Resolution 1-S21. Advocating for Inclusion of High Value Care, Quality Improvement, and Patient Safety in Medical School Curriculum

(Sponsor: Vermont Chapter)

WHEREAS, the American College of Physicians is a leader in the advancement of high value care, quality improvement, and patient safety; and

WHEREAS, the College promotes physician participation in patient safety and quality improvement activities as part of its Ethics Manual (1); and

WHEREAS, the safe, effective, and high-value care of patients are, and will remain, central tenants of the practice of medicine; and

WHEREAS, future physicians must gain foundational knowledge of these principles during their medical training; therefore be it

RESOLVED, that the Board of Regents collaborates with the Association of American Medical Colleges, the American Medical Association, and the Liaison Committee on Medical Education to include high value care, quality improvement, and patient safety principles into the curricular content standards for accreditation of medical education programs leading to the MD degree.

References:

(1) Sulmasy LS, Bledsoe TA; ACP Ethics, Professionalism and Human Rights Committee. American College of Physicians Ethics Manual: Seventh Edition. Ann Intern Med. 2019 Jan 15;170(2_Suppl):S1-S32. doi: 10.7326/M18-2160.

Resolution 2-S21. Defining What Constitutes Proper Use of the Terms "Residency" and "Fellowship" when Referring to Internal Medicine and Subspecialty Training

(Sponsor: Council of Resident/Fellow Members; Co-Sponsor: Tennessee Chapter)

WHEREAS, all internal medicine physicians are required to complete standardized and accredited training referred to as "residency", with the possibility for further sub-specialized training referred to as "fellowship"; and

WHEREAS, the term "resident" historically refers to physician training in the early 20th century, when medical trainees resided in hospitals during their formative years[1]; and

WHEREAS, some post-graduate training programs for non-physician clinicians have started utilizing the same nomenclature and labeling their programs as "residencies" and "fellowships"; and

WHEREAS, the public has been surveyed and has expressed confusion over which clinicians have medical degrees or degrees of osteopathic medicine and favor transparency of training[2]; and

WHEREAS, the American Academy of Dermatology has stated that labeling non-physician training programs as residencies or fellowships is misleading, and that this terminology should only apply to physician training programs[4]; and

WHEREAS, the American Academy of Emergency Medicine has stated that training programs for physician assistants and nurse practitioners should avoid use of the terms "resident" and "fellow"[3]; therefore be it

RESOLVED, that the Board of Regents develop a position statement that highlights the historical value and current nature of the terminology "residency" and "fellowship" to describe physician post-graduate training, and addresses the ramifications of non-physician clinician groups utilizing similar nomenclature.

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[3]American Academy of Emergency Medicine. *AAEM and AAEM/RSA Position Statement on Emergency Medicine Training Programs for Non-Physician Practitioners.* .https://www.aaem.org/resources/statements/position/em-training-programs-for--pas-and-nps *(*Accessed April 19, 2020)

[4]American Academy of Dermatology. *Position Statement on Dermatology Residency and Fellowship Training Nomenclature Exclusivity for U.S. Based Dermatology Residents and/or Fellows.* https://server.aad.org/Forms/Policies/Uploads/PS/PS-Dermatology%20Residency%20and%20Fellowship%20Training.pdf *(*Accessed April 19, 2020)

Resolution 3-S21. Supporting the Use of Fentanyl Test Strips as a Measure of Harm Reduction in Opioid Use Disorder

(Sponsor: Massachusetts Chapter: Co-Sponsor: New York and Oregon Chapters)

WHEREAS, the ACP views opioid use disorder as a treatable chronic medical condition that should be treated through the expansion of evidence-based public and individual health initiatives to promote recovery [2018 ACP Policy Compendium, p 33]; and

WHEREAS, the ACP endorses several harm reduction strategies to mitigate the dangers of substance use [Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper]; and

WHEREAS, Fentanyl test strip is one of the measures to reduce death related to an accidental overdose. There are some studies done to assess the awareness, use pattern and outcome of the fentanyl test strip. These studies have been shown that individuals with opioid use disorder want to use fentanyl test strip to avoid accidental overdose [1, 2, 3, 4]; and

WHEREAS, the ACP recognizes that our country is currently facing an overdose crisis of unprecedented proportions [2018 ACP Policy Compendium, p 31]; and

WHEREAS, given the current crisis, it is of utmost importance to utilize every harm reduction measure to minimize the death related to accidental overdoses; therefore be it

RESOLVED, that the Board of Regents issue a policy supporting the establishment of a channel to educate the affected population and increase the use of fentanyl test strips as a harm reduction approach in reducing the morbidity and mortality associated with opioid use disorder.

References:

1. Fentanyl test strips as an opioid overdose prevention strategy: Findings from a syringe services program in the Southeastern United States. Peiper NC1, Clarke SD1, Vincent LB2, Ciccarone D3, Kral AH1, Zibbell JE42.
2. Perspectives on rapid fentanyl test strips as a harm reduction practice among young adults who use drugs: a qualitative study. Goldman JE1, Waye KM1, Periera KA1, Krieger MS1, Yedinak JL1, Marshall BDL2.
3. High willingness to use rapid fentanyl test strips among young adults who use drugs. Krieger MS1, Yedinak JL1, Buxton JA2,3, Lysyshyn M2,4, Bernstein E5,6, Rich JD1,7, Green TC1,5,6,7, Hadland SE5,6, Marshall BDL8.
4. Use of rapid fentanyl test strips among young adults who use drugs. Krieger MS1, Goedel WC1, Buxton JA2, Lysyshyn M3, Bernstein E4, Sherman SG5, Rich JD6, Hadland SE4, Green TC7, Marshall BDL8.

Resolution 4-S21. Supporting the Establishment of Safe Consumption Sites as a Harm Reduction Approach for Improving the Health of Individuals Suffering from Substance Use Disorders

(Sponsor: Massachusetts Chapter; Co-Sponsors: New York and Oregon Chapters; Council of Resident/Fellow Members)

WHEREAS, the ACP views opioid use disorder as a treatable chronic medical condition that should be treated through the expansion of evidence-based public and individual health initiatives to promote recovery [2018 ACP Policy Compendium, p 33]; and

WHEREAS, the ACP endorses harm reduction strategies such as syringe exchange and diversion programs to mitigate the dangers of substance use among individuals who are not yet in recovery [Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper]; and

WHEREAS, numerous studies have shown safe consumption sites to reduce mortality and reduce harm to individuals suffering from opioid use disorders [1, 2, 3]; and

WHEREAS, the ACP recognizes that our country is currently facing an overdose crisis of unprecedented proportions [2018 ACP Policy Compendium, p 31]; and

WHEREAS, in the setting of such a crisis all harm reduction approaches should be utilized to keep individuals suffering from opioid use disorder alive until they are able to enter treatment and recovery; therefore be it

RESOLVED, that the Board of Regents issue a policy supporting the establishment of safe consumption sites as a harm reduction approach to reducing the mortality associated with opioid use disorder.

References:

1. Supervised injection services: what has been demonstrated? A systematic literature review. Drug Alcohol Depend. 2014 Dec 1;145:48-68.
2. Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. Lancet. 2011 Apr 23;377(9775):1429-37.
3. Estimated drug overdose deaths averted by North America's first medically-supervised safer injection facility. PLoS One. 2008 Oct 7;3(10):e3351.

Resolution 5-S21. Supporting Residents and Fellows Working During Global Emergencies

(Sponsor: Council of Resident/Fellow Members; Co-Sponsors: BOG Class of 2022, Council of Early Career Physicians, Council of Student Members; Massachusetts, Michigan, New Jersey, New Hampshire, and Puerto Rico Chapters)

WHEREAS, the world has been struck by the COVID-19 pandemic, with over 52 million COVID-19 cases worldwide, more than 10 million in the United States, and a global death toll of 1.29 million lives, with over 242,000 deaths in the U.S. (1); and,

WHEREAS, the shock of the COVID-19 pandemic has revealed weaknesses in our health care delivery system, including our ability to manage and distribute personal protective equipment (PPE) (2), rapidly implement appropriate infection control protocols, plan for hospital resource requirements, or manage healthcare professionals and personnel during a crisis of this magnitude (3); and

WHEREAS, there are over 135,000 residents and fellows in training programs across our nation's hospitals who work at the frontlines of this pandemic, including serving in communities hit hardest by the pandemic (4); and

WHEREAS, trainees are in the specifically vulnerable position of not being able to negotiate their work conditions beyond basic ACGME requirements, not being free to leave their employment contracts with hospitals when they feel unsafe due to their work requirements or lack of adequate PPE, as doing so would significantly impact their career and ability to become independently practicing physicians; and

WHEREAS, given shortages in healthcare workers during this pandemic, ACGME has allowed subspecialty fellows to act as attending physicians, affecting their educational schedule, curriculum, and training hours within their subspecialty, while not requiring hospitals to compensate them at the same level as attending physicians performing the same duties, at the same hospital, with equal responsibilities of patient care (6); and

WHEREAS, given the extraordinary circumstances during the COVID-19 pandemic, some institutions provided a form of compensation to their non-resident and fellow healthcare workers, but did not provide the same to their residents and fellows (5); and

WHEREAS, the American Medical Association (AMA) has released guidelines to protect resident and fellow physicians during the COVID-19 pandemic, which state among other guiding principles that residents should be candidates for compensation (financial or otherwise) in a way that is equitable to other health care workers within their institution, and that fellows who assume attending physician roles in core disciplines in which they are licensed and certified should receive benefits commensurate with these roles (4); and

WHEREAS, one of ACP's primary goals is to promote and respect equity in all aspects of the profession; therefore be it

RESOLVED, that the Board of Regents join other physician organizations (including the American Medical Association) in supporting equitable treatment of residents and fellows in times of global pandemic, by advocating for healthcare institutions to provide trainees with the same PPE, safety precautions, and compensation (financial or otherwise) as they do their non-resident and fellow

clinicians for the hardship they face during the crisis, while also recognizing the vulnerability of resident and fellow clinicians due to their inability to negotiate work conditions outside of ACGME requirements; and be it further

RESOLVED, that the Board of Regents collaborate with appropriate institutions and organizations to support the protection of trainees who have been requested to perform work outside of their primary specialty or training contract, such as performing attending-level clinical duties as an upper-level internal medicine resident or subspecialty fellow, by ensuring that they receive adequate PPE as well as appropriate clinical support and supervision, and to ensure that such trainees are permitted to decline such additional responsibilities if the foregoing conditions cannot be reasonably fulfilled.

References:

1. The New York Times. COVID World Map: Tracking the Global Outbreak. https://www.nytimes.com/interactive/2020/world/coronavirus-maps.html
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3. Slavitt A. The COVID-19 Pandemic Underscores the Need to Address Structural Challenges of the US Health Care System. *JAMA Health Forum.* Published online July 2, 2020. doi:10.1001/jamahealthforum.2020.0839.
4. AMA. Guiding principles to protect resident & fellow physicians responding to COVID-19. https://www.ama-assn.org/delivering-care/public-health/guiding-principles-protect-resident-fellow-physicians-responding.
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6. ACGME FAQs. Pandemic and Program Requirements. https://acgme.org/COVID-19/Frequently-Asked-Questions.

Resolution 6-S21. Updating ACP Policy on the Healthcare Rights and Humane Treatment of Incarcerated Persons

(Sponsor: Oregon Chapter)

WHEREAS, the United States Supreme Court has ruled in Estelle v Gamble in 1976 that "deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain", prisoners thus have a right to access care for their serious medical needs and persons in custody have a constitutionally protected right to health care under the 8th Amendment which affords them the right to be free from cruel and unusual punishment(1); and

WHEREAS, the United States Supreme Court has ruled that people in custody are to be free from discrimination and afforded equal protections of the law under the 14th Amendment (2); and

WHEREAS**,** the U.S. District Court for the Western District of Missouri in Ramsey v. Ciccone also found in 1970 that the intentional denial of needed medical treatment is cruel and unusual punishment in violation of the 8th Amendment (3); and

WHEREAS**,** with an estimated 84,000 inmates in the United States enduring solitary confinement (4), defined as restricting inmates to their prison cell for 22-24 hours per day under conditions of extreme isolation, sensory deprivation, and idleness; and these conditions are known to be detrimental to health (5) including significantly higher suicide rates among inmates in segregation units (6) and higher rates of PTSD among inmates who experienced solitary confinement (7); and with the United Nations having declared that solitary confinement lasting greater than 15 days to violate an inmate's human rights (8); and

WHEREAS**,** youth in the juvenile correctional system are considered a high-risk population who often have unmet physical, developmental, and mental health needs (9); and multiple studies have found that health issues occur at higher rates among incarcerated youth than in the general adolescent population and many have inconsistent or nonexistent care (10-12); and

WHEREAS*,* inadequate access to substance use and mental health treatment is correlated with higher rates of re-incarceration; and coordinated transition to community treatment of substance use and mental illness are necessary upon release (13) given the heightened risk of relapse into drug use, re-incarceration, and overdose upon reentry into society (14); investment in mental health and substance use disorder services during and after incarceration has a significant potential to help break the cycle of incarceration, reduce relapse into drug use, and prevent drug overdoses (15); and

WHEREAS, the COVID-19 pandemic has disproportionately affected individuals incarcerated in U.S. prisons at 5.5 times the case rate and 3.0 time the adjusted death rate as compared to non-incarcerated U.S. citizens (16); and 90 out 100 largest outbreaks in America have taken place in jails or prisons (17-19); and

WHEREAS, there is a distinct difference between medical isolation and punitive solitary confinement, yet often inmates with communicable diseases are placed in solitary confinement units for medical isolation and, while there, are subject to the rules and restrictions of punitive solitary confinement (33-35); and

WHEREAS, the United States maintains detention centers that that impact the well-being of other vulnerable populations including families in federal custody due to immigration status, and there are known significant adverse health outcomes associated with detention, especially with forced family detention (20-21); and

WHEREAS, Black Americans are incarcerated at 5.1 times and Hispanic Americans at 1.4 times the rate of white Americans (22, 36-37); and

WHEREAS, there is a long history of coerced or forced sterilization in U.S. prisons (23) and recent events in an ICE detention center in Georgia showed incarcerated people are still subject to this unethical practice (24-25); and

WHEREAS, the ACP had long-standing policy from 1985 through 2012 that advocated ensuring incarceration did not infringe on basic health rights of incarcerated persons, condemned inhumane punishments or torture methods of imprisoned persons[i](26), promoted collaborative efforts between public health and correctional entities, and offered guidance for the evidence-based treatment of diseases commonly found in incarcerated populations; and this policy was sunsetted without replacement (27-29); and

WHEREAS, since the ACP last visited this issue in 2012, research has continued to demonstrate disproportionate negative health effects among incarcerated individuals (29-31); and

WHEREAS, recent ACP policy recognizes racism and discrimination as social determinants of health and in October 2020 the College committed to becoming an anti-racist institution dedicated to action and policy to confront and eliminate racism and called for urgent actions to remedy for historical institutional injustices (32); therefore be it

RESOLVED, that Board of Regents review and update current policy related to healthcare in correctional institutions at the local, state and federal levels, including detention centers for undocumented people such as ICE detainment facilities, in order to support and advocate for providing appropriate high quality medical care to those who are incarcerated, including treatment for mental health and substance use disorders; and be it further

RESOLVED, in light of the current and future potential public health emergencies (particularly those related to communicable diseases) that the Board of Regents work in collaboration with other stakeholders to advocate for changes to incarceration and detention practices to include, but not limited to:

1) **The safe cohorting of incarcerated persons to limit the disproportionately high spread of SARS-CoV2 or other communicable diseases within these populations and among those who work with them.**
2) **Selected decarceration of individuals not thought to be a risk to their communities in order to reduce the density of facility populations during outbreaks of communicable diseases.**
3) **The limitation or elimination of using punitive solitary confinement as medical isolation for persons infected with SARS-CoV2 or other infectious organisms; and be it further**

RESOLVED, that Board of Regents, in collaboration with other stakeholders, advocate for changes to incarceration and detention practices to address human rights issues which impact the health of

inmates, those who work with them and the families and communities they return to, including but not limited to:

1) **Expanding access to substance use disorder and mental health treatment during incarceration and continuity of that care upon release**
2) **Limiting or eliminating the use of solitary confinement**
3) **Eliminating coercive or forcible sterilization practices**
4) **Consistent needs assessment on entry into correctional institutions and provision of age appropriate physical and mental health care for incarcerated or detained juveniles**
5) **Prohibiting cohorting of children away from their family unit**

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(2)https://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=5784&context=jclc
(3) https://law.justia.com/cases/federal/district-courts/FSupp/310/600/1382104/
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Resolution 7-S21. Increasing Access to Healthcare for Non-Detained Asylum Seekers Living in the United States

(Sponsor: Colorado Chapter; Co-Sponsors: New Mexico Chapter, Council of Student Members)

WHEREAS, an asylum seeker is defined as a person in the United States or arriving at a U.S. port of entry who is hindered from returning to their home country due to the threat of violence or mistreatment; and

WHEREAS, non-detained asylum seekers are asylum seekers who are released after initial screening by Immigration and Customs Enforcement (ICE) and may be waiting for up to a year before their court date; and

WHEREAS, there is minimal information on this vulnerable population, but the studies that do exist state that there are an estimated 338,000 non-detained asylum seekers awaiting their court decisions as of June 2018 (1); and

WHEREAS, unlike asylum seekers detained in ICE facilities and refugees, there are no protocols in place for non-detained asylum seekers to receive any access to medical care; and

WHEREAS, non-detained asylum seekers are disproportionately affected by psychological illnesses such as posttraumatic stress disorder and chronic pain syndromes; infectious diseases such as influenza; and chronic diseases such as diabetes (2); and

WHEREAS, decreased healthcare access for non-detained asylum seekers poses a public health threat involving the spread of infectious disease and places a burden on the U.S. healthcare system due to unmanaged chronic diseases; and

WHEREAS, asylum seekers who are processed and released immediately do not receive any previously confiscated medications, which contributes to the progression of chronic illnesses to emergent states and

WHEREAS, a goal of the ACP is: “to advocate responsible positions on individual health and on public policy related to health care for the benefit of the public, patients, the medical profession, and our members”; and

WHEREAS, the number of non-detained asylum seekers has drastically increased because nearly 50% of the Department of Justice Courts have halted cases for processing non-detained asylum seekers due to COVID-19, as of August 2020 (3); therefore be it

RESOLVED, that the Board of Regents advocates for policy and protocols to be implemented for increasing access to healthcare for non-detained asylum seekers living in the United States. This includes but is not limited to replacing confiscated medications upon release, independent physician access to medical records obtained during the health screening, and resources to ensure access to basic healthcare; and be it further

RESOLVED, Board of Regents encourages research into the medical needs of non-detained asylum seekers living in the United States as well as their current access to medical care; and be it further

RESOLVED, that the Board of Regents supports the development of educational materials for physicians and other health care providers to prepare them to care for non-detained asylum seekers living in the United States; and be it further

RESOLVED, that the Board of Regents supports the development of educational materials to provide non-detained asylum seekers living in the United States regarding access to medical care available to them.

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Resolution 8-S21. Calling for Increased Research into Period Poverty within the United States and the Repeal of the Tampon Tax

(Sponsor: Council of Student Members; Co-Sponsor: Council of Early Career Physicians)

WHEREAS, the average woman has her period 2,535 days (~7 years) of her life and uses 10-35 pads or tampons each cycle[1–3]; and

WHEREAS, unlike tax-exempt "necessities", like groceries, food stamp purchases, and medical purchases (like prescriptions, prosthetics, and some over-the-counter drugs), menstrual hygiene products are subject to taxation in most states[4,5]; and

WHEREAS, the taxation of menstrual hygiene products, including tampons, pads, and reusable menstrual cups, is colloquially termed the "tampon tax"; and

WHEREAS, women may not have a choice when it comes to menstruation; and

WHEREAS, there are barriers to menstrual hygiene product access and education that negatively impact women who are low-income, experiencing homelessness, migrants or refugees, or incarcerated; and

WHEREAS, nearly two-thirds of women accessing assistance from not-for-profit community organizations reported not having money to purchase menstrual hygiene products within the past year[2]; and

WHEREAS, women without other options resort to using rags, tissues, toilet paper, dirty socks, used paper bags, or a single tampon or pad for 12-14 hours instead of the recommended 8 hours or less[2,6]; and

WHEREAS, inadequate or improper use of menstrual hygiene products can lead to medical consequences like urinary tract infections, vulvar contact dermatitis, and poor quality of life[7–9]; and

WHEREAS, period poverty refers to the inadequate access to menstrual hygiene tools and education, an issue that has been largely overlooked in the United States[10]; and

WHEREAS, the United Nations declared menstrual hygiene a public health, gender equality, and human rights issue[3,11]; and

WHEREAS, other countries have made greater advancement in addressing period poverty than the United States by providing free menstrual hygiene products to women of all ages (Scotland) or by repealing their tampon taxes (including Kenya, Australia, Canada, and India)[12,13]; and

WHEREAS, the majority of American women believe access to menstrual hygiene products is a right[14]; and

WHEREAS, the American College of Physicians believes that women should have access to affordable, comprehensive, and nondiscriminatory health care coverage over the course of their life[15]; and

WHERAS, the American College of Physicians supports efforts to reduce socioeconomic inequalities and states that supportive public policies that address downstream educational social determinants of health should be implemented to encourage health equity[16]; and

WHEREAS, the American College of Physicians supports federal, state, tribal, and local funding efforts to address social determinants of health, including programs and social services shown to reduce health disparities[16]; and

WHEREAS, the American College of Physicians supports efforts that close gaps in the knowledge related to women's health issues[15]; and

WHEREAS, the American College of Physicians supports greater investment in public health research and public policy interventions that address social determinants of health and other factors that negatively impact health[17]; therefore be it

RESOLVED, that the Board of Regents supports increased research into barriers to accessing menstrual hygiene products and education in the United States and the implications of period poverty on vulnerable populations (including, but not limited to school-aged girls, women experiencing homelessness, low-income women, women who are migrants or refugees, women with disabilities, and LGBTQ+ people who menstruate); and be it further

RESOLVED, that the Board of Regents supports national, state, and local advocacy efforts to repeal the tampon tax and other policies that implement unnecessary barriers to menstrual hygiene products in order to address social determinants of health and promote health equity.

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Resolution 9-S21. Supporting Mandatory Universal Acceptance of SNAP Benefits for Online Purchases of Groceries and Grocery Delivery

(Sponsor: Massachusetts Chapter; Co-Sponsors: New York and Oregon Chapters)

WHEREAS, "the American College of Physicians supports the adequate and efficient funding of federal, state, tribal, and local agencies in their efforts to address social determinants of health, including investments in programs and social services shown to reduce health disparities or costs to the health care system and agency collaboration to reduce or eliminate redundancies and maximize potential impact" [ACP Policy Compendium, p. 27]; and

WHEREAS, it is a strategic priority of the ACP "to advocate responsible positions on individual health and on public policy relating to healthcare for the benefit of the public, our patients, the medical profession, and our members"; and

WHEREAS, of the 43 million Americans enrolled in the Supplemental Nutrition Assistance Program (SNAP), over 5 million (11.8%) are over 60 years old, the age group at highest risk of dying from COVID-19[1] [2]; and

WHEREAS, the Centers for Disease Control and Prevention (CDC) recommend using grocery delivery services when possible during the COVID-19 pandemic to minimize risk of exposure to the virus[3]; and

WHEREAS, the 2014 Farm Bill requires the United States Department of Agriculture (USDA) to pilot a program allowing SNAP recipients to purchase groceries online and have them delivered[4]; and

WHEREAS, even with implementation of the pilot in many states, very few grocers are accepting SNAP benefits for online grocery purchases and delivery, creating a hardship for SNAP recipients[5]; therefore be it

RESOLVED, that the Board of Regents implement a policy supporting mandatory universal acceptance of SNAP benefits for online purchases of groceries and grocery delivery.

[1] https://www.ers.usda.gov/topics/food-nutrition-assistance/supplemental-nutrition-assistance-program-snap/charts/snap-participants-by-age/
[2] https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm
[3] https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/essential-goods-services.html
[4] https://www.fns.usda.gov/snap/online-purchasing-pilot
[5] Ibid.

Resolution 10-S21. Identifying and Supporting Best Practices for Chapter Advocacy

(Sponsor Oregon Chapter; Co-Sponsors: Arizona, California, Massachusetts and Utah Chapters)

WHEREAS, ACP's vision includes global recognition as the leader in promoting advocacy in internal medicine and its subspecialties; and[1]

WHEREAS, ACP's goals include serving professional needs of the membership; advocating responsible positions on individual health and on public policy related to health care for the benefit of the public, patients, the medical profession, and our members; and being the foremost education and information resource for all internists; and[1]

WHEREAS, ACP's core values include leadership that upholds the highest standards of professionalism, education, and advocacy; and[1]

WHEREAS, the ACP State Health Policy program presently provides ACP chapters with resources to advocate for a limited number of state policies (e.g. stabilizing health insurance markets, addressing vaccine exemption, reducing firearm-related injuries, etc.); and[2]

WHEREAS, ACP chapter advocacy capacity, engagement, experience, and strategy vary from chapter to chapter; and

WHEREAS, many health and public policy issues impacting states call for chapter-level, rather than national-level advocacy; and

WHEREAS, engaging in advocacy is an opportunity to increase chapter member recruitment, retention, engagement, and leadership development;[3] therefore be it

RESOLVED, that the Board of Regents studies chapter-level advocacy and identifies best practices for chapter-level advocacy; and be it further

RESOLVED, that the Board of Regents creates best practices guidelines and a toolkit to support engagement in and efficacy of chapter-level advocacy at the state and federal level.

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[1] https://www.acponline.org/about-acp/who-we-are/mission-vision-goals-core-values (accessed 4/5/20)
[2] https://www.acponline.org/advocacy/state-health-policy (accessed 4/5/20)
[3] Wali S. ACP Advocacy Efforts in California. *The Capitol Key Newsletter*. Fall 2019: https://www.acponline.org/system/files/documents/advocacy/aimn/capitol_key_newsletter/assets/cap_keysep19.pdf (accessed 4/5/2020)

Resolution 11-S21. Studying the Impact of Social Media on Individual and Public Health and Promoting Health through Counseling for Healthier Use of Social Media Platforms

(Sponsor: New York Chapter; Co-Sponsors: Central America, Mexico, and Colorado Chapters; BOG Class of 2024)

WHEREAS**,** internet-based, commercial, social media platforms (social media) have become a common medium of news and information acquisition for large numbers of people in the United States and around the world; and

WHEREAS, the current business model for major social media companies prioritizes user "engagement" and advertising revenue without significant regard for the individual and social consequences of the use of their platforms (1); and

WHEREAS**,** there is currently very limited federal regulation of social media company practices; and

WHEREAS**,** increases in rates of depression, anxiety and even suicide have been linked to intensity of social media use (1); and

WHEREAS**,** social media platforms have been used to promote numerous false claims about many health issues, including vaccine safety, and public health measures for the coronavirus pandemic; and

WHEREAS**,** conversely, social media can also be a very effective communication tool for helping individuals to connect with others, especially at times when physical gathering is limited, as well as disseminating evidence-based medical information and public health service announcements to educate our learners and inform the public; and

WHEREAS**,** current ACP policy primarily focuses on "Supporting Chapters in Effective and Influential Social Media Communication" (2) and on the appropriate use of social media by physicians and medical students (3) rather than directly addressing potential adverse individual and public health impacts of social media use; therefore be it

RESOLVED, that the Board of Regents, along with other appropriate stakeholders, undertake a study of the best practices for screening for risky use and hazards of social media overuse, and counseling patients on appropriate use of social media; and be it further

RESOLVED, that after study, the Board of Regents, along with other appropriate stakeholders, develop guidelines and tools for counseling patients on the risks of overuse of social media to mitigate the individual and societal harms currently evident, while continuing to promote beneficial uses.

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2. Resolution 14-S19 adopted by the BoR April 2020
3. Farnan JM, Snyder Sulmasy L, Worster BK, Chaudhry HJ et al. Online medical professionalism: patient and public relationships: policy statement from the American College of Physicians and the Federation of State Medical Boards. Ann Intern Med. 2013 Apr 16;158(8):620-7. doi: 10.7326/0003-4819-158-8-201304160-00100. PMID: 23579867.

Resolution 12-S21. Achieving Carbon Neutrality by 2030 at ACP

(Sponsor: Oregon Chapter; Co-Sponsors: Maine, Massachusetts, Montana, New Jersey Northern, and Washington Chapters)

WHEREAS, ACP has had robust policy on the health impacts of climate change and the importance of pursuing reduction of greenhouse gas emissions for human health (1,3); and

WHEREAS, the Paris Climate Accords found that greenhouse gas emissions must be substantially curbed to hold the global average temperature increase to "well below" 2° C (and the more ambitious target of 1.5 ° C above preindustrial levels) (6); and

WHEREAS, the Intergovernmental Panel on Climate change has indicated we need to reduce greenhouse gas emissions by 40-50% of 2010 levels by 2030 in order to pursue limiting global warming to no more than 1.5° C and that, globally, current plans for greenhouse gas reductions by 2030 will actually result in a global temperature rise of 3° C by 2100 which will continue to rise thereafter (4); and

WHEREAS, under one scenario, cumulative carbon dioxide emissions could cause the global average temperature to reach the threshold of 2°C (3.6 °F) above preindustrial levels by 2045 (18); and

WHEREAS, the EPA estimates that 30% of the health care sector's energy use could be reduced without compromising care quality and the healthcare industry is being called upon to reduce their energy consumption and GHG emissions (13,17); and

WHEREAS, ACP has developed a robust toolkit for individual physicians to help their practices reduce energy consumption and greenhouse gas emission, as well as assisting their institutions to do this same work (12); and

WHEREAS, Pennsylvania, where the College headquarters are located, has recently made a commitment to join the Mid-Atlantic and New England States in the Regional Greenhouse Gas Initiative (RGGI.org) in order to reduce carbon emission in production of electricity (15,16); and

WHEREAS, tools now exist for individuals, companies and organizations to measure and monitor their own greenhouse gas emissions (7,5,11); and

WHEREAS, there are now easily available Certified Emission offsets for individuals, institutions and organizations (7,8,9); and

WHEREAS, ACP is recognized as a leader in the House of Medicine on matters of evidence based public health policy on climate change, being amongst the first to develop policy alerting and educating physicians and the public of the health hazards associated with climate change (1, 2, 10, 14); and

WHEREAS, ACP now has the opportunity to lead physician organizations in joining other healthcare stakeholders in making progress on reducing contributions to global warming by addressing the College's current contribution to greenhouse gas emissions; therefore be it

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RESOLVED, that the Board of Regents ask the College to measure and monitor the carbon footprint of the operation of ACP as an organization, including the Philadelphia and Washington offices, events and travel, but not the operation of chapters or membership, and then develop a plan to move the College toward carbon neutrality by 2030 by reducing its energy consumption and its greenhouse gas emissions, and by appropriate utilization of certified carbon offsets where reduction is not possible; and be it further

RESOLVED, that the Board of Regents will encourage individual chapters to lower their carbon footprints through the development of a chapter toolkit.

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1) https://annals.org/aim/fullarticle/2513976/climate-change-health-position-paper-american-college-physicians
2) https://climatehealthaction.org/cta/climate-health-equity-policy/
3) https://apps.who.int/iris/bitstream/handle/10665/276405/9789241514972-eng.pdf?sequence=1&isAllowed=y
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Resolution 13-S21. Advocating for Establishment of an ICD-10 Code for Multiple Chronic Conditions

(Sponsor: Maine Chapter)

WHEREAS, the population of older adults is increasing rapidly, and more than one half of this demographic has 3 or more chronic conditions (1), and one half of that population have 6 or more chronic conditions; and

WHEREAS, the care of persons with multiple chronic conditions requires a broader approach to that individual's health than an accumulation of approaches driven by the specific conditions (2); and

WHEREAS, a prior resolution 9-F05 addressed challenges for providing Complex Ongoing Medical Care and points out the need to address medical care in general, rather than medical care aimed at a limited number of specified chronic medical conditions; and

WHEREAS, this care requires understanding of the individual's goals, understanding and expectations relative to their overall health, function and prognosis (3); and

WHEREAS, care planning, preferences and feasibility of treatment regimens require a whole person perspective not specific to an individual condition; and

WHEREAS, documentation of this work under individual conditions does not support a patient centric approach, and does not recognize the interactions between conditions and treatment regimens nor provide opportunity for evaluation of the impact of social conditions and individual preferences on the whole person; and

WHEREAS, CMS has proffered a workable definition of Multiple Chronic Conditions, in defining Chronic Care Management Codes, ("Multiple {two or more} chronic conditions expected to last at least 12 months, or until the death of the patient. Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline"); therefore be it

RESOLVED, that the Board of Regents, in collaboration with other professional organizations whose members care for complex older adults, advocate for the establishment of an ICD-10 code specific for Multiple Chronic Conditions.

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2. Boyd CM, Fortin M. Future of multimorbidity research: How should understanding of multimorbidity inform health system design? Public Health Rev 2011;32:451–474.
3. Decision Making for Older Adults With Multiple Chronic Conditions: Executive Summary for the American Geriatrics Society Guiding Principles on the Care of Older Adults With Multimorbidity. Boyd, C et al J Am Geriatr Soc 67:665-673,2019.

Resolution 14-S21. Removing Barriers to Prescribe Buprenorphine for Opioid Use Disorder

(Sponsor: Council of Student Members; Co-Sponsors: Council of Resident and Fellow Members; Council of Early Career Physicians)

WHEREAS, one of ACP's goals is to advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession, and our members (1); and

WHEREAS, the opioid crisis was declared a nationwide public health emergency in 2017 (2); and

WHEREAS, the 2018 National Survey on Drug Use and Health reports 10.3 million people or 3.7% of the U.S. population is afflicted with opioid misuse (3); and

WHEREAS, several effective medications are now available for treating opioid use disorder but many patients who could benefit do not receive them (4); and

WHEREAS, the use of buprenorphine and buprenorphine/naloxone combination is an effective outpatient treatment for opioid use disorder with outcomes comparable to those of methadone programs (5); and

WHEREAS, under the Drug Addiction Treatment Act of 2000, physicians are required to complete an eight-hour training to qualify for a waiver to prescribe and dispense buprenorphine (6); and

WHEREAS, most prescription drugs, including opioids themselves, do not require a waiver or additional training; and

WHEREAS, the waiver requirement remains a barrier to buprenorphine access and implies medical uncertainty despite evidence to the contrary; and

WHEREAS, as of October 2019, only 74,547 physicians (less than 10% of prescribers) received a buprenorphine waiver, with the majority of physicians limited to treating 30 patients (7); and

WHEREAS, other barriers besides the training requirement can factor into a physician's decision to prescribe buprenorphine and must also be addressed; and

WHEREAS, there are no educational standards for trainees to receive addiction medicine training; and

WHEREAS, ACP's 2017 position paper on substance use disorder policy encourages policies that increase the number of buprenorphine prescribers (8); therefore be it

RESOLVED, that the Board of Regents advocates to decrease barriers for physicians to prescribe buprenorphine to treat opioid use disorder by recommending the removal of the mandatory training requirement under the Drug Addiction Treatment Act of 2000; and be it further

RESOLVED, that the Board of Regents work with AAMC and ACGME to establish medical student and resident training on medication-assisted treatment for opioid use disorder.

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