The American College of Physicians and Primary Care
Objectives

- To review ACP and Maryland Chapter membership
- To review the ACP’s strategic plan
- To review how the ACP addresses the needs of the primary care clinician
ACP Membership

- Effective June 30, 2015, total membership is 143,000, including international membership of over 13,000.

- ACP has 58 domestic chapters and 18 international chapters.

Member Categories:

- Fellows: 51,821, 37%
- Members: 35,301, 25%
- Resident/Fellow: 30,665, 22%
- Medical Student: 23,833, 17%

ACP has 58 domestic chapters and 18 international chapters.
‘Big M’ membership characteristics

- 52% specialize in GIM; 34% in IM subspecialty; 8% in Hospital medicine
- 96% have some clinical activity; 70% mostly clinical
- Employment: 39% private practice; 34% Academic Hospital; 13% private hospital
- Early career physicians less likely to be male, Caucasian, subspecialist, and more likely employed in Hospital medicine
# New Member Acquisition: Sources

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Terminating Associates</th>
<th>Total Auto-Elected to Membership</th>
<th>Percent Auto Elected</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2014</td>
<td>12,409</td>
<td>5,050</td>
<td>40.7%</td>
</tr>
<tr>
<td>July 2013</td>
<td>5,885</td>
<td>2,052</td>
<td>34.9%</td>
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<tr>
<td>July 2012</td>
<td>6,068</td>
<td>2,052</td>
<td>33.8%</td>
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<tr>
<td>July 2011</td>
<td>5,597</td>
<td>1,969</td>
<td>35.2%</td>
</tr>
<tr>
<td>July 2010</td>
<td>5,099</td>
<td>1,987</td>
<td>39.0%</td>
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<tr>
<td>July 2009</td>
<td>5,376</td>
<td>2,073</td>
<td>38.6%</td>
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<tr>
<td>July 2008</td>
<td>5,506</td>
<td>2,766</td>
<td>50.2%</td>
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<td>July 2007</td>
<td>4,752</td>
<td>2,245</td>
<td>47.2%</td>
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Maryland chapter

- Total members: 2476
  - 39% of all Maryland internists are members (rank 38)
  - 26% of all Maryland IM subspecialists are members (rank 14)

- Membership category
  - Masters: 20
  - Fellows: 552
  - Members: 994
  - Residents/Fellows: 511
  - Students: 390
Maryland chapter (2)

- Active Council
- Undergoing strategic plan development
- Two major meetings:
  - Winter Scientific Meeting (January 29-30, 2016)
  - Associates’ Meeting (April 7, 2016)
ACP Strategic Plan

Mission:

To enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine
ACP Strategic Plan

- To establish and promote the highest clinical standards and ethical ideals
- To be the foremost comprehensive education and information resource for all internists
- 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
Goals (2)

- To serve the professional needs of the membership, support healthy lives for physicians, and advance internal medicine as a career.
- To promote and conduct research to enhance the quality of practice, the education and continuing education of internists, and the attractiveness of internal medicine to physicians and the public.
- To unify the many voices of internal medicine and its subspecialties for the benefit of our patients, our members, and our profession.
Communicating the value of internal medicine

“Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness”
Priority initiatives

- Facilitate transitions to value-based payment and delivery models, including advocacy for:
  - Changes in Medicare payment policies that reimburse services outside the face-to-face visit
  - Identification of sound performance measures and their appropriate use
  - Practice transformation to include patient-centered approaches to care
Chapter develops and vets a resolution; submits to ACP
- List of resolutions distributed to chapters
- Chapters form an opinion on each resolution
- Resolutions discussed and amended at Board of Governors (BOG)
- Amended version voted on, then sent to Board of Regents (BOR)
- BOR votes; passed resolutions go to appropriate committee
Resolutions
Consultation in Evaluating Complex Medical Patients

In the fall of 2014, the BOG referred Resolution 4-F14, Affirming the Value of Physician to Physician Consultation in Evaluating Complex Medical Patients, for study and report back to the BOG with a recommendation regarding adoption.

The Reference Committee heard mixed testimony regarding Resolution 4-F14 and recommended referral for study as the sponsor stipulated, to which the BOG agreed. The Health & Public Policy (HPPC) and Medical Practice and Quality (MPQC) Committees have provided a recommendation on Resolution 4-F14 within a joint committee report available for your review. Resolution 4-F14 is inserted below for your reference. BOG members are encouraged to comment on this page regarding committee recommendation.

Resolution 4-F14. Affirming the Value of Physician to Physician Consultation in Evaluating Complex Medical Patients

(Sponsor: Pennsylvania Chapter)

4-F14 Background

WHEREAS, the involvement by mid-level practitioners is becoming more prevalent in specialty practices; and

WHEREAS, Primary Care Physicians (PCPs) as well as specialists in other disciplines continue to seek consultation with specialists when patients’ medical problems are complex or outside of their field of knowledge; and

WHEREAS, mid-level practitioners perform valuable services in working with specialists by performing preliminary evaluations of patients referred for such consultation; and

WHEREAS, mid-level practitioners lack the education and expertise to provide comprehensive specialty evaluation; and

WHEREAS, consultations are at times forwarded without adequate input from the supervising specialist physician; therefore be it

RESOLVED, that the Board of Regents affirms the value of physician to physician consultation in evaluating complex medical patients; and be it further

RESOLVED, that the Board of Regents affirms that such consultation cannot be appropriately provided unless the cognitive expertise of the physician providing such consultation is applied after a thorough review of the relevant history, ancillary data and the performance of a physical examination where necessary; and be it further

RESOLVED, that the Board of Regents creates guidelines defining the appropriate role of midlevel providers and their collaborating physicians in the performance of such consultation. (D13 &D14 of the ACP 2013 Strategic Plan).
Resolution 8-S15, Eliminating CMS Penalties for Not Using Certified Electronic Medical Records (EMRs)

In the spring of 2015, the BOG referred Resolution 8-S15, Eliminating CMS Penalties for Not Using Certified Electronic Medical Records (EMRs), for study and report back to the BOG with a recommendation regarding adoption.

Based on the testimony indicating the complex and rapidly evolving environment, including the SGR repeal bill and the way CMS finalized the CCM code, the Reference Committee recommended that Resolution 8-S15 be referred for study and the BOG at the Business Meeting agreed.

As a result, the Medical Practice and Quality (MPQC) Committee has provided a recommendation on Resolution 8-S15 within a committee report now available for your review. Resolution 8-S15 is inserted below for your reference. BOG members are encouraged to comment on this page regarding committee recommendation.

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

8-S15 Background

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

In the spring of 2015, the BOG referred Resolution 11-S15, Adopting Principles for Appropriate Use of Direct-to-Patient Telehealth, for study and report back to the BOG with a recommendation regarding adoption.

The Reference Committee recommended referral for study based on the sponsor’s testimony, as well as testimony that stated that the remaining principle (#6) required further study. At Business Meeting, the BOG agreed.

As a result, the Health and Public Policy Committee (HPPC) has provided a recommendation on Resolution 11-S15 within a committee report available for your review. Resolution 11-S15 is inserted below for your reference. BOG members are encouraged to comment on this page regarding committee recommendation.

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

11-S15 Background

(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 2005; and

WHEREAS, numerous private telehealth companies now offer medical diagnosis and treatment via the Internet (Direct-to-Patient Primary and Urgent Care Telehealth) 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 telehealth; 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.
Resolution 1-F15. Updating ACP Policy on Medical Student Debt

(Sponsor: Council of Resident/Fellow Members; Co-Sponsor: Council of Early Career Physicians)

WHEREAS, the median educational debt amongst 2014 medical school graduates is estimated at $180,000, with 43% of students graduating with $200,000 of debt or more (1); and

WHEREAS, high debt-to-income ratio, as a feature of “loan aversion,” may disincentivize medical school enrollment (2) and practice in a primary care field (3), and is furthermore associated with internal medicine (IM) resident burnout (4) and decreased career satisfaction (5); and

WHEREAS, in a 2003 American College of Physicians (ACP) policy statement, the College “advocates [for]... ease of the application process for scholarships, loan-forgiveness programs, and low-interest loan programs (6),” therefore be it

RESOLVED, that the Board of Regents provides a policy update on the topic of medical student debt in the context of a changing federal loan environment; and be it further

RESOLVED, that the Board of Regents prioritizes support for medical student, IM resident/fellow, and early career physician loan burden reduction, interest rate reform, and availability of subsidized loans; and be it further

RESOLVED, that the Board of Regents solicits a study for potential reform measures including, but not limited to:

1. Capping interest rates on federal loans at the prime lending rate,
2. Favorable tax climates for private lenders supplying medical education loans at or below federal interest rates,
3. An online marketplace providing medical students with comparative loan interest rates (7), and
4. Enhanced loan forgiveness for physicians practicing outpatient internal medicine for three or more years.
Resolution 2-F15. Evaluating the Feasibility, Safety, Cost Savings, and Adverse Effects of Allowing Importation of Prescription Drugs from Approved Pharmacies and Licensed Pharmacists in Canada

(Sponsor: Idaho Chapter)

2-F15 Background

WHEREAS, national health expenditure prescription drug spending increased 2.5% to $271.1 billion in 2013 and a per family increase of 13.6% in 2014 with expectations of even higher future prices; and

WHEREAS, in 2013, average prescription drug prices were twice as expensive in the United States as they were in Canada, with high costs leading some Americans to skip doses or forgo filling prescriptions altogether; and

WHEREAS, President Obama has supported drug price negotiation and asked Congress to allow Medicare officials to negotiate prices with drug manufacturers; and

WHEREAS, two U.S. Senators (McCain and Klobuchar) have introduced a bill (The Safe and Affordable Drugs from Canada Act) that would allow individuals to safely import prescription drugs from Canada, and create major savings for consumers by bringing greater competition into the pharmaceutical market; and

WHEREAS, the Idaho Chapter previously submitted Resolution 3-F14, Advocating for Legislation Empowering the Federal Government to Negotiate Medicare Drug Prices, which was met with great interest; therefore be it

RESOLVED, that the Board of Regents supports a study by the College to evaluate the feasibility, safety, potential cost savings and potential for adverse effects of legislation that allows the importation of prescription drugs from approved pharmacies and licensed pharmacists in Canada; and be it further

RESOLVED, that if this study reflects substantial benefits to patients, the Board of Regents supports importation of prescription drugs from approved pharmacies and licensed pharmacists in Canada and considers approving legislation that pertains to importation as an increased ACP legislative priority.
Resolution 3-F15. Promoting Students’ Meaningful Use of the Electronic Health Record

(Sponsor: Education and Publication Committee)

3-F15 Background

WHEREAS, in 2012, the Alliance for Clinical Education (ACE) proposed educational principles related to the electronic health record that included:

1) students must document in the patient's chart and their notes should be reviewed for content and format
2) students must have the opportunity to practice order entry in an EHR—in actual or simulated patient cases—prior to graduation
3) students should be exposed to the decision aids that typically accompany EHRs
4) schools must develop a set of medical student competencies related to charting in the EHR and state how they would evaluate it; and

WHEREAS, documentation of an E&M service by a student that may be referred to by the teaching physician is limited to the review of systems and/or past medical/family/social history; and

WHEREAS, the teaching physician may not refer to a student’s documentation of the history or physical exam findings, or medical decision making in his or her personal note; and

WHEREAS, these CMS standards significantly alter the involvement of medical students in the care of Medicare patients and many medical schools have interpreted the CMS documentation rules to forbid student access to the electronic health record; therefore be it

RESOLVED, that the Board of Regents encourages accreditation bodies such as the Liaison Committee for Medical Education to specify educational standards to ensure medical school compliance with the Alliance for Clinical Education educational principles or similar principles related to electronic health records; and be it further

RESOLVED, that the Board of Regents calls on the CMS to change the 2008 guidelines to allow teaching physicians to refer to a student’s documentation of the history and physical examination findings or medical decision making in his or her personal note for documentation of an E&M service.
The ACP and ABIM

- Meet monthly; communicate regularly
- Topics of interest:
  - Certification exam
  - Maintenance of certification requirements
  - Costs associated
ACP and trainees

- Resident/fellow membership at reduced rate ($119)
- National meeting opportunities/competitions
- MKSAP at a reduced rate
- Provides IM-ITE to all training programs
Questions/Comments?