the time it takes for resolutions to actually result in concrete action on the part of national ACP be significantly shortened; and be it further

RESOLVED, that the Board of Regents consider the following as a means by which the ACP BOG Resolutions Process can be sped up, including:

1. Shortening the interval of time from when chapters are required to submit their resolutions to national and when such resolutions are acted upon at the Board of Governors meetings. Moreover, consideration should be given to shortening the interval of time to even less than four months (It is noted that prior to 2010, the required interval of time was much shorter and Governors in a 2009 survey indicated they thought this shorter period of time was quite adequate.).
2. Reference Committees should take into consideration the immediacy of action required with respect to resolutions in deciding whether to recommend referral to committee. In particular, in the case of resolutions dealing with a measure for which a lack of immediate action will limit effectiveness of any eventual implementation of such resolutions, then Reference Committees should endeavor to help chapters amend such resolutions so that the resolutions may be directly submitted to the Board of Regents (if passed by the Board of Governors) rather than being sent off for further study/modification.
3. In the case where resolutions are referred for study to College staff or appropriate committees, such study should be completed by the time of the next Board of Governors meeting (rather than "within a year" as current rules require).

Resolution 8-F16. Separating the Reaffirmation Designation into Two Distinct Categories

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP BOG Resolutions Process is recognized to be a major conduit for membership to voice its wishes to the ACP leadership; and

WHEREAS, it is a mission/goal of the ACP to serve the professional needs of the membership; and

WHEREAS, the ACP BOG Resolutions Process can only be effective if it meets the needs of its membership; and

WHEREAS, there has been a concentrated effort to encourage chapters to accept Reaffirmation status for many of their submitted resolutions which limits significantly the ability for these resolutions to have any effect on ongoing active national ACP activities; and

WHEREAS, there are hundreds of pages of ACP policy and it is unrealistic to expect ACP to be actively promoting all these hundreds of policies simultaneously; and

WHEREAS, it may be appropriate for past forgotten or "relatively inactive" ACP policies to be promoted by the Board of Regents or national ACP staff in more active ways again; therefore be it

RESOLVED, that the Board of Regents separates the designation of Reaffirmation into two distinct categories: i.e., "Basic Reaffirmation" and "Reaffirmation Requiring Further Activity by ACP"; and, be it further

RESOLVED, that the "Reaffirmation Requiring Further Activity" be referred by the Board of Regents at its discretion to be acted on by national staff or standing committees and that the actions taken by the Board of Regents and national staff/standing committees be reported back to the Board of Governors at its next national meeting.

Resolution 9-F16. Calling Upon ABIM to Accept CME Provided by Other Legitimate Medical/Medical Educational Organizations

(Sponsor: District of Columbia Chapter)

WHEREAS, the ACP has become increasingly involved in efforts to improve the Maintenance of Certification (MOC) system (as evidenced by Board of Governors' resolutions and ACP policy statements); and

WHEREAS, it is a mission/goal of the ACP to promote the highest clinical standards and to serve the professional needs of the membership; and

WHEREAS, many ACP members feel that changes made by the American Board of Internal Medicine (ABIM) in its MOC process are not yet sufficient; and

WHEREAS, the ABIM itself has stated it will be more open to accepting CME provided by other organizations as long as it meets ABIM standards (though it is noted that the ABIM standards are highly influenced by actions taken by the Accreditation Council for Continuing Medical Education (ACCME); and

WHEREAS, in ACCME's most recent proposal organizations are required to fulfill a variety of criteria that have little to do with actual clinical care in order to be granted a full six year accreditation (see footnote below); therefore be it

RESOLVED, that the Board of Regents calls upon the ABIM to accept CME provided by other legitimate medical and/or medical educational organizations that are judged clinically relevant and valuable without requiring that these organizations meet full criteria set by the ACCME; and be it further

RESOLVED, that the Board of Regents will call upon the ACCME to be willing to fully accredit organizations that provide high quality CME without requiring them to fulfill new quasi-clinical criteria proposed by the ACCME; and be it further

RESOLVED, that the Board of Regents simultaneously discusses with other medical organizations the possibility of an MOC system built on CME chosen by the individual certificate holder including material generated by the ACP, ABIM or any certified CME provider. ("ACCME Proposes New Criteria for Accreditation with Commendation" from http://www.policymed.com/2016/01/accme-proposes-new-criteria-for-accreditation-with-commendation.html.)

Resolution 10-F16. Offering a Reduced Internal Medicine (IM) Meeting Registration Fee for Retired Physician Members

(Sponsor: New York Chapter)

WHEREAS, many members are or will be retired; and

WHEREAS, these members have contributed much to ACP both in their local chapters and on a national level; and

WHEREAS, these retired members still wish to contribute to the mission of ACP; and

WHEREAS, the annual national IM and Chapter meetings are venues to maintain their participation in this mission as well as continue to embrace the academics of internal medicine, its advocacy and the collegiality of the organization; therefore be it

RESOLVED, that the Board of Regents offers a reduced IM registration fee for retired physician members to encourage continued involvement.