American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

INTRODUCTION

2019 Annual Council Meeting
Thursday Evening, October 24 through Saturday, October 26, 2019
Hyatt Regency at the Colorado Convention Center

Visit the Council Meeting Web site: https://acep.elevate.commpartners.com/ to access all materials and information for the Council meeting.

The resolutions and other resource documents for the meeting are located under the "Document Library" tab. You may download and print the entire Council notebook compendium, or individual section tabs from the Table of Contents. You will also find separate compendiums of the Council officer candidates, President-Elect candidates, Board of Directors candidates, and the resolutions.

The ACEP staff and your Council officers have prepared background information for the resolutions submitted by the deadline. Please review the resolutions and background information in advance of the Council meeting. *We strongly encourage online discussion of the resolutions via the Council's engagED (the Council's e-list) community.* Post a message to the engagED community by using this email address, acep_council@ConnectedCommunity.org.

Councillors and others receiving these materials are reminded that these items are yet to be considered by the Council and are for information only.

Only resolutions subsequently adopted by both the Council and the Board of Directors (except for Council Standing Rules resolutions) become official. For those of you who may be new to the Council resolution process, only the RESOLVED sections of the resolutions are considered by the Council. The WHEREAS statements are informational or explanatory only.

Additional documents may be added to the Council Meeting Web site over the next several days, so please check back if what you need is not currently available.

We are looking forward to seeing everyone in Denver!

Your Council officers,

John G. McManus, Jr., MD, MBA
Speaker

Gary R. Katz, MD, MBA, FACEP
Vice Speaker

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

DEFINITION OF COUNCIL ACTIONS

For the ACEP Board of Directors to act in accordance with the wishes of the Council, the actions of the Council must be definitive. To avoid any misunderstanding, the officers have developed the following definitions for Council action:

ADOPT
Approve resolution exactly as submitted as recommendation implemented through the Board of Directors.

ADOPT AS AMENDED
Approve resolution with additions, deletions, and/or substitutions, as recommendation to be implemented through the Board of Directors.

REFER
Send resolution to the Board of Directors for consideration, perhaps by a committee, the Council Steering Committee, or the Bylaws Interpretation Committee.

NOT ADOPT
Defeat (or reject) the resolution in original or amended form.

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ADVANCING EMERGENCY CARE

Council Meeting Schedule of Events

Hyatt Regency at Colorado Convention Center
October 24-26, 2019
Denver, CO

Thursday, October 24

3:00 pm – 8:00 pm	Councillor Credentialing – *Centennial Ballroom Foyer, 3rd Floor*
4:30 pm – 6:00 pm	Candidate Forum Subcommittee – *Capitol Ballroom 3, 3rd Floor*
6:00 pm – 7:00 pm	Steering Committee Meeting – *Capitol Ballroom 5-7, 4th Floor*
7:00 pm – 8:00 pm	Tellers, Credentials, & Elections Committee – *Capitol Ballroom 3, 3rd Floor*
7:00 pm – 8:00 pm	Reference Committee Briefing – *Mineral Hall A, 3rd Floor*
8:00 pm – 9:00 pm	Councillor Orientation – *Capitol Ballroom 5-7, 4th Floor*

Friday, October 25

7:30 am – 5:30 pm	Councillor Credentialing – *Centennial Ballroom Foyer, 3rd Floor*
7:30 am – 8:00 am	Council Continental Breakfast – *Centennial Ballroom Foyer, 3rd Floor*
8:00 am – 9:15 am	Council Meeting – *Centennial Ballroom A-F, 3rd Floor*
9:30 am – 12:30 pm	Reference Committee A – *Capitol Ballroom 4, 4th Floor*
9:30 am – 12:30 pm	Reference Committee B – *Capitol Ballroom 5-7, 4th Floor*
9:30 am – 12:30 pm	Reference Committee C – *Capitol Ballroom 1-3, 4th Floor*
11:00 am – 12:30 pm	Reference Committee Boxed Luncheon – *Capitol Ballroom Foyer, 4th Floor*
12:30 pm – 2:30 pm	Reference Committee Executive Sessions A – Capitol Ballroom 4, *4th Floor* B – Capitol Ballroom 5-7, *4th Floor* C – Capitol Ballroom 1-3, *4th Floor*
12:45 pm – 1:45 pm	Town Hall Meeting – *Centennial Ballroom A-F, 3rd Floor*
2:00 pm – 2:30 pm	Candidate Forum for President-Elect Candidates – *Centennial Ballroom A-F, 3rd Floor*
2:45 pm – 4:30 pm	Candidate Forum for Board of Directors and Council Officer Candidates – Capitol Ballrooms 1-7, *4th Floor*
4:45 pm – 6:00 pm	Council Reconvenes – *Centennial Ballroom A-F, 3rd Floor*
6:15 pm – 7:15 pm	Candidate Reception – *Capitol Ballroom 2-3, 4th Floor*

Saturday, October 26

7:00 am – 8:30 am	Keypad Distribution – *Centennial Ballroom Foyer, 3rd Floor*
7:00 am – 5:30 pm	Councillor Credentialing – *Centennial Ballroom Foyer, 3rd Floor*
7:30 am – 8:00 am	Council Continental Breakfast – *Centennial Ballroom Foyer, 3rd Floor*
8:00 am – 12:00 pm	Council Meeting – *Centennial Ballroom A-F, 3rd Floor*
12:00 pm – 1:30 pm	Council Awards Luncheon – *Capitol Ballroom 1-7, 4th Floor*
1:45 pm – 5:45 pm	Council Reconvenes – *Centennial Ballroom A-F, 3rd Floor*
5:10 pm – 5:40 pm	Elections – *Centennial Ballroom A-F, 3rd Floor*

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2019 Council Meeting

October 25-26, 2019
Pre-Meeting Events Occur Thursday, Evening, October 24, 2019, Hyatt Regency at Colorado Convention Center
Centennial Ballroom, 3rd Floor
Denver, CO

TIMED AGENDA

Friday, October 25, 2019

Continental Breakfast – Centennial Ballroom, 3rd Floor ***7:30 am***

1.	Call to Order A. Meeting Dedication B. Pledge of Allegiance C. National Anthem	Dr. McManus	8:00 am
2.	Introductions	Dr. McManus	8:10 am
3.	Welcome from CO Chapter President	Dr. Stader	8:12 am
4.	Tellers, Credentials, & Election Committee A. Credentials Report B. Meeting Etiquette	Dr. Costello	8:14 am
5.	Changes to the Agenda	Dr. McManus	8:16 am
6.	Council Meeting Website	Mr. Joy	8:16 am
7.	EMF Challenge	Dr. Wilcox	8:21 am
8.	NEMPAC Challenge	Dr. Jacoby	8:23 am
9.	Review and Acceptance of Minutes A. Council Meeting – September 29-30, 2018	Dr. McManus	8:25 am
10.	Approval of Steering Committee Actions A. Steering Committee Meeting – January 29, 2019 B. Steering Committee Meeting – May 5, 2019	Dr. McManus	
11.	Call for and Presentation of Emergency Resolutions	Dr. McManus	
12.	Steering Committee's Report on Late Resolutions A. Reference Committee Assignments of Allowed Late Resolutions B. Disallowed Late Resolutions	Dr. McManus	
13.	Nominating Committee Report A. Speaker 1. Slate of Candidates 2. Call for Floor Nominations B. Vice Speaker 1. Slate of Candidates 2. Call for Floor Nominations C. Board of Directors 1. Slate of Candidates 2. Call for Floor Nominations D. President-Elect 1. Slate of Candidates 2. Call for Floor Nominations	Dr. McManus	8:30 am

Friday, October 25, 2019 (*Continued*)

14. Candidate Opening Statements	Dr. McManus	
A Speaker Candidates (2 minutes each)		8:35 am
B. Vice Speaker Candidates (2 minutes each)		8:37 am
C. Board of Directors Candidates (2 minutes each)		8:43 am
D. President-Elect Candidates (5 minutes each)		9:00 am
15. Reference Committee Assignments	Dr. McManus	9:10 am
BREAK		***9:10 am – 9:30 am***
16. Reference Committee Hearings –		9:30 am – 12:30 pm
A – Governance & Membership – *Capitol Ballroom 4, 4th Floor*		
B – Advocacy & Public Policy – *Capitol Ballroom 5-7, 4th Floor*		
C – Emergency Medicine Practice – *Capitol Ballroom 1-3, 4thFloor*		
Lunch Available – List Location		***11:00 am – 12:30 pm***
17. Reference Committee Executive Sessions		12:30 pm – 2:30 pm
A – *Capitol Ballroom 4, 4th Floor*		
B – *Capitol Ballroom 5-7, 4th Floor*		
C – *Capitol Ballroom 1-3, 4th Floor*		
BREAK – Return to main Council meeting room – Centennial Ballroom, 3rd Floor		***12:30 pm – 12:45 pm***
18. Town Hall Meeting – *Centennial Ballroom, 3rd Floor*	Dr. Katz	12:45 pm – 1:45 pm
A. Growth of the ACEP Council		
19. Candidate Forum for the President-Elect Candidates – *Centennial Ballroom 3rd Floor*		2:00 pm – 2:30 pm
BREAK – Return to Reference Committee meeting rooms – Capitol Ballrooms 1-7, 4th Floor		***2:30 pm – 2:45 pm***
20. Candidate Forum for Board and Council Officer Candidates – *Capitol Ballrooms 1-7, 4th Floor*		2:45 pm – 4:30 pm
Candidates rotate through Reference Committee meeting rooms.		
BREAK – Return to main Council meeting room – Centennial Ballroom, 3rd Floor		***4:30 pm – 4:45 pm***
21. Speaker's Report	Dr. McManus	4:45 pm
A. Leadership Development Advisory Committee		
B. Board Actions on 2018 Resolutions		
C. Introduction of Honored Guests		
D. Introduction of Council Steering Committee		
E. Introduction of Board of Directors		
22. In Memoriam	Dr. McManus	5:00 pm
A. Reading and Presentation of Memorial Resolutions	Dr. Katz	5:00 pm
Adopt by observing a moment of silence.		
23. ABEM Report	Dr. Baren	5:10 pm
24. AOBEM Report	Dr. Zabbo	5:15 pm
25. Secretary-Treasurer's Report	Dr. Rosenberg	5:20 pm
26. EMRA Report	Dr. Maniya	5:25 pm
27. EMF Report	Dr. Anderson	5:30 pm
28. NEMPAC Report	Dr. Jacoby	5:35 pm
29. President's Address	Dr. Friedman	5:40 pm

Candidate Reception ● 6:15 pm – 7:15 pm ● *Capitol Ballroom 2-3, 4th Floor*

Saturday, October 26, 2019

Keypad Distribution – Centennial Ballroom Foyer, 3rd Floor		***7:00 am***
Continental Breakfast – Centennial Ballroom, 3rd Floor		***7:30 am***
1. Call to Order	Dr. McManus	8:00 am
2. Tellers, Credentials, & Elections Committee Report	Dr. Costello	8:00 am
3. Electronic Voting A. Keypad Testing/Demographic Data Collection	Dr. Costello	8:05 am
4. Executive Directors Report	Mr. Wilkerson	8:30 am
5. Video – How to Submit Amendments Electronically		8:55 am
6. Reference Committee Reports A. Reference Committee _____ B. Reference Committee _____		9:00 am
7. Awards Luncheon – *Capitol Ballroom 1-7, 4th Floor*		*12:00 pm*
A. Welcome	Dr. McManus	12:45 pm
1. Recognition of Past Speakers and Past Presidents		
2. Recognition of Chapter Executives		
B. ACEP Awards Announcements	Dr. Friedman	12:55 pm
C. Reading and Presentation of Commendation Resolutions	Dr. McManus/Dr. Katz	
D. Council Award Presentations	Dr. McManus/Dr. Katz	
1. Council Service Milestone Awards – *5, 10, 15, 20, 25, 30, 35+ Year Councillors*		
2. Council Teamwork Award		
3. Council Horizon Award		
4. Council Champion Award in Diversity & Inclusion		
5. Council Curmudgeon Award		
6. Council Meritorious Service Award		
8. Luncheon Adjourns – ***Return to main Council meeting room – Centennial Ballroom, 3rd Floor***		***1:30 pm***
9. Council Survey on Firearms	Dr. Richardson	1:45 pm
10. Reference Committee Reports Continue C. Reference Committee ___		2:15 pm
11. President-Elect's Address	Dr. Jaquis	4:45 pm
12. Installation of President	Dr. Friedman/Dr. Jaquis	5:05 pm
13. Elections A. Speaker B. Vice Speaker C. Board of Directors D. President-Elect	Dr. Costello	5:10 pm
14. Announcements	Dr. McManus	5:40 pm
15. Adjourn	Dr. McManus	5:45 pm

American College of Emergency Physicians®
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2019 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 9-22

Larisa M. Traill, MD, FACEP (MI), Chair
Mariana Karounos, DO MS, FACEP (NJ)
Kurtis Mayz, JD, MD, MBA, FACEP (IL)
Robert C. Solomon, MD, FACEP (PA)
James D. Thompson, MD, FACEP (CO)
L. Carlos Zapata, MD, FACEP (NY)

Leslie Moore, JD
Maude Surprenant Hancock

Reference Committee B
Advocacy & Public Policy
Resolutions 23-39

Catherine A. Marco, MD, FACEP (OH), Chair
Bradley Burmeister, MD (WI)
Zachary J. Jarou, MD (EMRA)
Thom R. Mitchell, MD, FACEP (TN)
Randy L. Pilgrim, MD, FACEP (LA)
Lindsay M. Weaver, MD, FACEP (IN)

Ryan McBride, MPP
Harry Monroe

Reference Committee C
Emergency Medicine Practice
Resolutions 40-54

Michael A. Turturro, MD, FACEP (PA) Chair
Sara A. Brown, MD, FACEP (IN)
Angela P. Cornelius, MD, FACEP (LA)
Steven M. Hochman, MD, FACEP (NJ)
Matthew J. Sanders, DO, FACEP (OH)
John C. Soud, DO, (FL)

Margaret Montgomery, RN, MSN
Travis Schulz, MLS, AHIP

American College of Emergency Physicians®
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2019 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Paul D. Kivela, MD, MBA, FACEP *California Chapter*	
2	Commendation for Kevin M. Klauer, DO, EJD, FACEP *Ohio Chapter*	
3	Commendation for John G. McManus, Jr., MD, MBA, FACEP *Government Services Chapter*	
4	Commendation for Debra G. Perina, MD, FACEP *Virginia College of Emergency Physicians*	
5	Commendation for Rhonda R. Whitson, RHIA *Michael Brown, MD, MSc, FACEP* *Stephen Cantrill, MD, FACEP* *Stephen Karas, MD, FACEP* *Stephen Wolf, MD, FACEP*	
6	In Memory of Jonathan Eric Epstein, MD, FACEP *New York Chapter*	
7	In Memory of Rakesh Engineer, MD, FACEP *Ohio Chapter*	
8	In Memory of Kevin Scott Mickelson, MD, FACEP *Indiana Chapter*	
9	Criteria for Eligibility for EM Organizations Seeking Representation in the Council – College Manual Amendment *Council Steering Committee*	A
10	Procedures for Addressing Charges of Ethical Violations and Other Misconduct – College Manual Amendment *Ethics Committee* *Board of Directors*	A
11	International Member Eligibility for FACEP- Bylaws Amendment *Nicholas Peschanski, PhD, MD* *Rahul Sethi, MD*	A
12	ACEP Composition Annual Report *Emergency Medicine Resident's Association* *American Association of Women Emergency Physicians Section* *Diversity, Inclusion, & Health Equity Section*	A

Resolution #	Subject/Submitted by	Reference Committee
13	Eliminating Use of the Word "Provider" in All ACEP Communications *Utah Chapter*	A
14	Implicit Bias Awareness and Training *Elizabeth Dubey, MD, FACEP* *American Association of Women Emergency Physicians Section* *Diversity, Inclusion, & Health Equity Section* *Quality Improvement & Patient Safety Section* *Wisconsin Chapter*	A
15	Increased Transparency in NEMPAC Contributions *American Association of Women Emergency Physicians Section*	A
16	Opposition to the AAMC Standardized Video Interview *Emergency Medicine Residents' Association*	A
17	Pay Transparency *Sarah Hoper, MD, JD, FACEP* *American Association of Women Emergency Physicians Section* *Diversity, Inclusion, & Health Equity Section* *Quality Improvement & Patient Safety Section* *Wisconsin Chapter*	A
18	Promoting Emergency Medicine Physicians *Emergency Medicine Residents' Association* *Texas College of Emergency Physicians*	A
19	Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) *Illinois College of Emergency Physicians*	A
20	Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders *Illinois College of Emergency Physicians*	A
21	Video Conferencing for Chapter and Section Meetings *Hawaii Chapter*	A
22	Visual White Coat for Emergency Medicine Advocacy Efforts *Carrieann Drenten, MD, FACEP* *Douglas Gibson, MD, FACEP* *Vikant Gulati, MD, FACEP* *Susanne Spano, MD, FACEP* *Andrea Wagner, MD, FACEP* *Delaware Chapter*	A
23	Allow Emergency Physicians to Prescribe Buprenorphine *Alaska Chapter* *California Chapter* *New Mexico Chapter* *Oregon Chapter* *Washington Chapter* *Pain Management & Addiction Medicine Section*	B

Resolution #	Subject/Submitted by	Reference Committee
24	CMS Sepsis Core Measure and the Legal Standard of Care *Kyle Fischer, MD, FACEP* *Maryland Chapter* *New Jersey Chapter* *Ohio Chapter*	B
25	Rational Crystalloid Hydration in Sepsis *Illinois College of Emergency Physicians* *Maryland Chapter* *Pennsylvania College of Emergency Physicians* *South Carolina College of Emergency Physicians* *West Virginia Chapter*	B
26	EMTALA Professional Liability Coverage *Arjun Chanmugam, MD, FACEP* *Maryland Chapter* *New Jersey Chapter* *Ohio Chapter*	B
27	Ensuring Public Transparency & Safety by Protecting the Terms ED and ER as Markers of Physician-Led Care *Sean Ochsenbein, MD, MBA* *Nathaniel Westphal, MD*	B
28	Expanding the Benefits of EMTALA to Ensure the Safety of the Public *Darrell Calderon, MD* *Ricardo Martinez, MD, FACEP*	B
29	Extending Medicaid Coverage to 12-Months Postpartum *Sarah Hoper, MD, JD, FACEP* *Lisa Maurer, MD, FACEP* *Rachel Solnick, MD* *American Association of Women Emergency Physicians Section*	B
30	High Threat Emergency Casualty Care *David Callaway, MD, FACEP* *Eric Goralnick, MD, MS, FACEP* *Richard Kamin, MD, FACEP* *Gina Piazza, DO, FACEP* *E. Reed Smith, MD, FACEP* *Matthew Sztajnkrycer, MD, FACEP* *Disaster Medicine Section* *EMS-Prehospital Care Section* *Government Services Chapter* *Tactical Medicine Section*	B
31	Improving Emergency Physicians Utilization of Medication for Addiction Treatment *Missouri College of Emergency Physicians* *New Jersey Chapter* *Ohio ACEP*	B
32	Legal and Civil Penalties for the Routine Practice of Medicine *Kyle Fischer, MD, FACEP* *Maryland Chapter*	B

Resolution #	Subject/Submitted by	Reference Committee
33	National Medical Tort Reform as a "CMS Best Practice" *Bret Frey, MD, FACEP* *Nevada Chapter*	B
34	Opposing Naloxone Addition to the Prescription Drug Monitoring Program *Illinois College of Emergency Physicians* *Missouri College of Emergency Physicians* *Pennsylvania College of Emergency Physicians* *West Virginia Chapter*	B
35	Prudent Layperson Visit Downcoding *Georgia College of Emergency Physicians* *Missouri College of Emergency Physicians* *Ohio Chapter*	B
36	Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence *Illinois College of Emergency Physicians*	B
37	Single-Payer Health Insurance *Larry Bedard, MD, FACEP* *Kathleen Cowling, DO, MBA, FACEP* *Gregory Gafni-Pappas, DO, FACEP* *Jacob Manteuffel, MD, FACEP* *James Mitchiner, MD, MPH, FACEP* *Robert Solomon, MD, FACEP* *Nicholas Vasquez, MD, FACEP* *Bradford Walters, MD, FACEP*	B
38	Standards for Insurance Denials *Kerry Forrestal, MD, FACEP* *Mark Goldstein, MD, FACEP* *Maryland Chapter* *New Jersey Chapter*	B
39	Work Requirements for Medicaid Beneficiaries *Joseph J. Calabro, DO, FACEP* *Neal Cohen, MD* *Michael Gratson, MD, MHSA* *Dennis Hsieh, MD, JD* *James Maloy, MD* *Jacob Manteuffel, MD, FACEP* *Therese Mead, DO, FACEP* *Sar Medoff, MD, MPP* *James Mitchiner, MD, MPH, FACEP* *Dan Morhaim, MD, FACEP* *Larisa Traill, MD, FACEP* *Bradford Walters, MD, FACEP* *Nicholas Vasquez, MD, FACEP*	B
40	Advancing Quality Care in Rural Emergency Medicine *Rural Emergency Medicine Section* *Florida College of Emergency Physicians* *Idaho Chapter* *Nebraska Chapter* *West Virginia Chapter*	C

Resolution #	Subject/Submitted by	Reference Committee
41	Establish a Rural Emergency Care Advisory Board *Rural Emergency Medicine Section* *Young Physicians Section* *Alaska Chapter* *Florida College of Emergency Physicians* *Idaho Chapter* *Missouri College of Emergency Physicians* *Montana Chapter* *Nebraska Chapter* *Nevada Chapter* *New Mexico Chapter* *West Virginia Chapter* *Wyoming Chapter*	C
42	Artificial Intelligence in Emergency Medicine *Zach Jarou, MD* *John Rogers, MD, FACEP* *Emergency Medicine Informatics Section*	C
43	Droperidol is Safe to Use in the ED *Illinois College of Emergency Physicians* *Maryland Chapter* *Missouri College of Emergency Physicians* *Pennsylvania College of Emergency Physicians* *South Carolina College of Emergency Physicians* *West Virginia Chapter*	C
44	Independent ED Staffing by Non-Physician Providers *Indiana Chapter* *New Jersey Chapter* *Missouri College of Emergency Physicians* *Ohio Chapter*	C
45	Medical Neutrality *International Emergency Medicine Section* *Social Emergency Medicine Section*	C
46	Mental Health Care for Vulnerable Populations *Kerry Forrestal, MD, FACEP* *Erik Schobitz, MD, FACEP* *Maryland Chapter* *New Jersey Chapter*	C
47	Prevention of Self -Harm & Accidental Injury by Internet Challenges and Social Media Posts *Indiana Chapter*	C
48	Promotion of Maternal and Infant Health *Massachusetts College of Emergency Physicians*	C

Resolution #	Subject/Submitted by	Reference Committee
49	Protecting Emergency Physician Compensation During Contract Transitions Arizona *College of Emergency Physicians* *District of Columbia Chapter* *Idaho Chapter* *Illinois College of Emergency Physicians* *Maryland Chapter* *New Jersey Chapter* *Pennsylvania College of Emergency Physicians* *West Virginia Chapter*	C
50	Social Work in the Emergency Department *Social Emergency Medicine Section* *New York Chapter*	C
51	Stimulating Telemedicine Researchers and Programs *Alexander Chiu, MD, MBA, FACEP* *Mark E. Escott, MD, MPH, FACEP* *Adam Ash, DO, FACEP* *Joo Yup Shaun Chun MD, FACEP* *David Ernst, MD, FACEP* *Alina Ershova BA* *Hartmut Gross, MD, FACEP* *William Holubek, MD, FACEP* *Nizar Kifaieh, MD, MBA, FACEP* *Arkansas Chapter* *District of Columbia Chapter* *Hawaii Chapter* *Iowa Chapter* *Nebraska Chapter* *New Jersey Chapter* *New York Chapter* *Virginia College of Emergency Physicians* *West Virginia Chapter* *Critical Care Section* *EMS-Prehospital Care Section* *Wilderness Medicine Section*	C
52	Telehealth Emergency Physician Inclusion *Edward Shaheen, MD, FACEP* *Emergency Telehealth Section*	C
53	Supporting Vaccination for Preventable Diseases *Illinois College of Emergency Physicians*	C
54	Vaccine Preventable Illnesses Toolkit *New York Chapter*	C

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 1(19)

SUBMITTED BY: California Chapter

SUBJECT: Commendation for Paul D. Kivela, MD, MBA, FACEP

WHEREAS, Paul D. Kivela, MD, MBA, FACEP, has been an energetic and visionary leader for the American College of Emergency Physicians while serving on the Board of Directors 2010-19 and in his roles as Secretary-Treasurer 2013-14, Vice President 2014-15, President-Elect 2016-17, President 2017-18, and Immediate Past President 2018-19; and

WHEREAS, During his tenure on the Board of Directors, Dr. Kivela's top priority was to focus on initiatives that improved the daily lives and practice of emergency physicians; and

WHEREAS, Dr. Kivela facilitated several key initiatives for ACEP, including the redesign of the website, creation of the Reimbursement Leadership Development Program, development and promotion of the "Until Help Arrives" program, and outreach to other emergency medicine organizations; and

WHEREAS, Dr. Kivela was instrumental in ACEP moving forward with a comprehensive emergency medicine workforce study that addresses the future of emergency medicine practice for emergency physicians as well as the impact of nurse practitioners and physician assistants practicing in the emergency department; and

WHEREAS, Dr. Kivela has been a staunch advocate for preserving reimbursement for emergency physicians; and

WHEREAS, Dr. Kivela has served as a member, chair, and Board Liaison to various ACEP committees, task forces, and sections; and

WHEREAS, Dr. Kivela has championed ACEP's advocacy agenda and has served on the Board of Trustees of the National Emergency Medicine Political Action Committee; and

WHEREAS, Dr. Kivela demonstrated leadership through chapter involvement as a member of the California Chapter and served on the Board of Directors 2001-06 and as President 2004-05; and

WHEREAS, Dr. Kivela maintained an active clinical schedule during his time on the ACEP Board of Directors; and

WHEREAS, In all his meetings and travels, Dr. Kivela represented the College with diplomacy and was a role model of commitment and productivity; and

WHEREAS, Dr. Kivela has contributed to the growth and maturation of emergency medicine and will continue to be committed to its cause and mission; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Paul D. Kivela, MD, MBA, FACEP, for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 2(19)

SUBMITTED BY: Ohio Chapter

SUBJECT: Commendation for Kevin M. Klauer, DO, EJD, FACEP

WHEREAS, Kevin M. Klauer, DO, EJD, FACEP, has been a steadfast and dedicated member of the American College of Emergency Physicians since 1992; and

WHEREAS, Dr. Klauer served on the Board of Directors of the Emergency Medicine Residents' Association as secretary 1993-95; and

WHEREAS, Dr. Klauer served on the Ohio Chapter Board of Directors 1998-08 and as chapter president 2002-03; and

WHEREAS, Dr. Klauer has a long history of service to the Council as a councillor, alternate councillor, and as a member and chair of several Council committees, including the Council Steering Committee, Candidate Forum Subcommittee, Council Awards Committee, Nominating Committee, Leadership Development Advisory Group, and Reference Committees, and he was ultimately elected as Vice Speaker in 2011 and Speaker in 2013; and

WHEREAS, Dr. Klauer was elected to the national ACEP Board of Directors in 2016 and brought the depth and breadth of his experience to his role on the Board of Directors; and

WHEREAS, Dr. Klauer served as the Medical Editor in Chief of *ACEP Now* for six years and through his tireless efforts transformed the publication, which resulted in numerous awards for journalistic excellence and reinforced *ACEP Now* as "The Official Voice of Emergency Medicine;" and

WHEREAS, Dr. Klauer served as a member, chair, and Board Liaison to various ACEP committees, task forces, and sections; and

WHEREAS, Dr. Klauer has been an articulate spokesperson for ACEP's advocacy agenda and a champion for the National Emergency Medicine Political Action Committee by serving on its Board of Trustees 2010-19 and working to increase contributions to advance critical issues for ACEP members; and

WHEREAS, Dr. Klauer is a visionary and influential leader with a distinguished career in emergency medicine as a clinician, educator, and mentor and has received many awards and accolades; therefore be it

RESOLVED, That the American College of Emergency Physicians extends heartfelt appreciation and gratitude and commends Kevin M. Klauer, DO, EJD, FACEP, for his dedication as an emergency physician and his outstanding service and leadership to the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 3(19)

SUBMITTED BY: Government Services Chapter

SUBJECT: Commendation for John G. McManus, Jr., MD, MBA, FACEP

WHEREAS, John G. McManus, Jr., MD, MBA, FACEP, has served the American College of Emergency Physicians with distinction and dedication as Council Vice Speaker 2015-17 and Council Speaker 2017-19; and

WHEREAS, Dr. McManus represented the Council at Board of Directors' meetings during his terms as Vice Speaker and Speaker and provided thoughtful discourse and comments on a variety of issues; and

WHEREAS, Dr. McManus deftly and efficiently led the Council during debate of contentious issues; and

WHEREAS, Dr. McManus, diligently devoted significant amounts of time, creativity, humor, and enthusiasm to his duties as a Council officer; and

WHEREAS, Dr. McManus welcomed and encouraged the participation of new councillors and alternate councillors on Council committees; and

WHEREAS, Dr. McManus has demonstrated a long history of service to the Council including serving as a councillor and alternate councillor and on various Council committees; and

WHEREAS, Dr. McManus has maintained an active presence in the Government Services Chapter and served on the Board of Directors 2003-08 and as president 2006-07; and

WHEREAS, Dr. McManus has shown exemplary leadership and outstanding service with his participation on several committees and task forces of the College;

WHEREAS, Dr. McManus is a recognized leader, educator, and advocate for the specialty; and

WHEREAS, Dr. McManus will continue to be involved and committed to the cause and mission of ACEP and the specialty of emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians commends John G. McManus, Jr., MD, MBA, FACEP, for his service as Council Speaker and Council Vice Speaker, and for his enthusiasm and commitment to the specialty of emergency medicine and to the patients we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 4(19)

SUBMITTED BY: Virginia College of Emergency Physicians

SUBJECT: Commendation for Debra G. Perina, MD, FACEP

WHEREAS, Debra G. Perina, MD, FACEP, has served the American College of Emergency Physicians with honor and distinction since becoming a member in 1983; and

WHEREAS, Dr. Perina has served in many leadership roles at the national level, including the national ACEP Board of Directors 2013-19, chair of the Board 2017-18, as a member of the *ACEP Now* Editorial Board 2013-present, and as a member and Board Liaison to numerous committees, task forces, and sections; and

WHEREAS, As chair of the Board, Dr. Perina displayed extraordinary leadership by keeping participation balanced and meetings focused while guiding the Board through many difficult issues with exemplary and wise counsel; and

WHEREAS, During her tenure on the Board, Dr. Perina served as a liaison representative to the American Academy of Pediatrics and the American College of Surgeons – Committee on Trauma and provided keen insight for ACEP's relations with the American Board of Emergency Medicine, the Council of Emergency Medicine Residency Directors, the National Association of EMS Physicians, the Society of Academic Emergency Medicine, and other organizations; and

WHEREAS, Dr. Perina demonstrated leadership through chapter involvement as a member of the South Carolina College of Emergency Physicians 1983-94, the Board of Directors 1989-95, and as chapter president 1991-93, and as a member of the Virginia College of Emergency Physicians since 1995;

WHEREAS, Dr. Perina served the ACEP Council as a councillor 1992-94 and as an alternate councillor 2010-13; and

WHEREAS, Dr. Perina has helped train and mentor numerous emergency medicine residents, and has served as Professor, Department of Emergency Medicine at the University of Virginia, Charlottesville since 2012; and

WHEREAS, Dr. Perina's passion for emergency medicine includes serving on the Board of Directors of multiple emergency medicine organizations including the American Board of Emergency Medicine 2003-11 and as President 2009-10, the Council of Emergency Medicine Residency Directors 1996-05 and as President 2001-03, the National Association of EMS Physicians 2002-03, the Society for Academic Emergency Medicine 1997-98, and the Accreditation Council of Continuing Medical Education 2007-13 and as Chair 2010-2011; and

WHEREAS, Dr. Perina has enjoyed a distinguished career serving patients by continually striving for excellence in clinical care and as a compassionate and capable emergency physician; and

WHEREAS, Dr. Perina has contributed to the growth and maturation of emergency medicine and will continue to serve the College and the specialty of emergency medicine in the future; therefore, be it

RESOLVED, That the American College of Emergency Physicians commends Debra G. Perina, MD, FACEP, for her dedication as an emergency physician, educator, and leader in the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 5(19)

SUBMITTED BY: Michael Brown, MD, MSc, FACEP
Stephen Cantrill, MD, FACEP
Stephen Karas, MD, FACEP
Stephen Wolf, MD, FACEP

SUBJECT: Commendation for Rhonda R. Whitson, RHIA

WHEREAS, Rhonda R. Whitson, RHIA, served the American College of Emergency Physicians (ACEP) with distinction and dedication for nearly 33 years; and

WHEREAS, Ms. Whitson provided support to the Emergency Medicine Standards Task Force beginning in 1988 and later the Standards Committee and Clinical Policies Committee; and

WHEREAS, Ms. Whitson provided unwavering guidance to hundreds of members of the Clinical Policies Committee since its inception in 1992; and

WHEREAS, Ms. Whitson played a critical role in the evolution and development of the clinical policy process while providing advice and direction to the Clinical Policies Committee; and

WHEREAS, Ms. Whitson was instrumental in the development and publication of more than 60 clinical policies and 11 policy statements including ACEPs first clinical policy on chest pain in 1990; and

WHERAS Ms. Whitson was a vital part of the creation of the ACEP Member Wellness Booth and tirelessly involved in the development, growth, and implementation of the Member Wellness Booth for 26 years; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Rhonda R. Whitson, RHIA, for her service as Clinical Practice Manager.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 6(19)

SUBMITTED BY: New York Chapter

SUBJECT: In Memory of Jonathan Eric Epstein, MD, FACEP

WHEREAS, Jonathan Eric Epstein, MD, FACEP's very essence was about duty, responsibility, and kindness; and

WHEREAS, Dr. Epstein's entire career displayed his indefatigable work ethic, his intellect, and his dedication to improve the care of underserved populations, exemplified by collaboratively founding and leading the first ED-based observation unit among New York City public hospitals; and

WHEREAS, Dr. Epstein's career was driven by a commitment to service, working only in public hospitals, and creating clinical schedules that favored others above himself; and

WHEREAS, Dr. Epstein's even-keeled and steady leadership as Assistant Director of Emergency Medicine at Queens Hospital Center, one of New York City's busiest public hospitals, became instrumental in steering and grounding the department and its staff; and

WHEREAS, He advanced emergency medicine as an educator of students, residents and colleagues, and as an Assistant Professor at the Icahn School of Medicine at Mount Sinai; and

WHEREAS, He was reserved, but had a wry wit and dry sense of humor appreciated by all who knew him; and

WHEREAS, His devotion and love for his wife Stacey and son Steven were always evident, as was his loyalty and dedication to his family and friends; and

WHEREAS, Dr. Epstein was an avid attendee at ACEP events annually, both locally and nationally; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes Jonathan Eric Epstein, MD, FACEP, commemorates his dedication to emergency medicine and the College, and celebrates his many accomplishments during his too brief life and career.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 7(19)

SUBMITTED BY: Ohio Chapter

SUBJECT: In Memory of Rakesh Engineer, MD, .FACEP

WHEREAS, The field of emergency medicine lost an outstanding clinician and friend when Rakesh Engineer, MD, FACEP, passed unexpectedly in his sleep on May 10, 2019, at the age of 49; and

WHEREAS, Dr. Engineer earned his Bachelor of Science and Doctor of Medicine Degrees from The Ohio State University; and

WHEREAS, Dr. Engineer completed post-graduate training at Washington University in St. Louis, Missouri and Spectrum Health in Grand Rapids, Michigan; and

WHEREAS, Dr. Engineer devoted his 18 years of practice to the Cleveland Clinic and the Case Western Reserve University/MetroHealth/Cleveland Clinic residency program; and

WHEREAS, Dr. Engineer was an active member of Ohio ACEP, encouraging membership and participation from the beginning of residency; and

WHEREAS, Dr. Engineer contributed extensively to academic conferences, completing numerous research and quality improvement projects throughout his career, steadfast in his commitment to evidence-based medicine; and

WHEREAS, Dr. Engineer's legacy is concisely yet eloquently stated on an anonymous patient survey quote hanging in the halls of the Cleveland Clinic: "Dr. Engineer took great care of me"; and

WHEREAS, Dr. Engineer was a loving father and husband, always encouraging his residents and colleagues to spend quality time with their families; therefore be it

RESOLVED, That the American College of Emergency Physicians extends to the family of Rakesh Engineer, MD, FACEP, his friends, and his colleagues our condolences and gratitude for his service to his residents and the countless patients who have benefited from his care.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 8(19)

SUBMITTED BY: North Dakota Chapter

SUBJECT: In Memory of Kevin Scott Mickelson, MD, FACEP

WHEREAS, With the untimely death of Kevin S. Mickelson, MD, FACEP, on Monday, July 15, 2019, ACEP lost a gifted communicator and a tireless emergency medicine advocate; and

WHEREAS, Dr. Mickelson received his medical degree from the University of North Dakota and completed his emergency medicine residency at Hennepin County Medical Center in Minneapolis, MN in 1986; and

WHEREAS, Dr. Mickelson is widely viewed by those who knew him from Hennepin County Medical Center as having performed in an outstanding fashion as a former resident, colleague, and friend in emergency medicine; and

WHEREAS, Dr. Mickelson possessed an enthusiastically positive outlook on life, projected a happy and gregarious demeanor, and whose personal interactions were a pleasure; and

WHEREAS, Dr. Mickelson had a long and distinguished service as a member of ACEP and the North Dakota Chapter for 30 years; and

WHEREAS, Dr. Mickelson served the North Dakota Chapter as councillor, president-elect, and then president; and

WHEREAS, Dr. Mickelson was a passionate witness on behalf of emergency physicians in the state legislature; and

WHEREAS, Dr. Mickelson served his community for 30 years as an emergency physician and tirelessly worked at St. Alexius Medical Center in Bismarck; and

WHEREAS, Dr. Mickelson additionally practiced emergency medicine in Fargo, ND where he touched many lives with his kindness, compassion, and desire to truly help mankind; and

WHEREAS, Dr. Mickelson was recognized for his deep empathy and compassion for medicine which earned him the exuberant gratitude and admiration of his patients; and

WHEREAS, Dr. Mickelson will be missed by his friends and colleagues who were privileged to know him for his strength of character, but most importantly that he knew kindness mattered; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with honor and appreciation the accomplishments and contributions of a gifted emergency physician, Kevin S. Mickelson, MD, FACEP, and extends condolences and gratitude to his wife, Colette, family, and friends for his service to the specialty of emergency medicine and to patient care.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 9-22

Larisa M. Traill, MD, FACEP (MI), Chair
Mariana Karounos, DO MS, FACEP (NJ)
Kurtis Mayz, JD, MD, MBA, FACEP (IL)
Robert C. Solomon, MD, FACEP (PA)
James D. Thompson, MD, FACEP (CO)
L. Carlos Zapata, MD, FACEP (NY)

Leslie Moore, JD
Maude Surprenant Hancock

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

College Manual Amendment

RESOLUTION: 9(19)

SUBMITTED BY: Council Steering Committee

SUBJECT: Criteria for Eligibility for EM Organizations Seeking Representation in the Council

PURPOSE: Amends the College Manual to clarify that the eligibility criteria for emergency medicine organizations seeking representation in the Council must be met at the time the representation is sought.

FISCAL IMPACT: Budgeted staff resources to update the College Manual.

WHEREAS, The ACEP Bylaws Article VIII – Council, Section 1 – Composition of the Council, paragraph two states: "An organization currently serving as, or seeking representation as, a component body of the Council must meet, and continue to meet, the criteria stated in the College Manual. These criteria do not apply to chapters or sections of the College."; and

WHEREAS, The College Manual states that "a majority of the organization's physician members are ACEP members" but does not specify that this requirement must be met at the time the Bylaws resolution is submitted; therefore be it

RESOLVED, That the College Manual be amended to read:

VI. Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council:

Organizations that seek representation as a component body in the Council of the American College of Emergency Physicians (ACEP) must meet **at the time the Council representation is sought**, and continue to meet, the following criteria:

A. Non-profit.
B. Impacts the practice of emergency medicine, the goals of ACEP, and represents a unique contribution to emergency medicine that is not already represented in the Council.
C. Not in conflict with the Bylaws and policies of ACEP.
D. Physicians comprise the majority of the voting membership of the organization.
E. A majority of the organization's physician members are ACEP members.
F. Established, stable, and in existence for at least 5 years prior to requesting representation in the ACEP Council.
G. National in scope, membership not restricted geographically, and members from a majority of the states. If international, the organization must have a U.S. branch or chapter in compliance with these guidelines.
H. Seek representation as a component body through the submission of a Bylaws amendment.

The College will audit these component bodies every two years to ensure continued compliance with these guidelines.

Background

This resolution amends the College Manual to clarify that the eligibility for emergency medicine organizations seeking representation in the Council must be met at the time the representation is sought, i.e., when the resolution submitted.

The 2018 Council and the Board of Directors adopted resolution 9(18) ACOEP Councillor Allocation that amended the Bylaws to allocate one councillor to ACOEP. It was unknown at the time the resolution was submitted, and subsequently adopted, whether a majority of ACOEP's members were also members of ACEP. Staff were not successful in obtaining the ACOEP membership data for a comparison with ACEP membership data before the 2018 Council meeting. It was clarified at the Council meeting that the membership comparison would be completed based on the ACOEP membership as of December 31, 2018. This date is consistent with the Bylaws Article VIII – Council, Section 1 – Composition of the Council, that states: "Each chartered chapter shall have a minimum of one councillor as representative of all of the members of such chartered chapter. There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the membership rolls of the College on December 31 of the preceding year."

The membership data comparison of ACEP and ACOEP members was completed by February 5, 2019. Multiple reviews were conducted to verify the information, including a manual search of each non-member name to ensure that names were not missed when the electronic comparison was conducted. The analysis revealed that only 28% of ACOEP's physician members were ACEP members, therefore, ACOEP was not eligible for a councillor for the 2019 Council meeting.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective F – Provide and promote leadership development among emergency medicine organizations and strengthen liaison relationships.

Fiscal Impact

Budgeted staff resources to update the College Manual.

Prior Council Action

Resolution 9(18) ACOEP Councillor Allocation adopted.

Resolution 5(15) EMRA Councillor Allocation adopted. Increased EMRA's councillor allocation from four councillors to eight councillors.

Resolution 13(13) Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council – College Manual Amendment adopted. Amended the College Manual to include criteria for eligibility and approval of organizations seeking representation in the Council.

Resolution 9(13) Criteria for Inclusion of Organizations in the ACEP Council – Bylaws Amendment adopted. Amended the Bylaws to specify that organizations seeking representation in the Council must meet the criteria in the College Manual.

Resolution 12(12) Criteria for Inclusion of Organizations in the ACEP Council adopted. Tasked the Council Steering Committee to develop criteria for inclusion of additional organizations as component bodies of the Council and develop a report for the 2013 ACEP Council no later than six weeks prior to the deadline for submission of regular resolutions.

Resolution 17(11) SAEM Councillor Allocation adopted. Established that SAEM will be allocated one councillor.

Resolution 7(10) CORD Councillor Allocation adopted. Established that CORD will be allocated one councillor.

Resolution 8(09) AACEM Councillor Allocation adopted. Established that AACEM will be allocated one councillor.

Resolution 2(92) EMRA Councillor Allotment adopted. Increased EMRA's councillor allocation from two seats to four.

Resolution 1(88) EMRA Councillor Allotment adopted. Increased EMRA's councillor allocation to two seats.

Resolution 2(76) adopted, which codified in the Bylaws the allocation of one councillor for EMRA.

Resolution 1(75) adopted, which allocated one councillor for EMRA at the 1975 Council meeting with full voting privileges and future representation to be determined.

Prior Board Action

Resolution 9(18) ACOEP Councillor Allocation adopted.

Resolution 5(15) EMRA Councillor Allocation adopted.

Resolution 13(13) Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council adopted.

Resolution 9(13) Criteria for Inclusion of Organizations in the ACEP Council – Bylaws Amendment adopted.

Resolution 12(12) Criteria for Inclusion of Organizations in the ACEP Council adopted. Resolution 17(11) SAEM Councillor Allocation adopted.

Resolution 7(10) CORD Councillor Allocation adopted.

Resolution 8(09) AACEM Councillor Allocation adopted.

October 1992, Resolution 2(92) EMRA Councillor Allotment adopted.

September 1988, Resolution 1(88) EMRA Councillor Allotment adopted.

October 1976, Resolution 2(76) adopted.

October 1975, Resolution 1(75) adopted.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

College Manual Amendment

RESOLUTION: 10(19)

SUBMITTED BY: Ethics Committee
Board of Directors

SUBJECT: Procedures for Addressing Charges of Ethical Violations and Other Misconduct

PURPOSE: Amend by substitution the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to create a more efficient complaint review process and clarify procedural issues.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The review of complaints regarding ethical violations or other matters requires adequate due process to ensure it is fair to both the complainant and respondent; and

WHEREAS, A review by legal counsel, the ACEP Board of Directors and a subcommittee of the Ethics Committee determined that a more efficient complaint review process is needed based upon the increasing number of ethics complaints filed annually; and

WHEREAS, The ACEP Board of Directors approved a revision to the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* at its meeting in June 2019; and

WHEREAS, Approval by the ACEP Council is required to include the revised document in the College Manual; therefore be it

RESOLVED, That the College Manual be amended by substitution of the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* to read:

Procedures for Addressing Charges of Ethical Violations and Other Misconduct

Guiding Principle: Ethics charges and other disciplinary charges are important and will be addressed in accordance with College policy.

A. Definitions

1. ACEP shall mean the American College of Emergency Physicians

2. *Code of Ethics* shall mean the *Code of Ethics for Emergency Physicians*

3. *Principles of Ethics* shall mean *Principles of Ethics for Emergency Physicians*

4. *Procedures* shall mean *Procedures for Addressing Charges of Ethical Violations and Other Misconduct*

5. Ethics Complaint Review Panel consists of three (3) members of the Ethics Committee and two (2) members of the Medical-Legal Committee – in matters requiring the expertise of a different committee, the President may appoint two (2) members of the relevant committee to replace the standing members of the Medical-Legal Committee

6. Bylaws Committee refers to the Bylaws Committee or appointed subcommittee

7. Board Hearing Panel consists of the ACEP Vice-President, Chair of the Board, and Board Liaison to the Ethics Committee or Bylaws Committee, as appropriate

~~A.~~B. Complaint Received

A complaint may be initiated by an ACEP member, chapter, committee, or section. No others have standing to present a complaint.

1. Must be in writing and signed by the complainant;
2. Must specify in reasonable detail an alleged violation by an ACEP member of ACEP Bylaws, current ACEP "*Principles of Ethics*, for Emergency Physicians," other current ACEP ethics policies, or other conduct believed by the complainant to warrant censure, suspension, or expulsion;
3. Must allege a violation that occurred within twelve (12) **seven (7)** years prior to the submission of the complaint**, is not the subject of pending litigation, and any rights of appeal have been exhausted or have expired;**
4. Must state that the complainant has personal, first-hand knowledge or actual documentation of the alleged violation; substantiating documentation must accompany the complaint. Complainant is responsible for ensuring that the documentation does not provide information that can be used to identify a particular patient, including but not limited to, the patient's name, address, social security number, patient identification number, or any identifying information related to members of the patient's family;
5. Must state that the complainant is willing to have his or her name disclosed to the ACEP Executive Director, the Ethics Committee, the Bylaws Committee, the Board of Directors**any additional ACEP review body listed in these *Procedures***, and to the respondent should the complaint be forwarded to the respondent; **and**
6. Must be submitted to the ACEP Executive Director.

B. C. Executive Director

1. a. If any elements of the complaint have not been met, returns the complaint and supporting documentation to complainant, identifying the elements that must be addressed in an ethics complaint.

b. If all elements of the complaint have been met, sends 1. Sends a written acknowledgement to the complainant confirming the complainant's intent to file a complaint**. Includes a copy of ACEP's *Procedures* providing** and identifying the **guidelines and timetables** elements that **will** must be **followed** addressed in **this matter. Requests complainant sign acknowledgement specifying intent to file** an ethics complaint **and to be bound by the *Procedures*.**

1.2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the ***Procedures***. "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" ("Procedures")

2.3. Notifies the ACEP president and the chair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.

3.4. a. Determines, in consultation with the ACEP President and the chair of the Ethics **Committee** and/or **the** Bylaws Committee, that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the *Code of Ethics* **or** *for Emergency Physicians* or of ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or

b. Determines, in consultation with the **ACEP President and the Chair of the** Ethics Committee chair, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics for Emergency Physicians*, and if so, forwards the complaint and the response together, as soon as both are received, to each member of the Ethics **Complaint Review Panel** Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose, or

c. Determines, in consultation with the **ACEP President and the Chair of the** Bylaws Committee ~~chair~~, that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, as soon as both are received, to each member of the Bylaws Committee, or at the discretion of the ~~chair~~**Chair** of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose, or

d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues, the complaint will not be considered. The **Ethics Complaint Review Panel or the Bylaws Committee**~~Board of Directors~~ will review the President's action. ~~at the next regularly scheduled Board meeting.~~ The President's action can be overturned by a majority vote of the **appropriate review bodies**. ~~Board, or~~

~~4.~~5. Within ten (10) business days after the determination~~s~~ specified in Section ~~B~~C.4.b. or Section ~~B~~C.4.c. of these *Procedures*, forwards the complaint to the respondent by **USPS Certified Mail**~~certified U.S. mail~~ with a copy of these *Procedures* and requests a written response within thirty (30) days of receipt of the documents. The communication will indicate that ACEP is providing notice of the complaint, the reasons for the review action, that no determination has yet been made on the complaint, and that the respondent has the right to request a hearing if the ~~Board~~ **appropriate review panel** decides not to dismiss the complaint. A copy of the complaint and all supporting documentation provided by the complainant will be included in this communication. Such notice must also include a summary of the respondent's rights in the hearing, and a list of the names of the members of the ~~ACEP Ethics Committee or the ACEP Bylaws Committee, as~~ appropriate **review and hearing panels**~~,~~ and the Board of Directors. The respondent will have the right to raise any issues of potential conflict or reason that any individuals should recuse themselves from the review. Such recusal shall be at the discretion of the ACEP President.

6. When a written response to a complaint is received, the Executive Director will forward that response and any further related documentation to the complainant and the Ethics **Complaint Review Panel or** ~~Committee,~~ the Bylaws Committee~~, or the subcommittee~~ appointed to review the complaint, as appropriate.

~~C. Bylaws Committee~~ **D. Ethics Complaint Review Process** [within sixty (60) days of the forwarding of the complaint/response specified in Section ~~B~~C.4.~~b~~c. above]

1. Reviews the written record of any complaint that alleges a violation of current~~the~~ ACEP *Principles of Ethics* or other current ACEP ethics policies ~~Bylaws~~ and the accompanying response.
2. Discusses the complaint and response by telephone conference call~~:~~ .
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Current ACEP *Principles of Ethics* or other current ACEP ethics policies apply.
   b. Alleged behavior constitutes a violation of current ACEP *Principles of Ethics* or other current ACEP ethics policies.
   c. Alleged conduct warrants censure, suspension, or expulsion.

~~6. Develops a report regarding the complaint and recommendation for action. Minority reports may also be presented.~~

~~7. The Ethics Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Ethics Committee shall recommend that the Board of Directors:~~

5. **Decides to**:

a. Dismiss the complaint; or
b. ~~Take disciplinary action, the specifics of which shall be included in the committee's report.~~ **Ethics Complaint Review Panel renders a decision to impose disciplinary action based on the written record.**

~~8. At the discretion of the chair of the Ethics Committee, these functions may be carried out by a subcommittee of five or more members of the Ethics Committee. The Ethics Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.~~

6. If the Ethics Complaint Review Panel determines to impose disciplinary action pursuant to Section D.5.b., the respondent will be provided with notification of the Ethics Complaint Review Panel's determination and the option of:

a. A hearing; or
b. The imposition of the Ethics Complaint Review Panel decision based solely on the written record.

7. If the respondent chooses the option described in Section D.6.b., that is, an Ethics Complaint Review Panel decision based solely on the written record, the Ethics Complaint Review Panel will implement its decision to impose disciplinary action based on the written record.

E. Bylaws Complaint Review Process [within sixty (60) days of the forwarding of the complaint/response specified in Section C.4.c. above]

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:

a. Current ACEP Bylaws apply.
b. Alleged behavior constitutes a violation of current ACEP Bylaws.
c. Alleged conduct warrants censure, suspension, or expulsion.

5. Decides to:

~~5. Proceeds to develop its recommendation based solely on the written record.~~

~~6. Develops a report regarding the complaint and recommendation for action. A minority reports may also be presented.~~

~~7. The Bylaws Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Bylaws Committee shall recommend that the Board of Directors:~~

a. Dismiss the complaint; or
b. ~~Take disciplinary action, the specifics of which shall be included in the committee's report.~~ **Bylaws Committee renders a decision to impose disciplinary action based solely on the written record.**

~~8. At the discretion of the chair of the Bylaws Committee, these functions may be carried out by a subcommittee of five or more members of the Bylaws Committee. The Bylaws Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.~~

6. If the Bylaws Committee determines to impose disciplinary action pursuant to Section E.5.b., the respondent will be provided with notification of the Bylaws Committee's determination and the option of:
   a. A hearing; or
   b. The imposition of the Bylaws Committee's decision based solely on the written record.
7. If the respondent chooses the option described in Section E.6.b., that is, a Bylaws Committee decision based solely on the written record, the Bylaws Committee will implement its decision to impose disciplinary action based on the written record.

~~E. Board of Directors~~

~~1. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and receives the complaint and response.~~
~~2. May request further information in writing from the complainant and/or respondent.~~
~~3. Decides to:~~
~~Render a decision to impose disciplinary action based on the written record.~~
~~4. If the Bylaws Committee Board determines to impose disciplinary action pursuant to Section E.53.b., the respondent will be provided with notification of the Bylaws Committee'sBoard's determination and the option of:~~
~~a. A hearing; or~~
~~b. The imposition of the Bylaws Committee'sBoard decision based solely on the written record.~~
~~5. The decision to impose disciplinary action shall require a two-thirds vote of Directors voting at a meeting in which a quorum is present pursuant to ACEP Bylaws. Directors entitled to vote include members of the Board who have been present for the entire discussion of the complaint, either in person or by conference call, with no conflict of interest or other reason to recuse themselves from participation.~~
~~6 If the respondent chooses the option described in Section E.4.b., that is, a Board decision based solely on the written record, the Board will implement its decision to impose disciplinary action based on the written record.~~

~~F. Ad Hoc Committee~~

~~1. If a majority of Board members have recused themselves from consideration of a complaint, the Board shall delegate the decisions regarding disciplinary action to an Ad Hoc Committee composed of nine (9) members.~~
~~2. This Ad Hoc Committee shall be composed of all those Board members who have not recused themselves, if any, plus independent third parties who are ACEP members. Should the chair of the Board receive notification of recusal from consideration of an ethics complaint from a majority of Board members, the chair shall request those Board members who have not recused themselves to submit nominations of independent third parties who are ACEP members to serve on an Ad Hoc Committee to act on that ethics complaint. At the next meeting of the Board, the Board members who have not recused themselves shall elect from those nominees, by majority vote, the required number of independent third party members of the Ad Hoc Committee. Should all Board members recuse themselves, the chair shall appoint a committee of seven (7) independent third parties who are ACEP members without conflicts in this matter who will select the nine (9) members of the ad hoc committee.~~
~~3. The Ad Hoc Committee:~~
~~a. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and receives the complaint and response.~~
~~b. May request further information in writing from the complainant and/or respondent.~~
~~c. Decides to:~~
~~i. Dismiss the complaint; or~~
~~ii.Render a decision to impose disciplinary action based on the written record.~~

~~d. If the Ad Hoc Committee determines to impose disciplinary action pursuant to Section F.3.c.ii., the respondent will be provided with notification of the Ad Hoc Committee's determination and the option of:~~

~~i. A hearing conducted by the Ad Hoc Committee; or~~

~~ii. The imposition of the Ad Hoc Committee decision based solely on the written record.~~

~~e. If the respondent requests a hearing, the Ad Hoc Committee shall follow the hearing procedures described in Section H below.~~

~~f. An affirmative vote of two-thirds of the Ad Hoc Committee shall be required to take disciplinary action against the respondent. If the Ad Hoc Committee does not achieve a two-thirds vote of its members, the respondent shall be exonerated.~~

~~g. If the respondent does not request a hearing, the Ad Hoc Committee will report to the Board its decision to impose disciplinary action based on the written record. This decision will be final and will be implemented by the Board.~~

~~G.~~F. ~~Right of Respondent to Request a Hearing~~

If the **Ethics Complaint Review Panel or Bylaws Committee**~~Board~~ chooses **to impose disciplinary action,** the ~~option described in Section E.3.b., or an Ad Hoc Committee chooses the option described in Section F.3.cii., the~~ Executive Director will send to the respondent a written notice by ~~certified U.S. mail~~ **USPS Certified Mail** of the right to request a hearing. ~~or to have the Board or the Ad Hoc Committee impose its decision based solely on the written complaint.~~ This notice will list the respondent's hearing rights as set forth in Section G~~H~~. below. The respondent's request for a hearing must be submitted in writing to the Executive Director within thirty (30) ~~business~~ days of receipt of the notice of right to a hearing. In the event of no response, the ~~ACEP President may determine the manner of proceeding~~**applicable review body will implement its final decision**.

~~H.~~G. Hearing Procedures

1. If the respondent requests a hearing, the complainant and respondent will be notified in writing by ~~certified U.S. mail~~ **USPS Certified Mail** by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board **Hearing Panel**~~, its subcommittee pursuant to Section H.6. below, or an Ad Hoc Committee pursuant to Section F.,~~ intends to call in the hearing.
2. The Executive Director will send a notification **by USPS Certified Mail** of the date, time, and place of the hearing and will provide the parties with information regarding the hearing process and the conduct of the hearing. ~~by certified U.S. mail.~~
3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.
4. The complainant and respondent each may be represented by counsel or any other person of their choice. Each party will bear the expense of his or her own counsel.
5. The parties have the right to have a record made of the proceedings by transcript, audiotape, or videotape at the expense of the requesting party.
6. **The hearing will take place before the Board Hearing Panel. All members of the Board Hearing Panel must be present in person. Hearings may not take place by telephone conference call.**
7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.
8. The Board **Hearing Panel**~~, its appointed subcommittee, or an Ad Hoc Committee~~ will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the

filing of any written briefs, conclude the hearing.

~~9. In the event that the hearing is conducted by a subcommittee of the Board or an Ad Hoc Committee, such subcommittee or Ad Hoc Committee will, within one hundred twenty (120) days after the hearing concludes, submit the written record of the hearing, along with the subcommittee's recommendation or the Ad Hoc Committee's decision, to the Board of Directors. If the hearing is conducted by a subcommittee of the Board, within thirty (30) days after receiving a subcommittee report and recommendation, or, if the full Board conducts the hearing, within thirty (30) days after the hearing concludes, the Board shall render a decision. The affirmative vote of two-thirds of the Directors entitled to vote pursuant to this Section, with a quorum of Directors present pursuant to ACEP Bylaws, shall be required to take disciplinary action against the respondent. If the Board does not achieve a two-thirds vote of entitled Directors with a quorum present, the respondent shall be exonerated. Directors shall be entitled to vote if they have not recused themselves or been recused, and, in the case of a hearing conducted by the full Board, if they have attended the entire hearing. If the hearing is conducted by an Ad Hoc Committee pursuant to Section F., the decision of such Ad Hoc Committee will be final and will be implemented by the Board.~~

~~10.~~**9.** ~~The decision of the Board or Ad Hoc Committee~~ **The decision of the Board Hearing Panel** will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the ~~Board's or Ad Hoc Committee's~~ **Board Hearing Panel's**decision will be sent by ~~certified U.S. mail~~ **USPS Certified Mail** to the respondent and complainant within sixty (60) days of the decision. This written notice will include the ~~Board's or Ad Hoc Committee's~~ **Board Hearing Panel's**decision and a statement of the basis for that decision.

H. Notice to the Board of Directors

At the next meeting of the ACEP Board of Directors, following a final determination regarding a complaint, the Board shall be presented with an outline of the steps taken by the appropriate committee or panel in its review of the complaint. The Board shall review the *Procedures* used in the complaint review process but will not review the facts or merits of the case. Should the Board decide these *Procedures* were not followed appropriately, it will remand the case back to the reviewing committee or panel to correct the procedural error.

I. ~~Possible~~ Disciplinary Action and Disclosure to ACEP Members

1. Nature of Disciplinary Actions

a. Censure~~, Suspension, or Expulsion~~

~~1. Censure~~

~~a.~~i. Private Censure: a private letter of censure informs a member that his or her conduct ~~is~~**does** not ~~in conformity~~ **conform** with the College's ethical standards; it may detail the manner in which ~~the Board~~ **ACEP** expects the member to behave in the future and may explain that, while the conduct does not, at present, warrant public censure or more severe disciplinary action, the same or similar conduct in the future may warrant a more severe action. ~~The content~~ **Upon written request by a member** of **ACEP, ACEP may confirm the censure; however, contents of the** ~~a private~~ letter ~~of censure shall~~ **will** not be ~~disclosed,~~ **provided.** ~~but the fact that such a letter has been issued shall be disclosed.~~

~~b.~~ii. Public Censure: a public letter of censure shall detail the manner in which the censured member has been found to violate the College's ethical standards **set forth in Section ~~A.2.~~ B.2.** above**. The censure shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or bylaw was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action.**

~~2.~~**b.** Suspension from ACEP membership shall be for a period of twelve **(12)** months; the dates of commencement and completion of the suspension shall be determined by the ~~Board of Directors~~ **ACEP President**. At the end of the twelve **(12)** month period of suspension**,** the suspended member ~~shall be offered~~**may request** reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues). **The suspension shall be announced in an appropriate ACEP publication. The published announcement shall also state which ACEP policy or bylaw was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. ACEP is also required to report the suspension from membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.**

~~3.~~**c.** Expulsion from ACEP membership shall be for a period of five (5) years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors. **The expulsion**

~~**J. Disclosure**~~

~~1. Nature of Disciplinary Action~~

~~a. Private censure: the content of a private letter of censure~~ shall ~~not~~ be **announced in an appropriate ACEP publication. The published announcement**~~disclosed, but the fact that such a letter has been issued~~ shall **also state which ACEP policy or Bylaws provision was violated by**~~be disclosed. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed.~~

~~b. Public censure: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.~~

~~c. Suspension: the dates of suspension, including whether or not~~ the member **and shall inform ACEP members that they**~~was reinstated at the end of the period of suspension, along with a statement of the basis for the suspension, shall be disclosed. ACEP is also required to report the suspension of membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which~~ may **request further information about the disciplinary**~~result in a report of such~~ action. ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.

2. Scope and Manner of Disclosure

a. Disclosure to ACEP ~~members~~ **Members**: Any ACEP member may transmit ~~to the Executive Director~~ a request for information **to the Executive Director** regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section ~~J~~I.1.

b. ~~Public Disclosure:~~**Disclosure to Non-Members: If a non-member** ~~The Board of Directors shall publicize in an appropriate ACEP publication the names of members receiving public censure, suspension, or expulsion. This published announcement shall also state which ACEP bylaw or policy was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. If any person~~ makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication**. No further information shall be provided.**

~~K.~~J. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the ~~Board of Directors or an Ad Hoc Committee pursuant to Section F.~~**appropriate review body**, at which time the decision will be available upon request by ACEP members, to the extent specified in Section ~~J.~~**I.** Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics ~~Committee~~**Complaint Review Panel**, the Bylaws Committee, **or** the Board ~~of Directors, their appointed subcommittees, as appropriate, or an Ad Hoc Committee~~ **Hearing Panel**, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the ~~committee's, Board's, subcommittee's, or Ad Hoc Committee's overall time to complete its task. However, such requests and the responses thereto shall not extend the time to deliver a recommendation or a decision to the Board beyond ninety (90) days from the date the complaint is forwarded to the appropriate committee, subcommittee, or Ad Hoc Committee~~ **review body's overall time to complete its task**.
4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.
5. If a participant in this process (such as a member of the Ethics ~~Committee~~ **Complaint Review Panel**, the Bylaws Committee, or **the** Board ~~of~~ Directors **Hearing Panel**) is a party to the complaint, has a material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic competition with the respondent, that person shall recuse himself or herself from the process except as a complaining party or respondent, **at which time the ACEP President will appoint a replacement**. ~~Any committee member who recuses himself or herself shall report this recusal promptly to the committee chair, and any Board member who recuses himself or herself shall report this recusal promptly to the chair of the Board.~~
6. Once the ~~Board~~ **Ethics Complaint Review Panel or the Bylaws Committee** has made a decision ~~or implemented a decision of an Ad Hoc Committee pursuant to Section F.~~ on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.
7. The ~~Board's~~ **Ethics Complaint Review Panel or the Bylaws Committee's** decision ~~or the decision of an Ad Hoc Committee pursuant to Section F.~~ to impose an adverse action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the disciplinary process.
8. If a respondent fails to respond to a complaint, to **a** notice of the right to request a hearing, or to a request for information, the ~~Board or an Ad Hoc~~ **Ethics Complaint Review Panel, the Bylaws** Committee**, or the Board Hearing Panel** ~~pursuant to Section F.~~ may make a decision on the complaint solely on the basis of the information it has received.

~~9. If a complaint alleges a violation that is the subject of a pending ACEP Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.~~

~~10.~~**9.** If a respondent seeks to voluntarily resign his/her ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

Background

This resolution amends by substitution ACEP's "Procedures for Addressing Charges of Ethical Violations and Other Misconduct."

In 1997, ACEP established procedures by which its members may initiate complaints against fellow members for violations of ACEP's *Code of Ethics for Emergency Physicians* ("*Code of Ethics"*). These procedures have been revised several times, most recently in 2013. In accordance with the *Procedures for Addressing Charges of Ethical Violations and Other Misconduct* (the "*Procedures*"), the current structure for review of ethics complaints is:

1. ACEP's President, Chair of the Ethics Committee, and its Executive Director conduct an initial review of a filed complaint, with input from the General Counsel. This review is limited to providing a determination as to whether the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in ACEP's *Code of Ethics* or Bylaws or if it should move forward for additional review by ACEP's Ethics Committee or subcommittee.[1]
2. Should the case proceed to a formal review, a subcommittee of the Ethics Committee examines the complaint and response of the accused. It then provides the Board of Directors with a written recommendation to either dismiss the complaint or take disciplinary action.
3. The Board of Directors reviews the complaint, response, and any additional information it deemed relevant. At its next meeting, the Board deliberates the ethics case and renders a determination to dismiss the complaint or impose disciplinary action.
4. If the respondent requests a hearing after receipt of notice regarding disciplinary action taken against him or her, an in-person hearing is held before the Board of Directors or a subcommittee of the Board.

Following establishment of the *Procedures*, 20 cases have been decided by the Board of Directors, 4 of which have resulted in hearings. The frequency of complaints varies annually; however, on average 1-2 cases are reviewed per year. During the 2017-18 fiscal year, the Board reviewed 3 cases, one of which required a hearing.

A 2017 survey of Ethics Committee members who have served on the complaint subcommittee revealed that each member spends an average of 8-12 hours reviewing case documents, as well as participating in a 90-120-minute conference call to deliberate the facts of the case and vote on a recommendation to the Board of Directors. This does not include additional hours required of the subcommittee chair to collaborate with staff in drafting the recommendation, as well as participate in the Board deliberations and possible hearing.

The Board of Directors also spends a commensurate amount of time reviewing documents and preparing for ethics complaint deliberations. Should the respondent request a hearing in the case, a Board member will likely spend several hours refamiliarizing him/herself with the facts of the case. At Board meetings, deliberations and hearings can take up to 3 hours.

Because of the burden these responsibilities place on the Board and Ethics Committee, the committee was requested to develop an alternative process by which ethics complaints could be adjudicated in a manner that still provides adequate due process to the parties as required under the Health Care Quality and Improvement Act. After studying review processes used by other medical societies, researching ACEP's legal responsibilities, and discussing the needs of the College, the following revised process is proposed:

Step 1. This step remains the same, with a broad review of the complaint by the President, Ethics Chair and ACEP's Executive Director, with input from the General Counsel.

Step 2. A standing subcommittee of members from the Ethics Committee and Medical-Legal Committee will review the complaint and response from the parties and make its determination, which will be forwarded to the parties.

Step 3. Should a hearing be requested, a panel consisting of the Ethics Committee Chair, Medical-Legal Committee Chair, and one member of the Board of Directors will conduct the hearing and render its decision.

Step 4. At the next Board meeting following a final determination from the subcommittee or hearing panel, the Board will review the case for procedural matters only. It will not review the facts or merits of the case.

[1] The *Procedures* also provide an opportunity for members to file complaints regarding violations of ACEP's Bylaws; however, no complaint of this nature has ever been filed. As such, a discussion regarding complaints alleging violations of ACEP's Bylaws have been omitted from this memo.

It is important that the Board maintain oversight of the process; however, this streamlined version should substantially reduce the amount of time and preparation required of the Board, as its role will be limited solely to ensuring the reviewing body acted in compliance with the *Procedures.* Several medical specialty societies, such as the American Academy of Otolaryngology and the Society of Thoracic Surgeons, engage in similarly structured reviews.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Membership Engagement
Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 12(13) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. Amended by substitution the ethics procedures in the College Manual. The changes addressed the timeliness of filing allegations, clarifications of aspects of the process, ensuring that deadlines are reasonable in light of process and review requirements, a respondent's membership status during the pendency of an ethics complaint, and clarifications of the scope and disclosure of disciplinary actions.

Resolution 11(10) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes addressed issues relating to deadlines and provided mechanisms in the event that the number of Board recusals impacts the Board's ability to act on ethics complaints.

Resolution 14(07) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes addressed issues relating to due process and the hearing procedures.

Resolution 35(04) Procedures for Addressing Ethics and Other Disciplinary Charges adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes related to the categories of sanctions and clarifying when disclosure of such sanctions may be appropriate or necessary.

Amended Resolution 1(01) Procedures for Addressing Ethics and Other Disciplinary Charges adopted. The resolution amended by substitution the ethics procedures in the College Manual. The changes included enhancements related to communications, responsibilities, timelines, and voting.

Resolution 5(99) College Manual adopted that included the "Procedures for Addressing Ethics and Other Disciplinary Charges." The resolution established the College Manual and defined the method for amending it.

Prior Board Action

June 2019, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting a College Manual resolution to the 2018 Council.

December 2018, discussed revising the Procedures for Addressing Charges of Ethical Violations and Other Misconduct" to create a more efficient review process.

Resolution 12(13) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

June 2013, reviewed the proposed changes to the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" and approved submitting a College Manual resolution to the 2013 Council.

Resolution 11(10) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

April 2010, reviewed the proposed changes to the "Procedures for Addressing Ethics and Other Disciplinary Charges" and approved submitting a College Manual resolution to the 2010 Council.

Resolution 14(07) Procedures for Addressing Charges of Ethical Violations and Other Misconduct adopted.

June 2007, reviewed the proposed changes to the "Procedures for Addressing Ethics and Other Disciplinary Charges" and requested additional changes to be reviewed and approved by the Board. Approved submitting a College Manual resolution to the 2007 Council.

Resolution 35(04) Procedures for Addressing Ethics and Other Disciplinary Charges adopted.

Amended Resolution 1(01) Procedures for Addressing Ethics and Other Disciplinary Charges adopted.

Resolution 5(99) College Manual adopted.

August 1998 Procedures for Addressing Ethics Charges adopted.

Background Information Prepared by: Leslie Moore, JD
General Counsel and Chief Legal Officer

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Bylaws Amendment

RESOLUTION: 11(19)

SUBMITTED BY: Nicolas Peschanski, PhD, MD
Rahul Sethi, MD

SUBJECT: International Member Eligibility for FACEP

PURPOSE: Amends the Bylaws to clarify the requirements for international members to become an ACEP fellow.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

WHEREAS, Many international members are interested in becoming an ACEP fellow; and

WHEREAS, The criteria for international members to be eligible for FACEP are not clear; and

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility, be revised to read:

Fellows of the College shall meet the following criteria:

1. Be regular or international members for three continuous years immediately prior to election.
2. ~~Be certified in emergency medicine a~~At the time of election**, meet all the requirements for certification in emergency medicine** by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics. **Requirements for board certification, depending on the member's country of training, may include: holding Educational Commission for Foreign Medical Graduates (ECFMG) certification, passing all three United Stated Medical Licensing Examinations (USMLE), holding an active medical license that meets the certifying board's policy, and completion of a residency in emergency medicine in a country approved by the certifying board.**
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
   A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
   B. Satisfaction of at least three of the following individual criteria during their professional career:
      1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
      2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
      3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
      4. active involvement in emergency medicine administration or departmental affairs;
      5. active involvement in an emergency medical services system;
      6. research in emergency medicine;
      7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
      8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
      9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;

10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

Provision of documentation of the satisfaction of the above criteria is the responsibility of the candidate, and determination of the satisfaction of these criteria shall be by the Board of Directors of ACEP or its designee.

Background

This resolution amends the Bylaws to clarify the requirements for international members to become an ACEP fellow.

Many international members are confused about the requirements for FACEP, and particularly that they must be board-certified in emergency medicine by a certifying board recognized by ABEM. It is also unclear that international members who completed training outside of the U.S. must have ECFMG certification, having passed all three USMLE, hold an active medical license that meets the certifying board's policy, and completion of a residency in emergency medicine in a country approved by the certifying board.

ABEM was contacted to ensure understanding of the certification requirements for foreign medical graduates and Canadians who can apply through ABEM without holding ECFMG certification or completing the USMLE. ABEM responded:

> "ABEM recognizes ACGME-accredited, Royal College of Physicians and Surgeons of Canada-accredited, and Australasian College of Emergency Medicine-approved emergency medicine training. ABEM does not accept College of Family Physicians of Canada training and whether a provider takes the "step exam" is irrelevant. A provider must have a medical license that meets ABEM policy to become ABEM certified."

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective B – Increase total membership and retain graduating residents.
Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.

Fiscal Impact

Budgeted staff resources to update the Bylaws.

Prior Council Action

The Council has discussed and adopted many resolutions regarding fellowship. The following resolutions are relevant to fellowship for international members.

Resolution 8(10) International Honorary Fellow not adopted. The resolution called for creating a new category of fellowship for international members who are either current or former International Federation of Emergency Medicine board representatives.

Resolution 10(09) International Fellow not adopted. The resolution called for creating a new criterion for fellowship for international members.

Prior Board Action

None specific to fellowship requirements for international members.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 12(19)

SUBMITTED BY: Emergency Medicine Resident's Association
American Association of Women Emergency Physicians Section
Diversity, Inclusion, & Health Equity Section

SUBJECT: ACEP Composition Annual Report

PURPOSE: Provide the Council with an annual report, by chapter, on the demographics of councillors, alternate councillors, committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, life stage, and employment environment.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, ACEP has committed to working on strategies to increase diversity within its Council and its leadership[1]; and

WHEREAS, Studies have shown that increased diversity directly correlates to organizational performance[1]; and

WHEREAS, A resolution was adopted in 2018 encouraging ACEP chapters to select, appoint, or elect councillors that represent the diversity of their membership[2]; and

WHEREAS, The ACEP Council created a task force to study the size but not the composition of the Council[3]; and

WHEREAS, The purpose of Council is to represent the members of our organization and a regular report on various diversity metrics is a method used by other organizations in determining how well their deliberative bodies meet this representative goal[4]; and

WHEREAS, An annual report of the composition of ACEP's membership and leadership will provide members with transparency regarding Council representation of ACEP members and how they self-identify; and

WHEREAS, Currently ACEP does not regularly produce an official document that tracks the demographics of organizational leadership or councillors relative to its membership; therefore be it

RESOLVED, That ACEP provide the Council with an annual report on the demographics of its councillors and alternate councillors on a chapter-by-chapter basis, as well as the demographics of ACEP's committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, life stage, and employment environment.

References

[1] Parker RB, Stack SJ, Schneider SM, et al. Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians' Future Success. Annals of Emergency Medicine. June 2017. Volume 69, Issue 6, Pages 714–717.
[2] 2018 ACEP Council Resolution 14: Diversity of ACEP Councillors. Diversity of ACEP Councillors.
[3] 2018 ACEP Council Resolution 13: Growth of the ACEP Council.
[4] AMA Policy G-600.035 and G-635.125
AMA Policy G-600.035, "House of Delegates Demographic Report" which states: A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

Full Text: "1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year.
3. Future reports on the demographic characteristics of the House of Delegates will identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations."

AMA Policy G-635.125, "AMA Membership Demographics," which states: Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
Full Text: "1. Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. Our AMA will immediately release to each state medical and specialty society, on request, the names, category and demographics of all AMA members of that state and specialty.
3. Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand demographics collected about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner."

Background

This resolution call for ACEP to provide the Council with an annual report, by chapter, on the demographics of councillors, alternate councillors, committee and section leaders, Board of Directors, and general membership stratified by age, gender, race/ethnicity, education, board certification, life stage, and employment environment.

EMRA was asked to clarify the type of information requested for life stage and education. For education, they are seeking to capture whether someone is US/Canadian MD, DO, or International Medical Graduate. For life stage, they desire to capture: Student, Resident, Young Physician (Under Age 40 or First 10 Years of Practice), Mature (Age 40-64), Senior (Age 65+). "Age" would track: under 40, 40-49, 50-59, 60-69, 70 or more. Although "age" and "life stage" overlap, "life-stage" focuses on residency and then proximity to residency and retirement age, while "age" is a simple decade stratification.

The AMA's Council on Long Range Planning and Development recently developed a report that was used as the basis for the type of information this resolution requests. https://www.ama-assn.org/system/files/2019-08/a19-clrpd-report-1.pdf

ACEP is committed to increasing the diversity of members in leadership positions in the Council, the national Board of Directors, committees, sections, and chapters. It is important for residents, young physicians, and others who represent a minority of members of the College, to become active in their chapters and sections and to seek appointment or election as a councillor or alternate councillor, and to apply and be selected to serve on national ACEP committees. Increasing diversity in leadership at the chapter and section levels will automatically increase the diversity in leadership within the Council.

ACEP's membership database has the ability to capture the diversity components that are requested in the resolution. The data is limited to the extent that members provide this information in their membership profile. Many members choose not to answer the profile questions on race/ethnicity, career status, emergency medicine career information (the hospital where they practice), and group information (name of group).

Amended Resolution 14(18) Diversity of ACEP Councillors directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members. A notice was sent to chapters in March 2019 reminding them of this resolution.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership directed the ACEP Board of Directors to work in a coordinated effort with the component bodies of the Council to develop strategies to increase diversity within the Council and its leadership and report back to the Council on effective means of implementation. The

Diversity & Inclusion Task Force and the Leadership Diversity Task Force were appointed in response to the resolution. The Diversity & Inclusion Task Force conducted a survey of the membership to better understand the diversity within ACEP's membership and the degree to which members' backgrounds influence their interactions with ACEP and their practice of emergency medicine.

In May 2018, the Board of Directors approved the Leadership Diversity Task Force's recommendations:

1. Collection of demographic data, including the proportion of underrepresented populations within ACEP's overall membership and leadership (including the Board of Directors, Council, sections, and committees) and including, but not limited to, domains such as gender, race, ethnicity, sexual orientation, and age.
2. Reviewing diversity data every three years and presenting the findings to the ACEP Council to determine whether efforts have been effective in promoting increased diversity within ACEP leadership and to inform future initiatives to increase diversity.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective B – Increase total membership and retain graduating residents.

Fiscal Impact

Budgeted staff resources – approximately 16 hours of IT time develop and run reports.

Prior Council Action

Amended Resolution 14(18) Diversity of ACEP Councillors adopted. Directed ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including, but not limited to residents, fellows, and young physician members.

Resolution 11(17) Diversity of ACEP Councillors – Bylaws Amendment not adopted. The resolution sought to amend the Bylaws to encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of membership, including candidate physician and young physician members.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to work with component bodies of the Council to develop strategies to increase diversity within the Council and its leadership.

Prior Board Action

January 2019, accepted the final report of the Leadership Diversity Task Force.

Amended Resolution 14(18) Diversity of ACEP Councillors adopted.

September 2018, accepted the final report of the Diversity & Inclusion Task Force.
May 2018, approved the Leadership Diversity Task Force recommendations to collect demographic data. including the proportion of underrepresented populations within ACEP's overall membership and leadership and review the diversity data every three years and presenting the findings to the ACEP Council.

April 2017, approved the Diversity & Inclusion Task Force's recommendation to distribute a survey to the membership on diversity and inclusion to be administered by the American Association of Medical Colleges to the membership.

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted.

Background Information Prepared by: Sonja Montgomery, CAE
Governance Operations Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 13(19)

SUBMITTED BY: Utah Chapter

SUBJECT: Eliminating Use of the Word "Provider" in All ACEP Communications

PURPOSE: Eliminate the use of the word "provider' when referring to physicians and non-physicians and refer to them instead by their educational degree and titles.

FISCAL IMPACT: None

WHEREAS, The word/term "provider" has become commonplace in referring to medical professionals; and

WHEREAS, This term is generic, and provides no descriptor for patients or staff, giving them no clues as to the level of expertise or training attained by a given medical professional; and

WHEREAS, This generic term is ubiquitous and often refers to routine services such as internet provider, insurance provider, food service provider, sanitation provider, etc.; and

WHEREAS, No other professions such as attorneys, engineers, architects, dentists, or accountants, et al., refer to people with differing levels of training or expertise by a single non-specific generic term; and

WHEREAS, This generic term denigrates and devalues all medical professions and the people who have attained professional status in medicine; and

WHEREAS, It is not difficult to refer to medical professionals by the titles they have earned; and

WHEREAS, Referring to medical professionals by the generic term "provider" also devalues their role in patient care; therefore be it

RESOLVED, That ACEP, in its official publications, discussions, announcements, communications, and documents, etc., will work to eliminate the use of the word "provider" when referring to physician and non-physician healthcare practitioners, instead referring to them more accurately by the educational degree(s) and titles that they obtained.

Background

This resolution calls for ACEP to eliminate the use of the word "provider' when referring to physicians and non-physicians and refer to them instead by their educational degree and titles.

The word "provider" derives from the Latin *providere*, which means look ahead, prepare, supply. The word "physician" derives from *physic*, the Latin word for natural science and art of healing, The word "doctor" is derived from the Latin *doctus*, meaning to teach or instruct. The term doctor is used in many languages for a physician or medical doctor.

Federal statute 825.125 defines a health care provider as

(1) A doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or

(2) Any other person determined by the Secretary to be capable of providing health care services.

(b) Others capable of providing health care services include only:

(1) Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in the State and performing within the scope of their practice as defined under State law;

(2) Nurse practitioners, nurse-midwives, clinical social workers and physician assistants who are authorized to practice under State law and who are performing within the scope of their practice as defined under State law;

(3) Christian Science Practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts. Where an employee or family member is receiving treatment from a Christian Science practitioner, an employee may not object to any requirement from an employer that the employee or family member submit to examination (though not treatment) to obtain a second or third certification from a health care provider other than a Christian Science practitioner except as otherwise provided under applicable State or local law or collective bargaining agreement;

(4) Any health care provider from whom an employer or the employer's group health plan's benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits; and

(5) A health care provider listed above who practices in a country other than the United States, who is authorized to practice in accordance with the law of that country, and who is performing within the scope of his or her practice as defined under such law.

(c) The phrase authorized to practice in the State as used in this section means that the provider must be authorized to diagnose and treat physical or mental health conditions.

Under federal regulations, a "health care provider" is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the state and performing within the scope of their practice as defined by state law, or a Christian Science practitioner. Employers may use the term to identify a health care provider from whom their group health plan will accept medical certification for an insurance claim. The term has become common vernacular, appearing in pre-programed text on electronic medical records and insurance forms, and has become part of the language used inside and outside of hospitals. Interestingly in the UK, the term refers to a system or institution, rather than an individual person.

Many have decried the growing use of the word "provider" to include physicians. Hartzband and Groopman in *The New England Journal of Medicine*, wrote: "… care is fundamentally a prepackaged commodity on a shelf that is "provided" to the "consumer," rather than something personalized and dynamic, crafted by skilled professionals and tailored to the individual patient." Suneel Dhand wrote that "Calling us providers is a small but significant step in the commoditization of health care in general." He continues, "The word provider has done, and is doing, a tremendous amount of damage to our profession." He suggests we use the term "doctor" or "physician" for a physician, and the term "clinician" for all other non-physician providers. In a recent article in the *Journal of the American Medical Association (JAMA)*, Allan Goroll, MD wrote that "Assigning the 'provider' designation to primary care health professionals also risks deprofessionalizing them."

The nurse practitioners (NPs) and physician assistants (PAs) have also raised concerns with the term "provider." Once referred to as "mid-level providers," the preference is now to be called NPs or PAs.

The AMA has a policy regarding the use of the term provider in contracts, advertising, and communication that suggests that the writer specify the type of provider being referred to using a recognizable title that details their education, training, licensing and qualifications. The AMA policy goes on to state that provider as a term is inadequate to describe physicians. It has an editorial policy now in place that prohibits the term "provider" in lieu of "physician" in all AMA publications.

In 2014, as a result of a Council resolution, ACEP adopted the policy statement "Use of the Title 'Doctor' in the Clinical Setting," which states that "anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a 'doctor', and who is not a 'physician' {defined as an individual who has received a Doctor of Medicine or a Doctor of Osteopathic Medicine or equivalent degree} "must specifically and simultaneously declare themselves a 'non-physician' and define the nature of their doctorate degree."

ACEP has convened a multi-organizational task force examining the scope of practice and supervision requirements for PAs and NPs. That report will be presented to the ACEP Board of Directors on October 24, 2019 and may contain language regarding the titles used by non-physicians in the ED. ACEP does not have specific policy regarding the use of the term "provider."

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective A – Improve the practice environment and member well-being.

Fiscal Impact

None

Prior Council Action

Substitute Resolution 30(13) Use of the Title "Doctor" in the Clinical Setting adopted. Directed that ACEP affirm that a physician is an individual who has received a Doctor of Medicine or Doctor of Osteopathic Medicine degree or an equivalent degree; and that ACEP require anyone in a hospital environment who has direct contact with a patient who presents themselves as a "doctor" and is not a "physician" must declare themselves a non-physician and define the nature of their doctorate degree.

Prior Board Action

The Board has removed the term provider in lieu of physician in several policies and information papers in the past several years.

April 2014, approved the policy statement "Use of the Title 'Doctor' in the Clinical Setting."

Substitute Resolution 30(13) Use of the Title "Doctor" in the Clinical Setting adopted.

Background Information Prepared by: Sandra Schneider, MD, FACEP
Associate Executive Director, Clinical Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 14(19)

SUBMITTED BY: Elizabeth Dubey, MD, FACEP
American Association of Women Emergency Physicians Section
Diversity, Inclusion, & Health Equity Section
Quality Improvement & Patient Safety Section
Wisconsin Chapter

SUBJECT: Implicit Bias Awareness and Training

PURPOSE: Develop and publicize a policy statement that promotes implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles; and continue to create and advertise free, CME- eligible, online training related to implicit bias.

FISCAL IMPACT: Budgeted committee or section and staff resources to develop a policy statement. Minimum of $12,000 to accredit an enduring course. Actual costs depend on the scope of the course(s) and whether honorarium is provided to the content developer(s).

WHEREAS, Implicit bias is a ubiquitous and physiologic process by which unconscious assumptions and associations are attributed to individuals and groups based on characteristics such as gender, age, race, religious preference, and sexual orientation, resulting in oftentimes negative judgments, perceptions, and subsequent treatment towards these individuals and groups; and

WHEREAS, Implicit biases routinely influences management of both medical staff and patients and has been shown to result in poor outcomes; and

WHEREAS, ACEP's Diversity and Inclusion Survey of 2017 revealed that 23% of ACEP members feel that their career advancement was hindered or delayed based on gender, race, age, sexual orientation, or religious preference - 61% of whom cited gender as the issue[15]; and

WHEREAS, Implicit bias exists in medicine at all levels and affects hiring, pay and promotion[1-3];and

WHEREAS, Studies suggest that when hiring, both men and women show a stronger preference for male candidates, and that there is preference for male over female leaders[4]; and

WHEREAS, A 2016 study showed female physicians make $18,677 less than their male counterparts even after adjusting for hours worked, their productivity and years of experience[5]; and

WHEREAS, Minority physicians suffer from an even more evident pay gap, with one study showing that across specialties, black male physicians earn $64,812 less than while male physicians, and white and black female physicians earn $89,808 and $100,258 less than white males physicians, respectively[6]; and

WHEREAS, Women are less likely to get a raise than men when they ask for one[7]; and

WHEREAS, When women leaders engage in agentic traits, or historically "masculine" leadership traits, they receive lower evaluations among men and women leaders[8]; and

WHEREAS, While for 25 years, there have been near-equal percent of men and women in medical schools, women continue to lag behind in advancement and women currently make up only 38% of medical school faculty,

21% of full professors, and 16% of deans[9]; and

WHEREAS, Only 4% of full-time physician faculty are black or African American, when the general population is 8.9% black or African American[10]; and

WHEREAS, Studies have shown that gender and racial bias negatively influences clinical decision-making and outcomes as related to managing cardiovascular disease, pain management, and diagnosing mental illness[16, 17]; and

WHEREAS, Evidence indicates that the negative impact of implicit bias can be ameliorated by education to increase awareness and provide bias reduction strategies[11-13]; and

WHEREAS, The ACEP Diversity & Inclusion Task Force developed a three-part comprehensive CME-eligible online course on implicit bias entitled "Unconscious Bias in Clinical Practice: Protect Yourself and Your Patients"[14]; and

WHEREAS, The ACEP Board of Directors and staff underwent formal implicit bias training in June 2017; therefore be it

RESOLVED, That ACEP develop and publicize a policy statement that encourages implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles; and be it further

RESOLVED, That ACEP continue to create and advertise free, CME-eligible, online training related to implicit bias.

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15. ACEP/AAMC Diversity and Inclusion Survey. Web-based. July to September 2017.
16. Kim et al. Sex-based Disparities in Incidence, Treatment, and Outcomes of Cardiac Arrest in the United States, 2003-2012. Journal of American Heart Association. 2016 June 22;5(6).
17. Hoffman et al. Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences Between Blacks and White. Proceedings of Natl Academy of Sciences. 2016 Apr 19; 113(16): 4296-4301.

Background

This resolution calls for the College to develop and publicize a policy statement that promotes implicit bias training for medical residents and physician leaders in education, organized medicine, administrative, and managerial roles and encourages ACEP to continue to create and advertise free, CME-eligible, training related to implicit bias.

In March 2018, ACEP launched an Unconscious Bias in Clinical Practice 1- hour, accredited CME course, which was developed by the Diversity & Inclusion Task Force. The course focused on the following objectives:

- Defining unconscious/implicit bias and its manifestations, based on metacognition and brain function.
- Discuss the link between social determinants of health, cultural competence, bias, and patient care.
- Review evidence on effects of implicit bias on clinical practice and disparities in patient care and outcomes.
- Identify strategies to protect against and minimize the impact of implicit bias on patient care

ACEP's policy statement "Workforce Diversity in Health Care Settings" supports that hospitals and emergency physicians should staff emergency departments with a diverse workforce. ACEP's goal is to attain a diverse, well-qualified physician workforce that truly reflects our multicultural society. Implicit bias serves as an influencer of management and medical staff and be a hindrance of the career advancement of physicians based on characteristics, such as gender, race, age, sexual orientation or religious preference.

ACEP's policy statement "Cultural Awareness and Emergency Care" supports that cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP's position that resources be made available to emergency departments and emergency physicians to ensure they properly respond to the needs of all patients regardless of background. This is important to the subject of implicit bias, as cultural awareness helps combat negative assumptions and associations. Implicit Bias is recognized by the individual and mitigated through education recalling stereotypical thought processes.

ACEP's policy statement "Non-Discrimination and Harassment" advocates tolerance and respect for all and opposes all forms of discrimination and harassment.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine

Fiscal Impact

Budgeted committee or section and staff resources to develop and publicize a policy statement. Minimum of $12,000 to accredit an enduring course. Actual costs depend on the scope of the course(s) and whether honorarium is provided to the content developer(s).

Prior Council Action

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. The resolution directed that ACEP oppose all forms of discrimination against patients and oppose employment discrimination in emergency medicine.

Prior Board Action

June 2018, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved with the current title April 2012; originally approved October 2005 with the title "Non-Discrimination."

November 2017, approved the revised policy statement "Workforce Diversity in Health Care Settings;" reaffirmed June 2013 and October 2007; originally approved October 2001.

April 2014, reaffirmed the policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2008 with the current title; originally approved October 2001 titled "Cultural Competence and Emergency Care.")

Substitute resolution 41(05) Sexual Orientation Non-Discrimination adopted.

Background Information Prepared by: Riane Gay, MPA
Senior Manager, Grants & Development

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 15(19)

SUBMITTED BY: American Association of Women Emergency Physicians Section

SUBJECT: Increased Transparency in NEMPAC Contributions

PURPOSE: Support increased NEMPAC transparency by making available online to ACEP members the voting and sponsorship record of key ACEP legislation for NEMPAC sponsored candidates

FISCAL IMPACT: Budgeted staff resources to update relevant information on the NEMPAC website. Unbudgeted and unknown vendor costs.

WHEREAS, The National Emergency Medicine Political Action Committee (NEMPAC) is a voice for emergency medicine physicians in the federal political arena; and

WHEREAS, NEMPAC is a voluntary, nonprofit, unincorporated association operating as a separate segregated fund of ACEP; and

WHEREAS, NEMPAC accepts voluntary personal contributions from ACEP members and makes contributions to candidates for federal office; and

WHEREAS, Over 5,000 emergency medicine physicians make personal contributions annually; and

WHEREAS, NEMPAC currently ranks fourth among all physician specialty groups in funds raised and contributions made to candidates, and has brought in over $2 million each cycle since 2010; and

WHEREAS, In past election cycles, NEMPAC has given larger amounts of campaign contributions to candidates that have had voting records at odds with ACEP policy/supported legislation of grave public health impact[1-3]; and

WHEREAS, To determine campaign contributions, NEMPAC examines candidates' and incumbents' support of key ACEP legislative priorities by way of support and co-sponsorship of key ACEP legislation and other factors include: committee assignment, leadership position, competitiveness, working relationship with ACEP staff, and members and input from the state chapters; and

WHEREAS, NEMPAC releases an election report every cycle listing candidates supported; and

WHEREAS, NEMPAC does not release the internally tracked legislation record used to determine campaign contributions for these candidates; therefore be it

RESOLVED, ACEP support the practice of increased NEMPAC transparency through making available online to ACEP members the voting/sponsorship record of key ACEP legislation for NEMPAC sponsored candidates.

References

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2. https://www.acep.org/patient-care/policy-statements/firearm-safety-and-injury-prevention/
3. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2725483

Background

This resolution asks the College to support increased NEMPAC transparency by making available online to ACEP members the voting/sponsorship record of key ACEP legislation for federal candidates supported by NEMPAC.

The ACEP Board of Directors initially approved the National Emergency Medicine Political Action Committee (NEMPAC) Articles of Association on November 5, 1987. The amended Articles of Association were approved by the ACEP Board of Directors in April 2008 (Attachment A).

The NEMPAC Articles of Association Article IV – Purposes and Powers, Section 1 states: "The purpose of NEMPAC is to provide the opportunity for individuals interested in the future of emergency medicine to contribute to the support of worthy candidates for federal offices who believe, and have demonstrated their beliefs, in the principles to which emergency medicine is dedicated. To further these purposes, NEMPAC is empowered to solicit, directly or indirectly, and accept voluntary personal contributions, and to make expenditures in connection with the attempt to influence the selection, nomination, or election of any individual to any elective federal office."

Article VIII – Trustees, Section 1 establishes the governing body of NEMPAC. "Subject to the ultimate authority of the National ACEP Board of Directors, the governing body of NEMPAC shall be a Board of Trustees, composed of an Immediate Past President and twelve (12) additional individuals who shall serve staggered terms of three (3) years each."

Article VIII – Trustees, Section 2 states: "Subject to review and approval of the National ACEP Board of Directors, the Board of Trustees shall set basic policies with respect to the collection and disbursement of NEMPAC funds, including but not limited to protecting the property and affairs, and carrying out the purposes of the NEMPAC. In particular, the Board of Trustees shall determine, with assistance and advice of the Treasurer, the procedures for solicitation and collection of contributions and subsequent distribution of funds to candidates in accordance with the Act(s) and Regulations(s) of the Federal Election Commission, and other applicable laws and regulations."

Since its inception, NEMPAC has served a vital role in advancing ACEP's legislative agenda and in broadening ACEP's visibility with Congress. In the 2018 election cycle, NEMPAC contributed nearly $2.2 million to candidates, party committees, leadership PACs, and independent expenditure campaigns. At the beginning of each two-year election cycle, the NEMPAC Board of Trustees develops a NEMPAC Contribution Guidelines/Strategic Plan and Budget. The 2020 Cycle Plan and Budget was approved by the NEMPAC Board of Trustees on May 5, 2019 (Attachment B).

Federal candidates are evaluated using multiple criteria, including but not limited to, votes and co-sponsorship of ACEP priority legislation. The 2020 criteria follow the past NEMPAC practice of focusing on a candidate's support and co-sponsorship of ACEP's key legislative and regulatory initiatives, committee assignments, leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions. Incumbents and new candidates seeking NEMPAC support that meet criteria in several categories are eligible for more support. Additionally, a list of NEMPAC Champions was identified by the NEMPAC Board and staff. The Champions receive maximum financial support and additional resources that NEMPAC is able to provide.

Although a candidate may be budgeted a certain contribution amount, the candidate will not necessarily receive the full amount for which he or she is budgeted. A significant change in the legislative/political climate may dictate that we reach as many candidates as possible (rather than a targeted focus on candidates on a committee). Ongoing assessments by the NEMPAC Board of Trustees determine which overall approach is most compatible with ACEP's legislative and regulatory agenda.

An internal spreadsheet is maintained by NEMPAC staff and tracks criteria for every seated member of Congress and includes recommended budget amounts for each member. This document is reviewed and modified throughout the election cycle to reflect movement on legislation considered by Congress, campaign activity, election ratings, and ACEP staff and member interactions with legislators. The internal document includes voting/sponsorship records of

key ACEP legislation for that Congress and votes and sponsorships of key legislation in prior Congressional sessions if applicable. The decision to track specific votes and co-sponsorships is based on the legislative priorities established by the ACEP Federal Government Affairs (FGA) Committee at the beginning of each Congress. Although ACEP may track multiple issues and bills in any given congressional session, only those that are determined by the ACEP FGA Committee and ACEP Board of Directors to be key issues for emergency medicine that are moving through the congressional process either by accumulating co-sponsors, consideration by congressional committees, or inclusion in House or Senate floor votes, for example, are tracked.

The NEMPAC website contains detailed information on guidelines established by the NEMPAC Board of Trustees to determine candidate support and lists of candidates supported in current and past election cycles. NEMPAC also produces an Election Report at the end of each cycle that contains this information and is either mailed or sent electronically to all regular ACEP members.

The votes and co-sponsorships records of all members of Congress are available to the public on https://www.congress.gov/ and disbursement information from federally registered PACs to federal candidates is available to the public on www.Fec.gov. Currently, NEMPAC staff are evaluating several outside vendors that offer tools such as PAC and legislative scorecards that would have the ability to track activities by legislators such as votes or co-sponsorships relating to emergency medicine issues and advocacy activities with ACEP members and staff. The information could be made available on the member-protected NEMPAC website. There is currently no funding in the FY20 NEMPAC administrative budget for new vendor contracts for this purpose.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.

Goal 2 Enhance Membership Value and Member Engagement
Objective B – Increase total membership and retain graduating residents.

Fiscal Impact

Budgeted staff resources to update relevant information on the NEMPAC website. Unbudgeted and unknown costs in contracting with an outside vendor to purchase software to produce legislative scorecards and the framework for updating information on existing ACEP and NEMPAC websites. There are no funds budgeted in the FY20 NEMPAC administrative budget for hiring or contracting with new vendors for this purpose or for additional staff time.

Prior Council Action

None

Prior Board Action

April 2008, approved the amended NEMPAC Articles of Association.

November 1987, approved the NEMPAC Articles of Association.

Background Information Prepared by: Jeanne Slade
Director, NEMPAC and Grassroots Advocacy

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ARTICLES OF ASSOCIATION
OF THE
NATIONAL EMERGENCY MEDICINE POLITICAL ACTION COMMITTEE
OF THE
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

As initially approved by vote of the ACEP Board of Directors on November 5, 1987.
As amended by vote of the ACEP Board of Directors on April 4, 2008.

ARTICLE I – NAME

The name of this association shall be the National Emergency Medicine Political Action Committee of the American College of Emergency Physicians, also known and hereinafter referred to as "NEMPAC."

ARTICLE II – ORGANIZATION

NEMPAC shall be a voluntary, nonprofit, unincorporated association operating as a separate, segregated fund of the American College of Emergency Physicians, a national professional society incorporated in the state of Texas ("National ACEP"). NEMPAC's sole connected organization shall be National ACEP. Neither NEMPAC nor National ACEP has other affiliated committees.

National ACEP shall, within guidelines set forth by the National ACEP Board of Directors, pay all organizational and administrative costs of NEMPAC.

NEMPAC shall be a non-partisan "political committee" and qualify as a "multicandidate committee" under applicable Federal election law, the Federal Election Campaign Act as amended from time to time (the "Act") and implementing regulations ("Regulations") promulgated by the Federal Election Commission (the "Commission"). The NEMPAC is a political organization under federal tax exemption law.

ARTICLE III – PRINCIPAL OFFICE AND ADDRESS

The principal office of NEMPAC shall be located in the headquarters of the National ACEP or in any other location designated by National ACEP.

ARTICLE IV – PURPOSES AND POWERS

Section 1. The purpose of NEMPAC is to provide the opportunity for individuals interested in the future of emergency medicine to contribute to the support of worthy candidates for federal offices who believe, and have demonstrated their beliefs, in the principles to which emergency medicine is dedicated. To further these purposes, NEMPAC is empowered to solicit, directly or indirectly, and accept voluntary personal contributions, and to make expenditures in connection with the attempt to influence the selection, nomination, or election of any individual to any elective federal office.

Section 2. NEMPAC and its officers and subcommittees shall possess all powers and privileges necessary to the conduct, promotion, or attainment of the purposes set forth in this Article.

ARTICLE V – PARTICIPATION

All U.S. citizens are eligible to contribute to NEMPAC and NEMPAC is authorized to solicit contributions from the executive and administrative personnel and members (and their families) of National ACEP and its affiliated organizations. NEMPAC may only solicit contributions from its individuals within its "restricted class," as that term is defined by federal law. It may also accept contributions from all U.S. citizens and any other persons who legally may contribute as long as it does not solicit such contributions or inform individuals that such contributions are acceptable.

ARTICLE VI – CONTRIBUTIONS

All contributions to NEMPAC shall be voluntary, and no contribution shall be solicited or secured by physical force, job discrimination, or financial reprisal, or threat thereof, or as to a condition of employment by or of membership in National ACEP. The Executive Committee shall control the disbursement of funds to implement the

policies established by the Board of Trustees, subject to the ultimate authority of the National ACEP Board of Directors. No contribution shall be accepted, and no expenditure made by or on behalf of NEMPAC when the offices of the Treasurer and Assistant Treasurer are both vacant.

ARTICLE VII – SEPARATE SEGREGATED ACCOUNT

All legal contributions to NEMPAC, other than those from incorporated member practices, shall be maintained as a separate segregated account in one or more designated depositories, and all contributions to any candidate or political committee shall be made from that fund. Contributions from member corporate accounts received by NEMPAC shall be promptly transferred to the appropriate National ACEP general treasury account and used solely to offset NEMPAC administrative and solicitation costs. Any prohibited contributions received by National ACEP or NEMPAC shall be returned to the donor within the time limits established under federal law.

NEMPAC shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of its Board of Trustees and Executive Committee. All books and records are subject to the inspection of any member of the National ACEP Board of Directors, or his or her agent or attorney for any purpose at any reasonable time. NEMPAC books and records shall be maintained by the Treasurer. All records shall be kept, and the preparation and filing of all required reports of receipts and expenditures conducted in compliance with the Act(s) and Regulations(s) of the Federal Election Commission, and other applicable laws and regulations.

ARTICLE VIII – TRUSTEES

Section 1. Subject to the ultimate authority of the National ACEP Board of Directors, the governing body of NEMPAC shall be a Board of Trustees, composed of and Immediate Past President and twelve (12) additional individuals who shall serve staggered terms of three (3) years each. The initial twelve (12) individuals will be appointed by the ACEP President as follows:

Four (4) individuals to serve a one year term.
Four (4) individuals to serve a two year term.
Four (4) individuals to serve a three year term.

Other than the initial trustees, who will serve initial one-year or two-year terms and may serve an additional three-year term, the twelve (12) individuals appointed to the NEMPAC Board of Trustees may serve up to two (2) complete three (3)-year terms. The National ACEP President-Elect and Immediate Past President shall serve as a NEMPAC Trustee for the duration of his/her term in such National ACEP office. All Trustees must be members of National ACEP. The ACEP President shall appoint an individual to fill any vacancy in the NEMPAC Board of Trustees.

Section 2. Subject to review and approval of the National ACEP Board of Directors, the Board of Trustees shall set basic policies with respect to the collection and disbursement of NEMPAC funds, including but not limited to protecting the property and affairs, and carrying out the purposes of the NEMPAC. In particular, the Board of Trustees shall determine, with assistance and advice of the Treasurer, the procedures for solicitation and collection of contributions and subsequent distribution of funds to candidates in accordance with the Act(s) and Regulations(s) of the Federal Election Commission, and other applicable laws and regulations.

Section 3. The Chair of the Board of Trustees shall be appointed by the ACEP President from the twelve (12) Trustees who are not serving as National ACEP officers and who have one or more years remaining in his/her term as Trustee. The Chair shall be appointed for a one (1) year term and may be reappointed to subsequent terms by the National ACEP President if the Chair has one (1) or more years remaining in the Chair's term as Trustee.

ARTICLE IX – MEETINGS OF THE BOARD OF TRUSTEES

Section 1. Regular meetings of the Board of Trustees may be held without notice at such time and at such places as shall from time to time be determined by the Board of Trustees, provided that at least one regular meeting of the Board of Trustees shall be held each calendar year.

Section 2. Special meetings of the Board of Trustees may be called by the Chair or may be called by the Secretary upon the written request of a majority of the members of the Board of Trustees. Written notice of special meetings of the Board of Trustees shall be given to each Trustee at least seventy-two (72) hours before the time of the

meeting. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Trustees need be specified in the notice or waiver of such meeting.

Section 3. A majority of the Trustees shall constitute a quorum for the transaction of business and the actions of the majority of the Trustees present at a meeting at which a quorum is present shall be the actions of the Board of Trustees, unless a greater number is otherwise required by law or by these Articles for a vote on a particular matter. If a quorum shall not be present at any meeting of the Board of Trustees, the Trustees present thereat may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

Section 4. Any action required or permitted to be taken at a meeting of the Board of Trustees may be taken without a meeting if a consent in writing (including but not limited via fax or e-mail or other electronic transmission or voting method), setting forth the action taken, is signed by all members of the Board of Trustees, and such consent shall have the same force and effect as a unanimous vote of the Board of Trustees at a meeting.

Section 5. Trustees may participate in and hold a meeting by means of conference telephone or similar communication equipment by means of which all persons participating in the meeting can hear each other.

Section 6. Committees. The Board of Trustees may designate one or more committees, each consisting solely of members of the Board, with the authority to conduct the affairs of NEMPAC~~,~~ including but not limited to the Executive Committee.

ARTICLE X – EXECUTIVE COMMITTEE

Section 1. The policies established by the Board of Trustees shall be implemented by an Executive Committee composed of the Chair of the Board of Trustees, the President-Elect of National ACEP, the Immediate Past President of National ACEP, and a fourth member appointed from among the Board of Trustees by its Chair.

Section 2. The Executive Committee shall control the collection and expenditure of NEMPAC funds~~,~~ subject to the ultimate authority of the National ACEP Board of Directors.

Section 3. The Chair shall preside at meetings of the Executive Committee. In the absence of the Chair, the ACEP President-Elect shall temporarily serve as Chair.

Section 4. A majority of the members of the Executive Committee shall constitute a quorum for the transaction of business, and the actions of the majority of the members of the Executive Committee present at a meeting at which a quorum is present shall be the actions of the Executive Committee. If a quorum shall not be present at any meeting of the Executive Committee, the members present thereat may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

ARTICLE XI – ADMINISTRATIVE OFFICERS

Section 1. The administrative officers of NEMPAC shall be the Treasurer, the Assistant Treasurer, the Secretary, and the Assistant Secretary, who shall be selected by the Executive Committee. The Administrative Officers, as well as Executive Director and Associate Executive Director for Public Affairs of the National ACEP, shall serve as nonvoting ex officio members of the Board of Trustees and the Executive Committee.

Section 2. The chief financial officer of National ACEP shall serve as the Treasurer of NEMPAC. The Treasurer of NEMPAC shall be its chief financial officer, shall keep the financial and other records of NEMPAC, shall comply with all applicable laws, and shall perform such other duties as may be assigned to him/her by the Chair.

Section 3. The Assistant Treasurer shall, in the absence of the Treasurer, have all the power and perform all duties of the Treasurer. In the event of a vacancy in the office of the Treasurer, the Assistant Treasurer shall immediately become the acting Treasurer.

Section 4. The Secretary shall attend all meetings of the Board of Trustees and Executive Committee and shall record all the proceedings of such meetings in a book to be kept for that purpose and shall perform like duties for any standing or specially appointed committees of the Board of Trustees when required. The Secretary shall give, or cause to be given, notice of all meetings and shall perform such other duties as may be prescribed by the Chair, under whose supervision he/she shall be.

Section 5. The Assistant Secretary shall, in the absence of the Secretary, have all the power and perform all duties of the Secretary. In the event of a vacancy in the office of the Secretary, the Assistant Secretary shall immediately become the acting Secretary.

The Chair and all administrative officers of NEMPAC may be assisted in their duties by one or more National ACEP staff members.

ARTICLE XII – NOTICES

Section 1. Notices to Trustees shall be delivered personally, mailed to the Trustees at their last known addresses, or sent by fax or electronic mail. Notice by mail shall be deemed to be given at the time when deposited in the U.S. Mail.

Section 2. Whenever any notice is required to be given, a waiver thereof in writing signed by the person or persons entitled to such notice shall be equivalent to such notice. Any such waiver may be communicated by mail, fax, or electronic mail.

Section 3. Attendance of a Trustee at a meeting shall constitute a waiver of notice of such meeting, except where a Trustee attends a meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened.

ARTICLE XIII – ADOPTION AND AMENDMENTS

Section 1. These Amended Articles shall be adopted effective April 4, 2008.

Section 2. These Articles may be amended from time to time by a two-thirds (2/3) majority vote of the National ACEP Board members present and voting at any duly called and constituted meeting of the National ACEP Board.

ARTICLE XIV – DISSOLUTION

NEMPAC may be dissolved at any time by the two-thirds (2/3) majority vote of the National ACEP Board members present and voting at any duly called and constituted meeting of the National ACEP Board. In the event of such dissolution, all funds contained in NEMPAC's campaign depository shall be distributed for lawful purposes determined by Board of Trustees.

ARTICLE XV – DEPOSITORY

The Board of Trustees, upon advice and recommendation of the Treasurer, shall designate from time to time a depository institution in accordance with the Act(s) and Regulation(s) of the Federal Election Commission, and all other applicable laws and regulations for checking accounts and other accounts as deemed necessary or appropriate.

2020 Election Cycle Guidelines

NEMPAC Contribution Guidelines/Strategic Plan and Budget for 2020 Cycle

(as approved by the NEMPAC Board of Trustees on May 5, 2019)

Background

NEMPAC serves a vital role in advancing ACEP's legislative agenda and in broadening ACEP's visibility with Congress. As contributions to the PAC have increased, NEMPAC has become involved in more congressional races and expanded ACEP's influence. In the 2018 election cycle, NEMPAC contributed nearly $2.2 million to candidates, party committees, leadership PACs, and independent expenditure campaigns. NEMPAC's fundraising success in this cycle of $2,145,072 raised in hard and soft dollars allowed NEMPAC to be active in more races and to make larger contributions to individual candidates than in past cycles.

In the 2020 election cycle, it is recommended that we adopt the following strategies:

- Identify "Champions" of emergency medicine who would receive maximum funding for their re-election campaigns ($10,000) and for the Leadership PACs (if applicable) of $5000 per year, in addition to other benefits identified below.
- Continue to budget hard dollars for independent expenditures.
- Authorize a minimum contribution ($1000) to Senators and Representatives from the states and districts of members of the ACEP Board of Directors and the NEMPAC Board of Trustees. This strategy is designed to enhance the contacts between these two Boards and their Congressional representatives by giving the Board members the opportunity to attend local events for their Members of Congress.
- Prioritize check deliveries and attendance at fundraisers by ACEP members, in particular ACEP leaders, Chapter Leaders, and NEMPAC VIP Donors. In the 2018 election cycle, NEMPAC sent or delivered 1400+ checks. About 15 percent were delivered or associated with an ACEP member present.
- Concentrate remaining funds on candidates that meet some or all the criteria below.

This guidelines for the 2020 election cycle will expand and build upon past NEMPAC guidelines and reflect the projected level of funds available to NEMPAC. The NEMPAC budget will guide NEMPAC's contributions through the election cycle and it will be subject to modification as the election cycle progresses and races take shape.

Evaluation Categories

2020 evaluation criteria follow past NEMPAC practice of focusing on a candidate's support of ACEP's key legislative and regulatory initiatives, co-sponsorship of ACEP legislation, committee assignment, leadership position, relationship to state chapter and/or local ACEP members, and difficulty of the re-election race as the basis for evaluating possible NEMPAC contributions. As we look at incumbents and new candidates for NEMPAC support, those that meet criteria in several categories would be eligible for more support. In addition, an initial list of NEMPAC Champions will be identified by the NEMPAC Board and staff. The champions will receive maximum financial support and additional resources that NEMPAC can provide (see below).

Although a candidate may be budgeted a certain contribution amount, the candidate will not necessarily receive the full amount for which he or she is budgeted. A significant change in the legislative/political climate may dictate that we reach as many candidates as possible (rather than a targeted focus on candidates on a committee). Ongoing assessments will enable us to determine which overall approach is most compatible with ACEP's legislative and regulatory agenda.

2020 Senate Budget Spreadsheet Categories

The current Senate budget tracks the following metrics in additional to year of re-election:

- Committee Assignments and Leadership Positions
    - Finance, HELP, Appropriations Health Subcommittee
- Emergency Department Visit back home or district director meeting
- Dine-around participant at LAC meetings
- Co-sponsorship of S.527 in the 115th Congress, EMTALA Liability Reform Legislation
- Cosponsorship of S.916, POWER Act (Administration of MAT in the ED) in 115th Congress
- Co-sponsorship of S.260, IPAB Repeal in 115th Congress

- Co-sponsorship of S.2516, the ALTO Bill in the 115th Congress
- Signee of Drug Shortage Letter to FDA in the 115th Congress
- Co-sponsor of S.1531, Cassidy workgroup surprise billing legislation – 116th Congress
- Co-sponsor of S.1334, ACEP Mental Health/Psychiatric Patient Boarding Bill – 116th Congress
- Co-sponsor of S.851, Workplace Violence Bill – 116th Congress
- Co-sponsor of S.42, Background Check Expansion Act – 116th Congress
- Amounts donated in prior election cycles

*Also indicates if the Senator introduced ACEP resolution S.723 in the 115th Congress
**Indicates member of Cassidy transparency workgroup in the 116th Congress.

As we get closer to the 2020 elections, we will add indicators for competitiveness of race.

2020 House Budget Spreadsheet Categories

The current House budget tracks the following metrics:

- Committee Assignments and Leadership Positions
    - Ways and Means, Energy and Commerce, Education and Labor, Appropriations including health subcmt assignments
- Attended new member coffee, district meeting, Emergency Department Visit or fundraiser with ACEP member attendance back home
- Dine-around participant at LAC meetings
- Co-sponsorship of H.R.4365, EMS Standing Orders Bill in the 115th Congress
- Vote against ACA Repeal in the 115th Congress
- Vote for IPAB Repeal in the 115th Congress
- Cosponsorship of H.R. 5176, POWER Act (Administration of MAT in the ED) in 115th Congress
- Co-sponsorship of S.260, IPAB Repeal in 115th Congress
- Co-sponsorship of H.R.5197, the ALTO Bill in the 115th Congress
- Signee of Drug Shortage Letter to FDA in the 115th Congress
- Vote on HR.8 - Bipartisan Background Checks Act
- Co-sponsor of H.R. 3502 – Protect Patients from Surprise Medical Bills Act – 116th Congress
- Co-sponsor of H.R. 2519 – ACEP Mental Health/Psychiatric Patient Boarding Bill – 116th Congress
- Co-sponsor of H.R. 1309 – Workplace Violence Bill – 116th Congress
- Co-sponsor of H.R. 3984 – ACEP EMTALA Liability Bill – 116th Congress
- Amounts donated in prior election cycles

As we get closer to the 2020 elections, we will add indicators for competitiveness of race.

The relative weights placed on these issues will vary from year to year and will be determined by the NEMPAC Board of Trustees at the beginning of each election cycle. The Board will maintain flexibility throughout the cycle in assessing the importance of these issues and they will be considered important information when determining a candidate's level of support from NEMPAC.

"Friendly Incumbent" Guidelines

NEMPAC will continue to follow "friendly incumbent" guidelines for contributions used in past election cycles. These guidelines recommend that NEMPAC should not contribute campaign funds to a candidate running against an incumbent determined to be friendly or supportive to ACEP. In situations where physicians, members of ACEP, or other candidates strongly supported by an ACEP state chapter run against a "friendly incumbent," the NEMPAC Board may vote to modify this guideline after careful consideration of factors such as electability, support of ACEP's legislative and regulatory agenda and relationship to ACEP members in the district or state.

In an "open seat" situation, where neither candidate is an incumbent, each candidate will be evaluated to determine if the candidates' positions on important healthcare issues are consistent with ACEP policy.
Input from the state chapters, local ACEP leaders, and 911 Network members will also be considered. All open seat and challenger candidate contributions must be approved by the NEMPAC Board of Trustees or the NEMPAC

Executive Committee if time is of the essence. The open seat candidates will be asked to complete a 2020 NEMPAC Candidate Questionnaire.

NEMPAC Candidate Questionnaire

At the beginning of each election cycle, NEMPAC will develop a candidate survey that highlights ACEP core legislative and regulatory principles and requests information from the candidate about their background and campaign operation. Open seat and challenger candidates will be strongly urged to complete and return the survey for consideration of NEMPAC support. Exceptions may be permitted if time constraints are present if the NEMPAC Board of Trustees or Executive Committee are made aware of the circumstances, and they are documented, as to why the survey was not completed prior to making and/or approving a donation.

Contributing to Two Candidates Running for the Same Congressional or Senate Seat

NEMPAC will maintain the practice of supporting only one candidate in a race. In instances where the candidate supported by NEMPAC loses a primary election, the NEMPAC Board may consider supporting another candidate in the general election since the original candidate supported would be out of the race.
In rare circumstances and after careful consideration by the NEMPAC Board of Trustees, there may be flexibility in this practice so that an exception could be made for NEMPAC to donate to two different candidates running for the same office.

Contribution Strategy and Delivery Methods

Direct Contributions to Re-Election Campaigns and Leadership PACs.
As in previous election cycles, NEMPAC will direct its contributions to those candidates (primarily sitting Members of Congress) who serve on key committees and subcommittees, hold positions of leadership or who have supported ACEP's key legislative priorities through bill cosponsorship or votes in favor of ACEP-supported legislation. Candidates who have a history of working with ACEP staff and members and who have received contributions from NEMPAC in previous election cycles will also be considered for contributions.

When delivering contributions, we will give priority to participating in smaller healthcare-specific meetings and fundraisers. The smaller events allow the candidates to focus solely on healthcare issues and to hear ACEP's concerns and priorities in the current Congress.

Funds will also be set aside for "dine-around" events at future Leadership and Advocacy Conferences for targeted members.

NEMPAC will also target events and meetings back home in the state and district where ACEP members can deliver a NEMPAC check personally to their Member of Congress. NEMPAC will attempt to target contributions to Members of Congress who represent the states and congressional districts of ACEP Board of Directors members and members of the NEMPAC Board of Trustees. This strategy will enhance the contacts between these ACEP leaders and their federal legislators. The NEMPAC Board, ACEP Board and Council will be provided with regular updates of check deliveries and fundraisers attended by ACEP members.

Independent Expenditures

NEMPAC should continue to have the option to make independent expenditures in support of candidates in key races if funds are available for this allocation. Independent expenditure can be made for communications expressly advocating the election or defeat of a candidate that are not made in cooperation or consultation with or at the request or suggestion of, a candidate's campaign or representatives. These expenditures allow NEMPAC to go beyond the limits of $5,000 per primary and $5,000 per general to individual candidates' campaigns and can provide significant and much appreciated campaign support to candidates while enhancing ACEP's and NEMPAC's political influence.

Committee Assignments

NEMPAC contributions should be directed to those candidates who serve on committees with jurisdiction over healthcare issues. The committees can be designated as either a "key" committee (a committee with primary jurisdiction over healthcare issues), or a "secondary" committee (a committee with jurisdiction over some aspects of

healthcare legislation). Contribution amounts are based on which committee a Member serves, his or her leadership position on the committee, and whether the Member also serves on the healthcare subcommittee of the committee.
Key committees in the House are:

- Ways and Means
- Energy and Commerce
- Education and Labor (added in 2020 election cycle due to surprise billing issue)
- Appropriations

Secondary committees in the House are:

- Homeland Security
- Judiciary
- Rules

Key committees in the Senate are:

- Finance
- Health, Education, Labor and Pensions (HELP)
- Appropriations

Secondary Senate committees are:

- Budget
- Judiciary
- Homeland Security

Members of Congress on a key committee are eligible to receive a minimum of $2500 and/or $5000 if on the health subcommittee without Board approval. Members on Secondary Committees may receive up to $1,000 without Board approval. Additional funds to these members would require Board approval.

Relationship to ACEP

The relationship a candidate (Member of Congress) has with ACEP leadership, 911 members, staff and other ACEP members is another factor to consider when evaluating contribution requests. If a candidate has a good relationship with someone associated with ACEP, he or she is more likely to take the time to listen to ACEP's position on an issue. Although NEMPAC will direct most contributions to candidates (Members) who have shown concrete support for ACEP's priorities, a special relationship with ACEP can be an important factor in considering a contribution request.

Co-Sponsorship of ACEP Legislation

Members of Congress who do not serve on a key or secondary committee but who support ACEP's legislative agenda by co-sponsoring key legislation would be eligible for $2,500 - $5,000 during the election cycle. Also, Members of Congress who participate in press conferences, co-sign letters of support for an ACEP legislative priority, or host meetings for ACEP members, etc., would be considered for a NEMPAC contribution on a case-by-case basis in the same contribution range.

Difficulty of Race

As we move through the election cycle, the difficulty of a candidate's race or Members re-election campaign will become an important factor in determining if NEMPAC contributes to or increases the amount budgeted to a candidate. NEMPAC can have a greater impact by making contributions to candidates who face a difficult election.

National Party Committees

Prior to 2015, the maximum allowable annual donation from a PAC to a party committee was $15,000. NEMPAC consistently donated $15,000 to the NRSC, NRCC, DSCC and DCCC over the years to main parity and bi-partisanship in our giving strategy.
In 2015, three new types of political funds for national party committees went into effect.

- A **party convention fund** for the Republican National Committee and Democratic National Committee that may accept up to $45,000 per year from a multicandidate PAC.

- A **building fund** that may accept up to $45,000 per year from a multicandidate PAC. The RNC, NRSC, NRCC, DNC, DSCC and DCCC are eligible to accept these funds.
- A **recount & legal proceedings fund** that may accept up $45,000 per year from a multicandidate PAC. The above committees are also eligible for these types of funds.

In the 2018 election cycle, NEMPAC contributed:
$60,000 to the National Republican Congressional Committee (NRCC),
$45,000 to the Democratic Congressional Campaign Committee (DCCC)
$39,500 to the National Republican Senatorial Committee (NRSC)
$45,000 to the Democratic Senatorial Campaign Committee (DSCC).

Contributing to these Committees allows ACEP leadership (i.e., Board members, FGA Committee members, etc.) and staff to participate in special briefings, roundtables and out of town events throughout the year held specifically for donors to the campaign committees. These events allow for greater access to Congressional leaders and will help establish ACEP as an important player on the political scene, and the travel expenses for ACEP members and staff participating in these and other candidate-related activities can be reimbursed by NEMPAC's administrative fund or hard dollars if needed.

Going forward in the 2020 cycle, it is recommended that NEMPAC continue to make a $15,000 annual contribution to these four committees. Because the amount allowable from PACs to these committees has dramatically increased, the possibility of exceeding the status quo should be considered by the NEMPAC Board on a case-by-case basis. Higher contributions to these committees can also result in access and VIP treatment options at the two national Presidential conventions in the summer of 2020.

Leadership PACs

Leadership PACs are separate funds established by Members of Congress that have separate and distinct limits from their campaign committees. Leadership PACs can accept up to $5,000 per year from other PACs. Legislators often use their leadership PACs to support the campaigns of other federal candidates who may not have the ability to raise significant or adequate funds on their own. When considering a contribution to a Member's leadership PAC, NEMPAC will observe the same criteria as for contributions to that member's campaign committee.

NEMPAC will budget $5,000 annually to the leadership PACs of NEMPAC "Champions" and consider other requests on an ad hoc basis. Leadership PAC contributions should be looked at carefully and not be given if there is the potential to reduce the amount available for other approved candidate's re-election campaigns.

Post Election/Debt Retirement

Some Members of Congress request contributions following a general election to help retire debts from the previous campaign. Debt retirement can offer ACEP the opportunity to establish relationships with Members of Congress that NEMPAC did not contribute to in the general election, to forge relationships with newly elected Members of Congress, and to maintain strong relationships with Members of Congress who have generally been supportive of ACEP's legislative agenda.

NEMPAC will continue its policy of considering on a case-by-case basis, contributions to Members' debt retirement accounts. These contributions will be considered only to victorious candidates, will not count towards a Member's total NEMPAC eligibility for the upcoming election cycle, and will not exceed the contribution level the candidate was eligible for under NEMPAC criteria in the just completed election cycle.

NEMPAC "Champions"

It is suggested that NEMPAC develop a list of "NEMPAC Champions" not to exceed a total of 20 incumbent Senators or Representatives and candidates. These champions would be eligible to receive the following financial support and other benefits from NEMPAC if available:

- Maximum donation to primary and general election campaign ($5K to each)
- Maximum donation to leadership PAC if applicable ($5K)
- Campaign highlighted in NEMPAC newsletter during the cycle with link to campaign website
- Campaign highlighted on NEMPAC website

- NEMPAC would host or co-host a MADPAC event for the Member during the election cycle
- NEMPAC staff or ACEP member would attend one out of town event for the Member per cycle
- NEMPAC staff would serve on the Member's fundraising steering committee
- NEMPAC would "tally" part of our party committee donation to that member.
- NEMPAC would conduct a dine-around event for the member during LAC.
- NEMPAC would fund or co-fund an independent expenditure for the member.

Ethical Issues

The NEMPAC Board will consider contributions to Members of Congress under investigation for ethical violations in Congress and/or outside criminal or civil investigations on a case by case basis with no formal written policy.

NEMPAC Board and ACEP Board Involvement

To show ACEP members the strength of support for NEMPAC and its activities by the leadership of ACEP, all members of both the ACEP Board of Directors and the NEMPAC Board of Directors should make significant contributions to NEMPAC each year.

Members of both Boards will be encouraged to "Give-a-Shift" ($1,200) each year to NEMPAC and maintain this giving level throughout their tenures. They will also be encouraged to attend and contribute to NEMPAC dine-around events at LAC annually.

As previously, Members of both Boards will be encouraged to attend at least one fundraiser or other event for their Representative and Senators in the next two years to enhance contacts between these ACEP leaders and their Members of Congress. NEMPAC will contribute to the federal representatives of Board members to allow those Board members to attend the event. A minimum amount will be contributed to each Board member' Representative and Senators, even if that Representative or Senator is not a strong supporter of ACEP's legislative priorities. This minimum contribution is simply designed to foster improved contacts between Board members and their Members of Congress.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 16(19)

SUBMITTED BY: Emergency Medicine Residents' Association

SUBJECT: Opposition to the AAMC Standardized Video Interview

PURPOSE: Oppose further study or use of the Association of American Medical Colleges Standardized Video Interview (SVI) for emergency medicine applicants.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Medical students comprise 31.3% of ACEP's candidate members and 10.7% of ACEP's total membership (as of December 2018); and

WHEREAS, The number of applications per applicant to emergency medicine residency programs has doubled over the past decade[1], resulting in residency programs needing to screen applications when deciding which students to invite for in-person residency interviews; and

WHEREAS, A 2016 Association of American Medical Colleges (AAMC) survey revealed that program directors do not feel that they have adequate tools to assess an applicant's interpersonal and communication skills and professionalism[2]; and

WHEREAS, The AAMC has been piloting the Standardized Video Interview (SVI) since 2016, an 18-minute interview where applicants speak to a computer while responding to six questions for three minutes each; and

WHEREAS, the AAMC states that the SVI would benefit applicants by giving them the opportunity to feel holistically reviewed[3] yet only 31% of students agree that SVI would help program directors conduct a more holistic evaluation of applicants[4]; and

WHEREAS, Less than one-quarter of applicants agree that the SVI gave them an opportunity to describe their interpersonal and communication skills or knowledge of professional behavior and only half agree they were able to answer SVI based on past experiences[4]; and

WHEREAS, more than half of applicants were satisfied with program director use of USMLE Step 1 and Step 2 CK scores as filters in the residency selection process (55% and 64%, respectively), while only 10% were satisfied with SVI as a filter[4]; and

WHEREAS, SVI scores are currently assigned by human reviewers with the intention of being scored by machine learning algorithms in the future and 80% of students are not comfortable with SVI being scored by computer[4]; and

WHEREAS, After three years of the SVI pilot, the AAMC has not provided pricing information about the cost of the SVI if implemented or who would bear those costs; and

WHEREAS, There have been ethical concerns raised about coercing students to participate in a "mandatory" research study without their consent[5]; and

WHEREAS, The AAMC states that the goal of the SVI is to "widen the pool of applicants invited to interview in person, including those who might not have otherwise been considered for interview," yet a study

performed across nine residency programs showed that in 93% of cases, SVI scores did not change likelihood to interview[6]; and

WHEREAS, Evidence has shown that evaluation of professionalism and interpersonal communications skills by emergency medicine faculty during in-person interviews poorly correlate with SVI scores[7]; and

WHEREAS, Only 85% of residency programs initially opted to participate in the SVI pilot[8] and two-thirds of participating programs reported that SVI scores are not important in deciding whom to invite to an in-person interview, and most programs did not take missing SVI scores into consideration in making selection decisions, and only 57% of programs who used the SVI planned to use it in the future; therefore be it

RESOLVED, That ACEP oppose further study or use of the Association of American Medical Colleges Standardized Video Interview for emergency medicine applicants.

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Background

This resolution calls on ACEP to oppose further study or use of the Association of American Medical Colleges (AAMC) Standardized Video Interview (SVI) for emergency medicine applicants.

The AAMC designed the Standardized Video Interview (SVI) to assess knowledge in two ACGME competencies: interpersonal and communication skills, and knowledge of professional behaviors. According to the AAMC website, the SVI consists of six, non-clinical questions that ask an applicant to "demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals," and to "demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles." The questions are presented in an online, unidirectional (no live interviewer) interview as text prompts. Applicants have 30 seconds to read the prompt and up to three minutes to record their response. The videos are then evaluated by six reviewers, each assigned to a single question.

The AAMC website states that the "emergency medicine program community has endorsed the use of the Standardize Video Interview during the ERAS® 2020 application cycle for all applicants to emergency medicine residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). All applicants to

ACGME-accredited emergency medicine residency programs are required to complete the Standardized Video Interview as a component of the ERAS® 2020 application." The AAMC also states that the SVI is not intended to replace the in-person interview or Standardized Letters of Evaluation but is intended to "enable applicants to share objective, performance-based information about themselves" in order to demonstrate their abilities beyond traditional test scores. The AAMC's intent in launching the SVI was to provide programs with an objective data point (outside of a CV or SLOE) to assess an applicant's professionalism as well as provide information about an applicant beyond Board scores and academic metrics. Their goal was to provide more holistic data to potentially broaden the scope of those invited to interview. The AAMC decided to pilot the SVI first with emergency medicine because of its "proven record of working to improve the selection process," diversity of applicant pool, and specialty size.

The AAMC conducted its own survey of EM program directors participating in the SVI 2019 pilot. One of the key findings discovered that 42% of survey respondents considered SVI scores during the selection process, down from 54% in the 2018 pilot. Thirty percent said that they used SVI scores to "identify applicants with strong interpersonal and communication scores and professionalism," and 27% used the SVI to find "diamonds in the rough." The survey also found that of the 50 respondents who said they did not use the SVI scores at any point, the majority said that it was because they were not sure how to incorporate the scores into their current selection process and they were waiting for additional research as to the utility of the scores. An additional reason cited by programs for not utilizing SVI videos was lack of time to watch them. Of the 34 respondents using the SVI scores during the selection process, both the SVI video and SVI total score ranked least when considering an applicant for an in-person interview. However, of the 34 respondents using the scores, 41% said they were somewhat or more likely to extremely likely to consider SVI scores when finalizing rank order lists.

One study looked at applicant's USMLE and SVI scores to determine if there was correlation. The findings suggest that while there was no correlation between the scores, the SVI provides unique information to program directors that is distinct from USMLE Step 1 and 2 scores and might provide some dimensionality to the applicant. Another study's findings suggest that SVI scores did not change the likelihood of being invited to an in-person interview in 93% of cases; however it did find that there was an impact on the likelihood to invite on subgroup analysis (i.e., those with lower SVI scores were less likely to be invited). A survey of SVI interviewees found that applicants had generally negative reactions to the SVI with most dissatisfaction towards the overall SVI and total score.

Arguments against the use of SVI include: redundancy with the Step 2 Clinical Skills examination; questions about the utility of an additional interview (i.e., there are approximately 192-288 hours of observed EM performance during EM rotations where an applicant's professionalism and communication are directly observed); the potential added expense and time to the applicant; and additional time/burden on the residency program to review more materials. One study noted the potential administrative burden to the residency program. Using the example of a program that receives more than 1,500 applications a year, it estimated that 450+ hours might be spent watching the SVIs. Other arguments against use of the SVI include: discomfort with the potential for computer (rather than human) scoring; studying students as a vulnerable population; questions about the potential impact on diversity; and questions about the validity of SVI score on predicting future performance.

The AAMC has convened an Emergency Medicine Standardized Video Interview Working Group (EMSVI), composed of SAEM, CORD, CDEM, AACEM, EMRA, AAEM-RSA, AAMC-GSA, and AAMC-GDI representatives. The AAMC website states that the committee has met monthly since the fall of 2016 with the group's efforts focused on SVI policy, research agenda, utility of the SVI, interpreting findings to date, and disseminating results. The website also states that an additional group, the SVI Local Validity Study Working Group, has been established to conduct a longitudinal study on the Emergency Medicine SVI, evaluating psychometrics, application and program director reactions, fairness and preparation, and prediction of PGY-1 performance.

An AMA resolution, "Medical Student Involvement and Validation of the Standardized Video Interview Implementation," was submitted to the 2017 House of Delegates by the Medical Student Section. It called on the AMA to advocate for delaying the expansion of the SVI until the utility of scores on performance was established and for the AMA to work in collaboration with the AAMC to study the potential implications of the SVI. Since the 2017 resolution was adopted, a 2018 AMA status report indicates that the AAMC was notified of the action, a meeting was

scheduled with a program director, and the AAMC and the Council will continue to monitor the issue. An additional resolution (314 "Evaluation of Changes to Residency and Fellowship Application and Matching Processes"), adopted by the 2019 AMA House of Delegates (HOD), called on the AMA to oppose changes to the application requirements until a number of conditions have been met, such as, "data available to demonstrate that the new application requirements, reduce, or at least do not increase, the impact of implicit bias…" and that "costs to medical students and residents are mitigated."

EMRA supports the National Residency Match Program and National Matching Services process as it exists in 2013. The EMRA Policy Compendium (Section XI. The Match and Residency and Fellowship Application Process) outlines a number of criteria that must be met before EMRA will consider supporting any proposed changes to the resident and fellowship application or match process. Changes will only be considered when: changes have been evaluated by working groups which have adequate students and residents as representatives; there are published data which demonstrates that the proposed application components contribute to an accurate and novel representation of the candidate, and are shown from an applicant and program perspective to add value to the application overall; there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds; costs to medical students and residents are mitigated. EMRA also "opposes the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application and match process until such time as the above conditions are met." Based on the criteria outlined, the SVI does not meet the EMRA requirements.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective B – Increase total membership and retain graduating residents.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

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Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 17(19)

SUBMITTED BY: Sarah Hoper, MD, JD, FACEP
American Association of Women Emergency Physicians Section
Diversity, Inclusion, & Health Equity Section
Quality Improvement & Patient Safety Section
Wisconsin Chapter

SUBJECT: Pay Transparency

PURPOSE: Develop a policy statement in favor of physician salary and benefit package transparency.

FISCAL IMPACT: Budgeted committee and staff resources for development and distribution of policy statements.

WHEREAS, Men in academic emergency medicine make 18% more than women[1]; and

WHEREAS, In 2019, Doximity reports that male physicians make $1.25 for every $1 female physicians earn and this equates to $90,490 less compensation for the average female physician; and

WHEREAS, Female specialists make 23% less than their male counterparts and female primary care physicians make 15% less than their male counterparts[2]; and

WHERAS, A 2016 study showed female physicians make $18,677 less than their male counterparts even after adjusting for how hard a physician works, their productivity, and years of experience[3]; and

WHEREAS, Women are viewed as less likable when they negotiate [4]; and

WHEREAS, Women are less likely to get a raise than men when they ask for a raise[5]; and

WHEREAS, The U.S. Bureau of Labor Statistics estimates the national gender gap across industries and occupations is 19%, in other words, women are taking home .81 cents on the dollar[6]; and

WHEREAS, Minorities also suffer from the pay gap; and

WHEREAS, According the US Department of Labor in April 2019, the median weekly earnings for black men are 74.7% of the median for white men and the median earnings for hispanic men are 70.5% of the median for white men, and black women's median earnings are 85.8% of white women, and earnings for Hispanic women are 76.4% of white women[7]; and

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WHEREAS, A 2013 study has shown that workers are more productive when salary is transparent[8]; and

WHEREAS, pay transparency can make employers aware of implicit bias in payment structures, allow employees to know their fair value, and give employees a basis for negotiation; therefore be it

RESOLVED, That ACEP develop a policy statement in favor of physician salary and benefit package transparency.

Background

This resolution calls for ACEP to develop a policy statement in favor of physician salary and benefit package transparency.

Women currently are paid less than men in many fields, including emergency medicine. The pay gap in emergency medicine has remained the same for the past four years, even though wages increased in the industry as a whole. A recent report from Doximity[2] found that male physicians still earn roughly $1.25 for every $1 paid to female physicians.

Pay transparency – where employees know what each of their colleagues make – could be a tool to close the pay gap. Several companies from different fields have started to make pay information available publicly; some have even gone so far as to publish this information, while others are simply encouraging colleagues to discuss pay rates among themselves. According to a 2016 study, pay transparency can lead to higher rates of employee productivity and satisfaction. In some states, it can be illegal for colleagues to discuss salaries and compensation. Several states have passed laws banning employers from penalizing workers for discussing their salary with colleagues.

There are several factors that contribute to pay inequality. Conscious and unconscious biases can result in lower pay for women, specifically minority women. There is an assumption that women will leave the workforce to raise children, and this assumption is reflected in pay. Women are also less likely than men to negotiate their salaries, which can lead to a legacy of lower pay and poorer benefits. Research indicates that women are more likely to be penalized than men for negotiating salary and benefits, which also contributes to a legacy of lower pay.

ACEP policy statements "Non-Discrimination and Harassment" and "Workforce Diversity in Health Care Settings" do not address pay transparency specifically, but the Workforce Diversity policy statement affirms that "hospitals and emergency physicians should work together to promote staffing of hospitals and their emergency departments with qualified individuals of diverse race, ethnicity, sex (including gender, gender identity, sexual orientation, pregnancy, marital status), nationality, religion, age, ability or disability, or other characteristics that do not otherwise preclude an individual emergency physician from providing equitable, competent patient care." The policy also states that "attaining diversity with well qualified physicians in emergency medicine that reflects our multicultural society is a desirable goal." The Non-Discrimination policy statement affirms that ACEP opposes all forms of discrimination based on "race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, sexual orientation, or any other classification protected by local, state or federal law."

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments

Goal 2 Enhance Membership Value and Member Engagement

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Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine

Fiscal Impact

Budgeted committee and staff resources for development and distribution of policy statements.

Prior Council Action

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. The resolution directed that ACEP oppose all forms of discrimination against patients and oppose employment discrimination in emergency medicine.

Prior Board Action

June 2018, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved with the current title April 2012; originally approved October 2005 with the title "Non-Discrimination."

November 2017, approved the revised policy statement "Workforce Diversity in Health Care Settings;" reaffirmed June 2013 and October 2007; originally approved October 2001.

Substitute resolution 41(05) Sexual Orientation Non-Discrimination adopted.

Background Information Prepared by: Mandie Mims, MLS
Clinical Practice Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
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RESOLUTION: 18(19)

SUBMITTED BY: Emergency Medicine Residents' Association
Texas College of Emergency Physicians

SUBJECT: Promoting Emergency Medicine Physicians

PURPOSE: Create a public awareness campaign to highlight the unique skill set, knowledge base, and value of residency trained and board-certified emergency medicine physicians.

FISCAL IMPACT: Costs could range from $5,000 to $1 million depending on the scope of the campaign.

WHEREAS, The American College of Emergency Physicians (ACEP)[1], the Emergency Medicine Residents' Association (EMRA)[2], the Society of Academic Emergency Medicine (SAEM)[3], and the American Academy of Emergency Medicine (AAEM)[4] have policy highlighting board certified emergency physicians are the most appropriately trained and safest practitioners of emergency medicine; and

WHEREAS, ACEP believes that "PAs and APRNs do not replace the medical expertise and patient care provided by emergency physicians;"[1] and

WHEREAS, "ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care"[1] but are valued members of physician-led emergency care teams; and

WHEREAS, Nationally there has been an increase in the number of patients seen by PAs and NPs in the emergency department from 12.9% of all patients in 2005[5] to 28.8% of all patients in 2016,[6] and 42% of these patients seen by PAs and NPs are not currently seen by an emergency physician[6]; and

WHEREAS, The American Association of Nurse Practitioners (AANP) supports independent practice for NPs in the emergency department[7] and the American Academy of Physician Assistants (AAPA) recently adopted a resolution that to "replace obsolete supervisory agreement laws with practice-level decision-making about collaboration" and "authorize PAs to be directly reimbursed by all public and private insurers"[8]; and

WHEREAS, There is literature showing lower quality care provided by PAs and NPs in non-emergency settings related to avoidable imaging[9], antibiotic prescriptions[10,11], appropriateness of specialist referrals[12], unnecessary opiate, antipsychotic, and antidepressant medication prescriptions[13]; and

WHEREAS, Non-academic emergency departments staffed with non-physician providers have higher rates of imaging and admissions compared to emergency departments staffed solely by physicians, with projected additional costs of $425,725 per 1,000 visits;[14] and

WHEREAS, The combined number of osteopathic and allopathic residency positions in emergency medicine has increased 20.5% between 2015 and 2019[15], creating more board eligible/certified emergency physicians, decreasing the need for non-emergency physicians to practice emergency medicine;[16] and

WHEREAS, Public campaigns have been created by non-physician providers in the health care space to promote their positions to the general public[17]; and

WHEREAS, In September 2018, a resolution was adopted by the Representative Council of the Emergency

Medicine Residents' Association, asking EMRA to submit a resolution to ACEP requesting a public awareness campaign highlighting the value of residency-trained, board-certified emergency physicians; therefore, be it

RESOLVED, That ACEP create a public awareness campaign to highlight the unique skill set, knowledge base, and value of residency trained and board certified emergency medicine physicians.

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Background

This resolution calls for the College to create a public awareness campaign to highlight the unique skill set, knowledge base, and value of residency trained and board-certified emergency medicine physicians.

There has been an increase nationally in the number of patients seen by PAs and NPs in the emergency department, and many of those patients are not treated by an emergency physician. However, studies show that non-academic emergency departments staffed with non-physician providers have higher rates of imaging and admissions compared to emergency departments staffed solely by physicians. Meanwhile, there has been a significant rise in the number of

osteopathic and allopathic residency positions in emergency medicine, creating more board eligible/certified emergency physicians, and decreasing the need for non-emergency physicians to practice emergency medicine. In addition, some non-physician providers in the health care space have created public awareness campaigns to promote their positions.

A campaign of this nature would build on previous public relations campaigns that highlight the value of emergency medicine, including:

- The "2 percent campaign," which highlighted that emergency medicine represents only two percent of health costs;
- "Saving Millions," which recognized that emergency physicians save lives and limit spending in other areas; and
- Most recently, ACEP's 50th anniversary campaign, which showcased the evolving role and increasing value of emergency physicians within hospital walls and beyond.

There is a wide range in scope for a potential public education campaign. The College should consider the ultimate goal of a public education campaign, including the key decision makers. Campaigns with a discrete objective that target a limited number of audiences will be less costly and likely easier to measure its effectiveness compared to a national campaign that seeks to influence the "general public."

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.

Fiscal Impact

Costs could range from $5,000 for simple campaign collateral development to $1 million for a comprehensive paid national campaign. Costs are dependent on the type and scope of activities undertaken.

Prior Council Action

Amended Resolution 30(17) Demonstrating the Value of Emergency Medicine to Policy Makers and the Public adopted. Directed ACEP to develop a repository of public relations materials on the ACEP Website demonstrating the value of emergency medicine and develop public relations materials regarding the value of emergency medicine for legislators; and

Amended Resolution 24(13) Promulgation of Emergency Medicine adopted. Directed ACEP to continue efforts to promulgate the value and role of emergency medicine as a critical component of an effective health care delivery system to other medical and healthcare organizations, the media, and the American public.

Prior Board Action

The Board has supported multiple public relations efforts to promote the value and role of emergency physicians and emergency medicine.

October 2017, approved funding of up to $100,000 to fund a study on the value and cost effectiveness of emergency care.

Amended Resolution 30(17) Demonstrating the Value of Emergency Medicine to Policy Makers and the Public adopted.

Amended Resolution 24(13) Promulgation of Emergency Medicine adopted.

Background Information Prepared by: Maggie McGillick
Public Relations Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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RESOLUTION: 19(19)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM)

PURPOSE: 1) Support a public health approach to firearms-related violence and prevention of firearm injuries and deaths as enumerated in the 2018 American College of Physicians Position Paper. 2) Support the mission and vision of AFFIRM and partner with them to advocate for the allocation of federal and private research dollars.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, In 2015, the American College of Emergency Physicians joined with eight professional health organizations and the American Bar Association in a call to action, and put forth a list of specific measures aimed at reducing deaths and injury related to firearms[1]; and

WHEREAS, In October 2018, the American College of Physicians (ACP) published a list of position statements and recommendations to develop and support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths[2]; and

WHEREAS, The American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) is a 501(c)(3) non-profit corporation comprised of healthcare professionals and researchers working together to find lasting solutions to curb the epidemic of firearm violence across the United States[3]; and

WHEREAS, AFFIRM funding goes directly to research that will inform protocols for everyone working on the frontlines of healthcare, develop innovative solutions that connect our network to other first responders and stakeholders, and create education and information for healthcare professionals and the public; and

WHEREAS, Our organizations share a common vision to reduce the human and financial costs of firearm injury and ACEP abhors the current level of intentional and accidental firearm injuries and supports AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury and death[4]; and

WHEREAS, ACEP also supports the development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence[2]; therefore be it

RESOLVED, That ACEP support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 American College of Physicians Position Paper; and be it further

RESOLVED, That ACEP support the mission and vision of the American Foundation for Firearm Injury

[1] Weinberger SE, et al. Firearm-related injury and death in the United States: a call to action from 8 health professional organizations and the American Bar Association. *Ann Intern Med*. 2015;162:513-6.

[2] Butkus R, Doherty R, Bornstein SS, for the Health and Public Policy Committee of the American College of Physicians. Reducing Firearm Injuries and Deaths in the United States: A Position Paper From the American College of Physicians. *Ann Intern Med*. 2018. 169:704–707. doi: 10.7326/M18-1530

[3] affirmresearch.org

[4] Letter to Dr. Chris Barsotti from Dr. Paul Kivela, ACEP President. March 8, 2018.

Reduction in Medicine (AFFIRM) and will partner with AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

Background

This resolution calls for ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 American College of Physicians Position Paper; and support the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) and partner with AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

In March 2018, ACEP provided a letter of support for the mission and vision of AFFIRM. The letter outlined ACEPs support of AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence. In January 2019, the Board of Directors approved a $20,000 donation to AFFIRM.

ACEPs legislative and regulatory priorities over the years have included working with members of Congress to promote efforts that may prevent firearm-related injuries/deaths and to support public/private initiatives to fund firearm research. ACEP has worked with the AMA and other stakeholders to address firearm injury prevention and research on this issue.

The College has addressed the issue of firearms multiple times over the years through Council resolutions and policy statements. A compilation of resources for physicians impacted by active shooter mass casualty incidents is available on the ACEP website.

The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on research grants. An Early Career Research Development Grant for $150,000 was awarded to Kristen Mueller, MD from Washington University in St. Louis in June 2019 for "Firearm Injuries and Recidivism at St. Louis Level 1 Trauma Hospitals." AFFIRM contributed $37,5000 and EMF contributed $112,000 to fund this grant. A $5,000 Medical Student Research Grant was awarded in June 2019 to Henry Schwimmer, BA from Emory University School of Medicine for "Rural Emergency Department Firearm Assessment, Screening, and Treatment (FAST) Trial." AFFIRM contributed $2,500 and EMF contributed $2,500 for this award. AFFIRM, EMF and the Emergency Nurses Association Foundation (ENAF) are partnering to fund another research grant to be awarded in July 2020, with each organization contributing $25,000. ACEP members are represented as leaders in AFFRIM, have attended strategic planning meetings, and an ACEP staff member is also member of their Research Council, participating in monthly conference calls.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 45(18) Support for Extreme Risk Protection Orders to Minimize Harm adopted. Directed ACEP to support Extreme Risk Protection Orders (ERPO) legislation at the federal level; promote and assist chapters to enact ERPOs by creating a toolkit and other appropriate resources; and encourage and support further research of the effectiveness and ramifications of ERPOs and Gun Violence Restraining Orders

(GVROs).

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted. Directed ACEP to revise the policy statement, "Firearm Safety and Injury Prevention" to reflect the current state of research and legislation.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. Directed ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence, devise strategies to help emergency physicians to work with stakeholders to mitigate patient risk of self-directed or interpersonal harm, investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes, and explore similar precedents currently in use.

Resolution 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for funding for research on firearm injury prevention and to work with the AMA and other medical societies to achieve this common cause.

Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs referred to the Board of Directors. Called for a task force to develop a research network of EDs to study the impact of firearm violence and invite interested stakeholders to participate in the network.

Amended Resolution 31(12) Firearm Violence Prevention adopted. Condemned the recent massacres in Aurora, CO and WI and the daily violence throughout the U.S. and reaffirmed ACEP's commitment against gun violence including advocating for public and private funding to study the health effects of gun violence.

Amended Resolution 41(04) Assault Weapon Ban adopted. ACEP deplores the threat to public safety that is the result of widespread availability of assault weapons and high capacity ammunition devices and urges the Congress and the President to enact and sign into law a comprehensive ban on all sales of assault weapons and high capacity magazines.

Resolution 14(00) Childhood Firearm Injuries referred to the Board of Directors. Directed ACEP to support legislation that requires safety locks on all new guns sold in the USA and support legislation that holds the adult gun owner legally responsible if a child is accidentally injured with the gun.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted. Sought to collaborate with other medical specialty organizations on firearms issues.

Resolution 22(96) National Center for Injury Prevention and Control adopted. Directed ACEP to continue supporting funding for Injury Prevention and Control in the CDC in which firearms research was included.

Amended Resolution 69(95) Firearm Legislation adopted. Sought to limit access to Saturday night specials.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. Advocated for increased taxes on handguns and ammunition with proceeds going to fund the care of victims and/or programs to prevent gun violence and to fund firearm safety education.

Resolution 47(94) Firearm Classification referred to the Board of Directors. Directed ACEP to support legislation classifying firearms into three categories: 1) prohibited; 2) licensed; and 3) unlicensed.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted. Directed ACEP to support legislation requiring photo identification and specific qualifications for firearm possession.

Substitute Resolution 45(94) Firearm Possession adopted. Supported legislation (as was passed in the crime bill) to make it illegal for persons under 21 and persons convicted of violent crimes, spousal and/or child abuse or subject to a protective order to possess firearms; illegal to transfer firearms to juveniles; and support legislation making it illegal to leave a loaded handgun where it is accessible to a juvenile.

Substitute Resolution 44(94) Firearm Legislation adopted. Support comprehensive legislation to limit federal firearms licenses.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted. Supported national safety regulations for firearms.

Amended Resolution 18(93) Firearm Injury Reporting System adopted. Explore collaboration with existing governmental entities to develop a mandatory firearm injury reporting system.

Amended Resolution 17(93) Firearm Injury Prevention adopted. Consider developing and/or promoting public education materials regarding ownership of firearms and the concurrent risk of injury and death.

Amended Resolution 16(93) Possession of Handguns by Minors adopted. Support federal legislation to prohibit the possession of handguns by minors.

Amended Resolution 11(93) Violence Free Society adopted. Develop a policy statement supporting the concept of a violence free society and increase efforts to educate member about the preventable nature of violence and the important role physicians can play in violence prevention.

Resolution 15(90) Gun Control not adopted. Sought for ACEP to undertake a complete review of all medical, legal, technical, forensic, and other pertinent literature regarding firearm-related violence with emphasis on the effects of firearm availability to the incidence of such violence, and that ACEP withhold public comment on gun control until such study is completed and an informed, unemotional, and unpolarized position on weapons can be formulated.

Amended Resolution 14(89) Ban on Assault Weapons adopted. Support federal and state legislation to regulate as fully automatic weapons are regulated, the sale, possession, or transfer of semi-automatic assault weapons to private citizens and support legislation mandating jail sentences for individuals convicted of the use of a semi-automatic assault weapon in the commission of a crime.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted. Support federal and state legislation to require 15-day waiting period for the sale, purchase, or transfer of any firearm to allow time for a background check on the individual and also support legislation mandating significant penalties for possession of a firearm while committing a crime.

Substitute Resolution 16(84) Ban on Handguns adopted. Deplored the loss of life and limb secondary to the improper use of handguns; supported legislation mandating significant penalties for possession of a handgun while committing a crime; support legislation mandating significant penalties for the illegal sale of handguns; support a waiting period for all prospective handgun buyers; supported successful completion of an education program on handgun safe for all prospective handgun buyers; support development of educational programs on the proper use of handguns for existing owners; support requiring screening of prospective handgun buyers for previous criminal records and mental health problems that have led to violent behavior.

Resolution 15(83) Handgun Legislation not adopted. Urged legislative bodies to enact legislation restricting the availability of handguns to the general public and to monitor the results.

Prior Board Action

June 2019, discussed proposed revisions to the statement "Firearm Safety and Injury Prevention." The policy statement was referred back to the Public Health & Injury Prevention Committee for further revision.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

April 2019, approved the revised policy statement "Domestic Family Violence;" reaffirmed June 2013; originally approved October 2007 replacing seven rescinded policy statements.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

January 2019, approved $20,000 contribution to the American Federation for Firearm Injury Reduction in Medicine (AFFIRM).

Amended Resolution 45(18) Support for Extreme Risk Protection Orders to Minimize Harm adopted.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted.

June 2018, reviewed "Resources for Emergency Physicians" Reducing Firearm Violence and Improving Firearm Injury Prevention."

June 2014, approved the Research Committee's recommendations to convene a consensus conference of firearm researchers and other stakeholders to: 1) develop a research agenda and to consider the use of available research networks (including the proposed EM-PRN) to perform firearm research; 2) identify grant opportunities and promote them to emergency medicine researchers; 3) recommend EMF consider seeking funding for a research grant specifically supporting multi-center firearm research; and 4) advance the development of the EM-PRN so as to create a resource for representative ED-based research on this topic and others.

Substitute Resolution 21(14) Emergency Department Mental Health Exchange adopted.

Resolution 27(13) Studying Firearm Injuries adopted.

December 2013, assigned Referred Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs to the Research Committee to provide a recommendation to the Board of Directors regarding further action on the resolution.

April 2013, approved the revised policy statement, "Firearm Safety and Injury Prevention;" replacing the "Firearm Injury Prevention" policy statement that was revised and approved in October 2012 and January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

Amended Resolution 31(12) Firearm Violence Prevention adopted.

Amended Resolution 41(04) Assault Weapon Ban adopted.

November 2000, assigned Resolution 14(00) Childhood Firearm Injuries to the Public Health & Injury Prevention Committee.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted.

Resolution 22(96) National Center for Injury Prevention and Control adopted.

Amended Resolution 69(95) Firearm Legislation adopted.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Resolution 47(94) Firearm Classification referred to the Board of Directors.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted.
Substitute Resolution 45(94) Firearm Possession adopted.

Substitute Resolution 44(94) Firearm Legislation adopted.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted.

Amended Resolution 18(93) Firearm Injury Reporting System adopted.

Amended Resolution 17(93) Firearm Injury Prevention adopted.

Amended Resolution 16(93) Possession of Handguns by Minors adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Amended Resolution 14(89) Ban on Assault Weapons adopted.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted.

Substitute Resolution 16(84) Ban on Handguns adopted.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Sandra M. Schneider, MD, FACEP
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Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 20(19)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders

PURPOSE: Promote awareness of ACEP policy statements that oppose barriers to physicians seeking treatment for mental health and substance use issues and work with the AMA and state medical societies to advocate for changes by state medical boards for protections for licensure for physicians that seek help and treatment.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The physician suicide rate is 1.5 times higher for male physicians and 2.3 times higher for female physicians compared to the general population[1]; and

WHEREAS, According to a 2014 study by the Substance Abuse and Mental Health Services Administration, 43.6 million American adults suffer from some form of mental illness, 20.2 million report having a substance abuse disorder, and 7.9 million report having both a mental illness and a substance abuse disorder[2]; and

WHEREAS, Physicians have similar rates of mental illness and substance use disorders compared to the general population according to studies from the *Journal of the American Medical Association*[3]; and

WHEREAS, All but three states – California, Nebraska, and Wisconsin – have Physician Health Programs (PHPs) that refer doctors to a treatment program where they can spend up to 90 days in an inpatient facility without fear of disciplinary action from a state medical board[4,5]; and

WHEREAS, Physicians in general and emergency physicians enrolled in PHPs for substance use disorders have a high rate of success with reported 5-year abstinence rate between 75-90%[6,7,8]; and

WHEREAS, There is renewed focus on the reintegration of physicians into medical practice while ensuring patient safety[9]; and

WHEREAS, There is movement to focus on wellness and safety and solutions that are supportive rather than punitive; and

WHEREAS, For physicians, whether for substance use disorder, mental health, or other issues, there remains significant stigma that instills judgement, loss of privacy, or discriminatory treatment; and

WHEREAS, For physicians, whether for substance use disorder, mental health, or other issues, there is a significant fear of loss of licensure, loss of income, and fear of required in-patient treatment preventing them from seeking support and treatment; therefore be it

RESOLVED, That ACEP promote awareness of current ACEP policy statement that supports decreasing the barriers, perceived or real, to physicians to feel safe seeking treatment for mental health, substance use, and other issues; and be it further

RESOLVED, That ACEP work with the American Medical Association and state medical societies to advocate for a change at state medical boards for protections for licensure for physicians to seek help and treatment for mental health, substance use, and other disorders.

References

[1] Drummond, D. Stop Physician Burnout: What to Do When Working Harder Isn't Working. 2014.
[2] https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUHFRR1-2014.pdf.
[3] https://jamanetwork.com/journals/ jama/fullarticle/2474424 and the Mayo Clinic Proceedings (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2704134/).
[4] https://www.modernhealthcare.com/article/20160514/MAGAZINE/305149988/when-the-addict-is-a-doctor
[5] https://www.fsphp.org/state-programs
[6] Boisaubin EV, Levine RE. Identifying and assisting the impaired physician. Am J Med Sci. 2001;322(1):31-36. doi: S0002-9629(15)34629-2 [pii].
[7] Rose JS, Campbell M, Skipper G. Prognosis for emergency physician with substance abuse recovery: 5-year outcome study. West J Emerg Med. 2014;15(1):20-25. doi: 10.5811/westjem.2013.7.17871 [doi].
[8] Rose JS, Campbell MD, Yellowlees P, Skipper GE, DuPont RL. Family medicine physicians with substance use disorder: A 5-year outcome study. J Addict Med. 2017;11(2):93-97. doi: 10.1097/ADM.0000000000000278 [doi].)
[9] ACP Position Paper, Physician Impairment and Rehabilitation: Reintegration Into Medical Practice While Ensuring Patient Safety: A Position Paper From the American College of Physicians, 4 June, 2019.

Background

This resolution calls ACEP to promote awareness of ACEP policy statements that oppose barriers to physicians seeking treatment for mental health and substance use issues and work with the AMA and state medical societies to advocate for changes by state medical boards for protections for licensure for physicians that seek help and treatment

After the passage of the Americans with Disabilities Act (ADA) in 1990, professional organizations, such as the American Psychiatric Association (APA), proposed guidelines for state licensing boards when asking about a physician's mental health. Title II of the ADA prohibits discrimination by public entities on the basis of disability, including psychiatric disabilities. Since the ADA's passage, medical board screening of applicants of prior history of mental illness or substance use disorders (SUD) using broad or hypothetical questions has been increasingly seen as discriminatory. Arguments have been raised about the necessity and legitimacy of broad-based inquiries into a physician's history with mental illness or SUD and their use as a proxy for a physician's ability to currently practice competently and without impairment. However, state boards often find challenges complying with the recommendations as they attempt to identify the line between an applicant's right to privacy with the sense of duty to protect the public.

State board licensing application questions about physician mental health vary. Some states ask broad, general questions such as, "Are you now, or have you ever been, diagnosed with or treated for mental illness?" while others follow the recommendations of the American Medical Association (AMA), Federation of State Medical Boards (FSMB), and APA, using a more targeted question intended to address *current* functional impairment. The AMA, FSMB, and APA have issued formal guidelines opposing expansive questions about mental health. In June 2018, the AMA amended its policy on *Access to Confidential Health Services for Medical Students and Physicians*. The policy states in part, "Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept 'safe haven' non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety." The FSMB, in it's policy *Physician Wellness and Burnout,* adopted in April 2018, recommends that state medical boards consider whether it is necessary to include "probing questions about a physician applicant's mental health, addiction, or substance use on applications for medical licensure," noting also that these questions are likely to discourage treatment-seeking among applicants.

A recent analysis of medical licensure application questions found that only 18 of 32 applications appropriately addressed this issue by either limiting their questions to "current impairment from a mental health condition," or refrained from the question all together. The remining licensing bodies asked questions considered by many to be outside the limits of ADA standards (i.e. probing too far into the past to demonstrate current impairment, etc.). It has been noted that in states with broad questions about mental health care, physicians are less likely to seek care. One key factor shaping behavior is fear of punitive consequences (either real or perceived) and/or loss of esteem. ACEP

met with the FSMB in the fall of 2018 to further discuss this issue and also met with the National Association of Medical Staff Services (NAMSS) to address these issues in training and certification credentialing processes.

ACEP's policy statement "Physician Impairment" states: "The existence of a health problem in a physician is NOT synonymous with occupational impairment..." and that most physicians with "appropriately managed personal health problems and other stressors are able to function safely and effectively in the workplace."

The Federation of State Physician Health Programs (FSPHP) evolved from an initiative of the AMA and state-based physician health programs focused on the rehabilitation and monitoring of physicians with psychoactive SUD as well as physical and mental illness. To date, nearly every state has state physician health programs (PHP) that operate within the parameters of state regulation and legislation. These state programs vary in terms of services they can provide, and typically focus on substance use disorders. The FSPHP website states that the FSPHP and FSMB frequently schedule their meetings in the same location to foster communication and understanding as well as joint participation. A 2010 survey of physicians' taking part in a PHP program found general satisfaction with the program with 92.5% stating they would recommend it to others. However, some recent criticism of PHPs has raised issues such as: concern about its scope of influence, unnecessary treatment and costs of care.

In 2010, the Well-being Committee contributed to a health resource document for emergency physicians. In 2017, ACEP began working with partner organizations, such as CORD and AAEM, on a campaign to raise awareness about physician suicide. One study examined the suicide rates among physicians. It discovered that physicians have higher rates of suicide than the general population. For males, it is 1.41 times higher and for females 2.27 times the general population. A suicide awareness campaign was held in September of 2018, with another campaign planned to occur during National Suicide Prevention Week in 2019. The campaign goals are to shed light on physician suicide, decrease stigma and contribute to a culture of change. In addition, the Wellness Section screened the documentary, DO NO HARM, at *ACEP18* to continue to engage in dialogue about this issue. Another viewing is planned for *ACEP19*. The Well-Being Committee was assigned an objective for the 2018-19 committee year to study specialty-specific factors leading to depression and suicide and develop an action plan to address them. The committee is currently reviewing manuscripts looking at stories told by survivors of suicide attempts and anticipate distributing a quantitative survey to members to gather data for a larger project on suicide prevention.

In response Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care, in June 2019, materials were distributed to chapters with an explanation of the issue with background and talking points as well as a template letter to be used to send to their state medical board and a template letter asking for hospital support on the issue.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Member Engagement
Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted. Directed ACEP to work with stakeholders to advocate for changes in state medical board licensing application questions about physician's mental health.

Resolution 16(18) No More Emergency Physician Suicides adopted. Directed ACEP to study the unique specialty-specific factors leading to depression and suicide in emergency physician and develop an action plan to address them.

Amended Resolution 32(04) Disability in Emergency Physicians adopted. Directed ACEP to evaluate and communicate issues related to disability and impairment in the practice of emergency medicine to members and address barriers to participation for members with disabilities. Also directed ACEP to request that ABEM include information on disability in their Longitudinal Study of Emergency Physicians.

Substitute Resolution 9(99) Federation of State Medical Board Recommendations adopted. Directed ACEP to consider establishing a formal relationship with the FSMB and to develop strategies and tools for members to respond to the FSMB's recommendations in "Maintaining State-Based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession."

Substitute Resolution 43(88) Emergency Physician Wellness adopted. Directed ACEP to endorse the concept of promoting emergency physician wellness and for the Board to report back to the Council Steering Committee on their actions related to the Wellness Working Group report.

Amended Resolution 29(82) Physician Impairment adopted. Directed ACEP to establish a committee to develop a program on addiction education for members and a program to encourage colleagues with substance use disorders to seek help and provide a report to the 1983 Council about the progress on these efforts.

Prior Board Action

Amended Resolution 18(18) Reducing Physician Barriers to Mental Health Care adopted.

Resolution 16(18) No More Emergency Physician Suicides adopted.

October 2013, approved the revised policy statement "Physician Impairment;" revised and approved October 2006; reaffirmed September 1999; revised and approved April 1994; originally approved September 1990.

Amended Resolution 32(04) Disability in Emergency Physicians adopted.

Substitute Resolution 9(99) Federation of State Medical Boards adopted.

Substitute Resolution 43(88) Emergency Physician Wellness adopted.

Amended Resolution 29(82) Physician Impairment adopted.

Background Information Prepared by: Loren Rives, MNA
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Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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RESOLUTION : 21(19)

SUBMITTED BY: Hawaii Chapter

SUBJECT: Video Conferencing for Chapter and Section Meetings

PURPOSE: Facilitate electronic meetings for chapters and sections using the contracted National ACEP videoconferencing service.

FISCAL IMPACT: The cost to ACEP depends on the number of hosts signed up with the service. The annual cost ranges from less than $200 to more than $7,000.

WHEREAS, Technology for videoconferencing and audio meetings has improved to the point of widespread use by multiple organizations including ACEP; and

WHEREAS, Meeting participation for ACEP chapters and sections is challenged by geographic and scheduling constraints; and

WHEREAS, Improved chapter and section communication will help support local and national ACEP initiatives; and

WHEREAS, ACEP "Chapter Services offers a wide range of services and resources to help ACEP chapters and their leaders maximize their effectiveness"; therefore, be it

RESOLVED, That ACEP provide and pay for one videoconference meeting host* for each chapter and section that requests this service.

References

1. Zoom. *Zoom Meeting Plans for Your Business.* Retrieved May 27, 2019 from https://zoom.us/pricing
2. Edinger, S. Harvard Business Review. (June 29, 2018). *Stop Scheduling Conference Calls and Finally Commit to Videoconferencing.* Retrieved May 27, 2019, from https://hbr.org/2018/06/stop-scheduling-conference-calls-and-finally-commit-to-videoconferencing
3. ACEP. (2019). *ACEP Chapter Services.* Retrieved May 27, 2019, from https://www.acep.org/how-we-serve/chapter-services/

* A host is the "owner" of a meeting or webinar and the person who can control the meeting via the host controls.

Background

This resolution calls for ACEP to provide and pay for one videoconference meeting host for each chapter and section that requests this service.

Zoom is the leader in modern enterprise video communications, with an easy, reliable cloud platform for video and audio conferencing, collaboration, chat, and webinars across mobile devices, desktops, telephones, and room systems. ACEP began using Zoom in December 2018. Every staff member has their own user (host) account linked to ACEP's Business account, and can host meetings for their committees, sections, etc., with 200 or less participants per ACEP's contract with Zoom.

The 2019 Chapter Services Survey indicates that "member engagement" is the top item that chapters wish they could spend more time on if they had more resources. Currently, chapters use a variety of teleconferencing services with varied associated costs, and some chapters may already be using Zoom. Zoom may offer more functionality than

many of the other services. Increased functionality may provide an incentive for increased use of webinars and video conference calls, which could increase efficiency and reduce meeting and travel expenses significantly for chapters.

Sections are a subcategory of national ACEP membership. As such, sections are part of national ACEP and do not have separate bylaws or formal incorporation documents. All sections have a staff liaison, employed by ACEP, who already has a Zoom account and can schedule and facilitate Zoom meetings as desired by the section.

Each chapter is a separate corporate entity organized pursuant to the laws of its state. There are 53 ACEP chapters and 10 of those chapters have contracted with ACEP to provide management services. The executive director of the 10 chapters managed by ACEP is employed by ACEP. The other 43 chapters either contract their management services to the state medical society, an association management company, an individual or firm, or employs its own staff. There are currently 40 chapter executive directors who are not employed by ACEP.

Zoom has several options for their services. The Enterprise plan is the top tier with the most benefits. The cost is $19.99 per month and per host for a minimum of 50 hosts. With chapters having only 40 possible hosts (chapter executive directors not employed by ACEP), the Enterprise tier is not an option. The Business plan is the second tier and this is the type of account contracted by ACEP. The retail cost is $19.99 per month and per host for a minimum of 10 hosts. ACEP negotiated a discount for this service at $14.99 per month and per host. Although the benefits are not as comprehensive as the Enterprise plan, the Business plan meets ACEP's needs.

ACEP uses single sign-on (SSO) which allows staff to log in with their computer credentials. The ACEP Business account is administered by ACEP's Chief Technology Officer. Since most chapter staff are not employed by ACEP, they do not (and cannot) have access to ACEP's Zoom account. The 10 chapters currently managed by ACEP do have access to ACEP's account since their executive director is an ACEP employee.

ACEP would need to establish a separate Zoom account for 43 chapters and administer all of the user accounts (hosts). Per Zoom's terms and conditions and ACEP policy, a host subscription may not be shared or used by anyone other than the individual assigned as a host.

It is unknown whether all chapters would utilize such an account. If offered by ACEP, all chapters would likely sign up for the service with the intention of using it because there is no charge to the chapter. ACEP's Chief Technology Officer and ACEP's Zoom account manager, suggests that the Pro tier should meet the needs of chapters. Most small businesses' needs are met by the Pro tier. The Pro tier has less features than the Business tier, but it is unknown whether the added features of the Business tier would be useful to the chapters. The cost of the Pro tier is the same as ACEP's Business account, $14.99 per month per host, with the advantage of having no minimum number of hosts. This means that individual chapters can sign up at the Pro tier and administer their own account. The expense for this service could be submitted to national ACEP for reimbursement annually and would reduce ACEP staff expenses associated with managing the account and users (hosts) on behalf of chapters.

One feature of the Pro tier that could be problematic for some chapters is the 100 participant limit. ACEP meetings with anticipated attendance of 100-500 participants are set up using Zoom Video Webinars, which is an additional feature that is not included in any of the Zoom Meeting plans. ACEP does have a Zoom Video Webinars plan that includes five user accounts (hosts). ACEP staff could help facilitate this option using its Video Webinar account for chapters with this need. For more information on Zoom pricing, visit: https://www.zoom.us/pricing.

ACEP's Chapter Services staff provide other services to improve communications within chapters, including access to the engagED platform, ACEP's online member community. This service is available to all chapters that wish to have an all-member chapter community or communities for their chapter committees, leaders, etc. Chapter Services also offers a free quarterly e-newsletter service to chapters. For each issue, chapters must provide at a minimum a letter from the chapter president or another leader and a calendar of chapter events. National ACEP supplies clinical or state advocacy content, a list of new members to the chapter, and any other valuable information for the chapter, formats the newsletter into an email, and distributes it to the chapter members. Additionally, ACEP also designed, hosts, and helps maintain 29 chapter websites at no cost to the chapter.

It is advisable that ACEP gather data on the usage of Zoom by chapters prior to making a financial commitment. Chapters interested in using Zoom could start with the Basic tier, which is free, or the Pro tier at $14.99 per month per host and report its usage back to ACEP for analysis and further consideration.

ACEP Strategic Plan Reference

Goal 2 Enhance Membership Value and Engagement
Objective B.5. – Strengthen chapter operations with resources and services that the growth and efficient operation of chapters.

Fiscal Impact

Option 1: Business tier including ACEP-negotiated discount is $14.99 per month per host with a minimum of 10 hosts. ACEP would need to set up the account and administer all of the user accounts. Possible scenarios:

10 hosts x 12 months at $14.99 per month = $1,798.80
25 hosts x 12 months at $14.99 per month = $4,497.00
40 hosts x 12 months at $14.99 per month = $7,195.20

Option 2: Pro Tier is $14.99 per month per host and has no minimum number of hosts. Chapters can set up and administer their own account. Possible scenarios:

1 host x 12 months at $14.99 per month = $179.88
5 hosts x 12 months at $14.99 per month = $899.40
Pricing for 10 or more hosts is the same as above.

Unbudgeted staff labor to set up a Business account for chapters and administer the individual user accounts (hosts), estimated at a minimum of 8 hours per month.

Prior Council Action

None specific to national ACEP providing videoconferencing services for chapters.

Prior Board Action

None specific to national ACEP providing videoconferencing services for chapters.

Background Information Prepared by: Maude S. Hancock
Chapter Services Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 22(19)

SUBMITTED BY: Carrieann Drenten, MD, FACEP
Douglas Gibson, MD, FACEP
Vikant Gulati, MD, FACEP
Susanne Spano, MD, FACEP
Andrea Wagner, MD, FACEP
Delaware Chapter

SUBJECT: Visual White Coat for Emergency Medicine Advocacy Efforts

PURPOSE: Encourage LAC attendees to wear white coats for their Congressional meetings and require ACEP Board members attending LAC to wear ACEP-branded white coats in their Congressional meetings that day.

FISCAL IMPACT: $2,000 – $5,000 depending on the quality of the medical coats.

WHEREAS, As ACEP continues to be a strong advocate for emergency medicine healthcare; and

WHEREAS, The Leadership & Advocacy Conference continues to grow and become a powerful and effective tool in getting our important message across; and

WHEREAS, The topics we discuss have the opportunity to change legislators, staffers, and regulators minds on issues that impact all emergency physicians, patients, and communities; and

WHEREAS, The white coat symbolizes compassion, honor, and trusted respect; and

WHEREAS, Consultant and advocacy experts advise that legislators respond favorably to those in white coats, which in turn may make our message more effective; and

WHEREAS, When ACEP leaders and members are advocating they do not represent any group but the collective voice of emergency physicians and the patients and communities we serve; and

WHEREAS, Many Leadership & Advocacy Conference participants assume that they should not be wearing their white coat to hill visits because they witness the leaders of the organization wearing more business professional dress over clinical professional dress during previous events; therefore be it

RESOLVED, That ACEP encourage Leadership & Advocacy Conference participants to bring and wear their white coat when making Hill visits to help make a visual impact when meeting with legislators, staffers, and the public who may be also visiting the Hill; and be it further

RESOLVED, ACEP work with a third party vendor to issue branded ACEP white coats to all active national ACEP Board of Directors members to help create a powerful visual that accompanies our advocacy message while also ensuring clarity that our national representative is speaking on behalf of our organization and the specialty while not creating confusion of favoring any group, practice style, etc.

Background

This resolution calls for ACEP to encourage attendees of the Leadership & Advocacy Conference (LAC) to wear white coats for their Congressional meetings and to require the ACEP Board members attending LAC to wear ACEP-branded white coats in their own Congressional meetings that day.

Promotional materials for LAC encourage attendees to wear business attire for their Congressional meetings. Occasionally, some attendees have chosen to wear medical coats on such visits, and it is not discouraged to do so. It is recommended that if medical coats are worn, that business attire be worn underneath the medical coats instead of scrubs.

A poll of 27 medical specialty societies was conducted. Including ACEP, there were 21 responses, and all indicated that they encourage business attire instead of white medical coats for Congressional visits.

American Academy of Dermatology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Neurological Surgeons
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Physical Medicine & Rehabilitation
American College of Physicians
American College of Radiology
American Psychiatric Association
American Society of Anesthesiology
American Society of Clinical Oncology
American Society of Hematology
American Society of Nephrology
American Society of Plastic Surgeons
American Urological Association
College of American Pathologists
Society of Critical Care Medicine
The Society of Thoracic Surgeons

In 2005, Scientific Assembly was hosted in Washington, DC, and as part of the programming, ACEP organized a rally on the lawn of the U.S. Capitol and requested that attendees wear white coats as a visible call for improving access to emergency care for all Americans through legislation that addressed medical liability reform and additional Medicare payments.

In 2017, Scientific Assembly was again hosted in Washington, DC. As part of the programming, ACEP offered "White Coat Day" where conference attendees were able to register to have ACEP arrange Congressional meetings for them and provide advocacy messaging and talking points for these meetings.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.
Strategy 6 – Promote and increase visibility of emergency physicians as leaders in health care.

Fiscal Impact

$2,000 – $5,000 (15 Board members and 2 Council officers) depending on the quality of the medical coats.

Prior Council Action

None

Prior Board Action

June 2005, reviewed the plans to promote ACEP's Rally on the Hill, which included encouraging everyone to wear their white coats.

Background Information Prepared by: Laura Wooster, MPH
Associate Executive Director, Public Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Council Meeting
Reference Committee Members

Reference Committee B
Advocacy & Public Policy
Resolutions 23-39

Catherine A. Marco, MD, FACEP (OH), Chair
Bradley Burmeister, MD (WI)
Zachary J. Jarou, MD (EMRA)
Thom R. Mitchell, MD, FACEP (TN)
Randy L. Pilgrim, MD, FACEP (LA)
Lindsay M. Weaver, MD, FACEP (IN)

Ryan McBride, MPP
Harry Monroe

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RESOLUTION: 23(19)

SUBMITTED BY: Alaska Chapter
California Chapter
New Mexico Chapter
Oregon Chapter
Washington Chapter
Pain Management & Addiction Medicine Section

SUBJECT: Allow Emergency Physicians to Prescribe Buprenorphine

PURPOSE: Advocate for the removal of the Drug Enforcement Agency X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine for opioid use disorder.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

WHEREAS, The opioid epidemic shares responsibility for declining life expectancy in the USA by killing 130 Americans daily[1,2,3,4]; and

WHEREAS, Buprenorphine has proven benefit for achieving remission from opiates and decreasing mortality;[5,6] and

WHEREAS, Emergency department-initiated buprenorphine/naloxone treatment increases engagement in addiction treatment;[7] and

WHEREAS, Prescribing buprenorphine requires physicians to obtain a Drug Enforcement Agency (DEA) X license, which can only be obtained after an 8-hour course and caps the number of patients to whom the medication can be prescribed; and

WHEREAS, The requirement for the DEA X-waiver is a barrier to physicians prescribing buprenorphine;[8] and

WHEREAS, More than half of rural counties in the United States have no DEA X-waivered prescribers and consequently no ability to prescribe buprenorphine;[9] and

WHEREAS, Physicians already have unrestricted ability to prescribe far more dangerous and addictive opioids; and

WHEREAS, A country that eliminated special training requirements to prescribe buprenorphine decreased opiate deaths 79%;[10] and

WHEREAS, ACEP already supports the development of educational content around the role of medication assisted treatment with buprenorphine and opioid use disorder for emergency physicians; therefore be it

RESOLVED, That ACEP advocate for the removal of the Drug Enforcement Agency X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine[11] for opioid use disorder.

References

1. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2017. Available at http://wonder.cdc.gov.
2. Contribution of Opioid-Involved Poisoning to the Change in Life Expectancy in the United States, 2000-2015 Deborah Dowell, MD, MPH1; Elizabeth Arias, PhD2; Kenneth Kochanek, MA2; et al Robert Anderson, PhD2; Gery P. Guy Jr, PhD, MPH1; Jan L. Losby, PhD, MSW1; Grant Baldwin, PhD, MPH1 JAMA. 2017;318(11):1065-1067. doi:10.1001/jama.2017.9308
3. NCHS Data Brief ■ No. 328 ■ November 2018 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention National Center for Health Statistics Mortality in the United States, 2017 Sherry L. Murphy, B.S., Jiaquan Xu, M.D., Kenneth D. Kochanek, M.A., and Elizabeth Arias, Ph.D.
4. NCHS Data Brief ■ No. 329 ■ November 2018 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention National Center for Health Statistics Drug Overdose Deaths in the United States, 1999–2017 Holly Hedegaard, M.D., Arialdi M. Miniño, M.P.H., and Margaret Warner, Ph.D.
5. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD002207. DOI: 10.1002/14651858.CD002207.pub4.
6. BMJ 2017;357:j1550 Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies
7. JAMA. 2015 Apr 28;313(16):1636-44. doi: 10.1001/jama.2015.3474.Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. D'Onofrio G1, O'Connor PG2, Pantalon MV1, Chawarski MC3, Busch SH4, Owens PH1, Bernstein SL1, Fiellin DA5.
8. "To Help Providers Fight The Opioid Epidemic, "X The X Waiver", " Health Affairs Blog, March 5, 2019.DOI: 10.1377/hblog20190301.79453
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11. Ref AMA: https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-9-19-Letter-to-President-re-Interim-Opioid-Report.pdf

Background

This resolution calls for ACEP to advocate for the removal of the Drug Enforcement Agency X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine[11] for opioid use disorder.

The scope of this resolution is similar to Resolution 31(19) Improving Emergency Physician Utilization of Medication for Addiction Treatment; therefore, the content of the background information is similar for both resolutions.

The immense scope of opioid use disorder and its associated public health impacts have become increasingly evident across all fields of medicine. The size of the crisis prompted the Department of Health and Human Services to declare the opioid crisis a public health emergency in October of 2017. Yet, despite the wide-ranging nature of this issue, nowhere are its impacts clearer than in the Emergency Department (ED). According to the National Survey on Drug Use and Health, in 2015 approximately 3.8 million people misused pain medications and 329,000 people used heroin. An estimated 135,000 of those people tried heroin for the first time during that year. Despite the scale of opioid misuse in this country, the consequences of that misuse are even more profound. Since 2001 there has been a 200% increase in the rate of death from opioids. In 2016 alone nearly two thirds (66.4%) of all drug overdose deaths involved prescription opioids, illicit opioids, or both, an increase of 27.7% from 2015. Put simply, opioid use disorder is widespread, and its associated mortality is getting worse.

Given the impact of opioid use disorder on ED patients, emergency medicine providers are taking the lead on addressing this crisis. Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. However, ED physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from opioid use disorder.

Medication for opioid use disorder refers to any addiction treatment that includes pharmacologic therapy. In the context of opioid use disorder this includes medications that act as opioid agonists, partial agonists, or antagonists. Popular examples are methadone, buprenorphine, and naltrexone. There is a growing body of literature showing that Medication Assisted Treatment (MAT) for opioid use disorder improves patient outcomes. Data suggest that patients receiving medication for opioid use disorder have decreased fatal overdose compared to with those who receive counseling alone. Additionally, patients maintained on buprenorphine for at least a year are noted to have less ED visits and inpatient hospital stays.

Yale University recently published a randomized controlled study evaluating the viability and efficacy of ED initiated buprenorphine. They determined that not only was it safe to administer buprenorphine to ED patients, but it also improved patient outcomes. Specifically, they found that compared to brief behavioral counseling or usual care, ED patients receiving buprenorphine where significantly more likely to be engaged in addiction treatment 2 months after their ED visit.

Despite the promise of this therapy they are currently significant barriers to ED administration of medication for opioid use disorder. The Drug Addiction Treatment Act of 2000 (DATA 2000) created a special licensing process for prescribing opioid-based addiction treatment. This special license, colloquially referred to as the X -Waiver, requires physicians to complete an 8-hour training course before they can legally prescribe. This training includes information on identifying appropriate patients for buprenorphine treatment and how to best use this medication within addiction treatment programs. However, the training is not specifically designed with ED providers in mind. Furthermore, the 8-hour training provides a significant barrier for the widespread adoption of medication assisted therapy.

ACEP's policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department" supports all patients being treated appropriately for acute pain with prompt, safe, and effective pain management. The policy statement acknowledges that acute pain management is patient-specific and provides guidance on pharmacological and non-pharmacological pain interventions. This is a joint statement by ACEP, the American Academy of Emergency Nurse Practitioners, and the Emergency Nurses Association. ED physicians will continue to be on the front lines of this public health emergency as the nation struggles with opioid use disorder. Given the scale of this problem it is incumbent upon us to use the best treatment available for our patients. While there are many potential solutions to this issue, medication for opioid use disorder is a promising tool, and is the only evidence-based treatment available for the treatment of opioid use disorder. It has proven to be both an effective and safe treatment for ED patients suffering from opioid addiction.

Most recently, ACEP met with the head of the Substance Abuse and Mental Health Services Administration (SAMHSA), Assistant Secretary for Mental Health and Substance Use Dr. Elinore McCance-Katz, on May 15, 2019. During our meeting with Dr. McCance-Katz, we discussed issues that are extremely important to emergency physicians and our patients, including the ability to administer buprenorphine in the ED for patients with opioid use disorder and how to improve care for patients with mental health illnesses. ACEP mentioned the resources and tools that we have created to help our physicians and patients, highlighting the EM-specific DATA 2000/Medications for Addiction Treatment waiver training course that is now being offered to our members, as well as new web-based and mobile device applications around opioids and the management and treatment of suicidal patients. One of SAMHSA's major goals is to boost the community resources that are available to help clinicians across specialties treat patients with substance abuse disorders and mental illnesses. We expressed our commitment to helping SAMHSA achieve the goal and identified opportunities to work together going forward.

On July 16, 2019, ACEP member Dr. Eric Ketcham participated in a panel discussion sponsored by Pew Charitable Trusts focused on how to reduce barriers that impede the ability for providers to treat patients with Substance Use Disorder (SUD). Dr. Ketcham emphasized the need to remove the X-waiver training requirement. Dr. Ketcham also discussed the importance of initiating buprenorphine in the ED, and how the X-waiver requirement creates an unnecessary barrier that impedes access to this potentially life-saving medication. Finally, he and other panelists talked about other treatment barriers to SUD, including stigma and misperception, outpatient access issues, and insurance prior-authorization, and how policy makers can best address these impediments. Representative Paul Tonko (D-NY) also was present and kicked off the panel discussion. Representative Tonko is the sponsor of the ACEP-supported H.R. 2482, the "Mainstreaming Addiction Treatment Act," which would remove the X-waiver requirement

as well as address other barriers to SUD treatment. ACEP also supports the Senate companion bill, S. 2074, sponsored by Senators Maggie Hassan (D-NH) and Lisa Murkowski (R-AK).

After the panel discussion, Dr. Ketcham and the other panelists met with Admiral Brett Giroir, the Assistant Secretary for Health at the U.S. Department of Health and Human Services (HHS). Adm. Giroir's office is looking into possibly reforming the restrictive "three-day" rule for administering buprenorphine. This rule allows non-waivered providers to administer (but not prescribe) buprenorphine to patients for a three-day period. However, the rule forces providers to administer buprenorphine one-day at a time, requiring patients to come back to the ED or other settings each day to receive treatment. ACEP has long advocated for eliminating this unnecessary hurdle and allowing providers to provide the patient with three-days' worth of treatment during one session. We have previously met with Admiral Giroir and others at HHS to discuss this issue and are encouraged that the Department is considering a policy change.

On August 29, 2019, ACEP responded to an HHS request for information on ensuring appropriate access to opioid treatments. In the response, HHS is urged to do what is in their authority to reduce barriers to the treatment of patients with OUD. ACEP also issued a press release highlighting the major points contained in the letter.

In addition to advocating for Congress to remove the X-waiver and pushing for regulatory changes to the "three-day rule," ACEP also:

- Offers an emergency-medicine specific X-waiver training course (including one being held during *ACEP19* in Denver);
- Provides clinical tools for emergency physicians to improve decision making and clinical practices; and
- Operates the EQUAL Network Opioid Initiative, which engages emergency clinicians and leverages emergency departments to improve clinical outcomes.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP position to federal Executive and Legislative branch officials.

Prior Council Action

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research

of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Prior Board Action

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

February 2018, revised and approved the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012.

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.

June 2012, approved the Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 24(19)

SUBMITTED BY: Kyle Fischer, MD, FACEP
Maryland Chapter
New Jersey Chapter
Ohio Chapter

SUBJECT: CMS Sepsis Core Measure and the Legal Standard of Care

PURPOSE: 1) Not consider the Sepsis CMS Core (SEP-1) Measure as the standard of care for the treatment of patients with sepsis. 2) Approach the CMS to request revision of the current sepsis quality metrics.

FISCAL IMPACT: Budgeted committee/task force and staff resources.

WHEREAS, The Centers for Medicare and Medicaid Services (CMS) is increasingly moving towards reimbursing physicians based on quality of care, rather than quantity; and

WHEREAS, In order to tie reimbursement to quality of care, CMS creates metrics based on medical conditions; and

WHEREAS, The Sepsis Core Measure (SEP-1) has been released as a quality metric for the initial resuscitation of patients in sepsis; and

WHEREAS, SEP-1 defines quality by a bundle of metrics, including but not limited to, serial lactate measurement, a 30mL/kg IV fluid bolus, and reassessment that may include measurement of central venous pressure or central venous oxygenation; and

WHEREAS, Several clinical trials[1,2,3] have demonstrated the addition of many aspects of the bundle do not add clinical benefit; and

WHEREAS, Unique, complex, and oftentimes common clinical scenarios require the clinician to deviate from the SEP-1 bundle to provide high quality emergency care; and

WHEREAS, Core metrics may be cited in quality review or legal settings as the "standard of clinical care;" therefore be it

RESOLVED, That ACEP does not view the current CMS sepsis quality metrics as the standard of care for the treatment of patients with sepsis; and be it further

RESOLVED, That ACEP reach out to the Centers for Medicare and Medicaid Services to revise the current sepsis quality metrics.

References

1. The ProCESS Investigators. A randomized trial of protocol-based care for early septic shock. *NEJM*. 2014;370:1683-1693.
2. The ARISE Investigators and the ANZICS Clinical Trials Group. Goal-directed resuscitation for patients with early septic shock. NEJM. 2014;371:1496-1506.
3. Mouncey PR, Osborn TM, Power GS, et al. Trial of early, goal-directed resuscitation for septic shock. *NEJM*. 2015;372:1301-1311.

Background

This resolution requests ACEP not consider the Sepsis CMS Core (SEP-1) Measure as the standard of care for the treatment of patients with sepsis and that ACEP approach the CMS to request revision of the current sepsis quality metrics.

ACEP has had numerous discussions with the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), and the measure stewards regarding the merits and deficiencies of the various components of the sepsis metrics. To support the highest quality of sepsis care, ACEP has worked closely with the CMS to develop our own quality measures as part of the Clinical Emergency Data Registry (CEDR). Specifically, the CEDR Qualified Clinical Data Registry (QCDR) measures are CMS-approved entities that strive to improve healthcare quality.

For year 2019, ACEP worked closely with the CMS to develop CEDR QCDR measures, ACEP #30 and ACEP #48, that address sepsis and include exclusion criteria specific to fluid resuscitation and lactate levels among sepsis patients with unique, complex, and common comorbidities. The exclusion criteria for ACEP #30 and ACEP #48 include patients with any of the following:

- Acute trauma
- Acute myocardial infarction
- Acute Pulmonary Edema
- Advanced directives present in patient medical record for comfort care
- Anuria
- Burn
- Cardiac arrest within the emergency department visit
- Died during the emergency department visit
- Drug-related conflict with ability to clear lactate (ie, Nucleoside Reverse Transcriptase Inhibitors)
- End stage renal disease
- Gastrointestinal bleeding
- Left before treatment was complete
- Left Ventricular Assist Device (LVAD)
- Liver dysfunction or cirrhosis with decompensation
- Liver failure - End-stage liver disease
- patient hospital setting Left before treatment was complete
- Patient or surrogate decision maker declined care
- Patients with any of the following:
- Receiving epinephrine
- Secondary diagnosis of
- Secondary diagnosis of o Gastrointestinal bleeding
- Seizures
- Severe Heart Failure (LVEF <20%)
- Status Epilepticus
- Stroke
- Toxicological emergencies
- Transferred into the emergency department from another acute care facility or other in-patient hospital setting

ACEP recognizes the current CMS sepsis quality metrics are an ongoing concern with membership and is continually devoting resources and staff time to ensure member voices are heard at the CMS. ACEP will continue to work closely with the CMS to find equitable solutions to the current sepsis quality metrics and influence a revision of the metrics.

In addition to the CEDR QCDR metrics, to support the highest quality of sepsis care, ACEP also developed the Emergency Quality (E-QUAL) Network Sepsis Initiative and the DART online point-of-care tool to assist members in the identification and treatment of patients who develop sepsis, severe sepsis, and septic shock. ACEP is also

currently coordinating a multispecialty panel to develop consensus-based recommendations that address the underlying background, rationale, evaluation, and management of patients with sepsis who present to the emergency department. The deliverables of this project will be a manuscript containing the consensus-based recommendations and an update to the content of the DART online point-of-care tool.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

Resolution 18(16) Opposition to CMS Mandating Treatment Expectations amended and adopted. Directed ACEP to: oppose CMS mandated reporting standards that require potential harm to patients without the recognition of appropriate physician assessment and evidence-based goal directed care of individual patients; actively communicate to members and the public the dangers of CMS overstep of physician responsibility to patients for quality indicators; and communicate to hospitals the need and options to recognize appropriate physician treatment.

Prior Board Action

April 2019, supported appointing a Sepsis Task Force to develop consensus guidelines for the treatment of sepsis in the emergency department.

Resolution 18(16) Opposition to CMS Mandating Treatment Expectations amended and adopted.

October 2015, approved 2016 Sepsis Measures for CEDR.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 25(19)

SUBMITTED BY: Illinois College of Emergency Physicians
Maryland Chapter
Pennsylvania College of Emergency Physicians
South Carolina College of Emergency Physicians
West Virginia Chapter

SUBJECT: Rational Crystalloid Hydration in Sepsis

PURPOSE: 1) Work with CMS to create a formal caveat to withhold 30cc/kg crystalloid bolus(es) from patients with select comorbidities that put them at higher risk of fluid overload and harm. 2) Affirm with the CMS that the bedside emergency physician may exercise clinical judgement to withhold 30cc/kg crystalloid bolus(es) without penalty in situations where it could be potentially harmful to the patient.

FISCAL IMPACT: Budgeted committee/task force and staff resources.

WHEREAS, Key emergency department evidence improved the care and outcomes of those with sepsis and CMS SEP-1 has helped improve care across the country; and

WHEREAS, Despite new trials showing that early care in sepsis improves outcomes, the exact composition of fluids vs. vasopressors in initial care is unclear and many patients are at risk for harm from fluid therapy; and

WHEREAS, CMS has included appropriate "physician documentation caveats" that allow for clinical exceptions for compliance with CMS Sepsis Bundle compliance (such as "no infection present," etc.); and

WHEREAS, In patients with Sepsis (SIRS signs, Suspected Infection, and Lactate 4 or greater) the CMS Bundle mandates 30cc/kg crystalloid in all patients causing physicians to potentially cause patient harm in those at risk (existing heart failure, renal failure, depressed ejection fraction, etc.); therefore be it

RESOLVED, That ACEP work with CMS to create a formal caveat allowing clinicians to withhold 30cc/kg crystalloid bolus(es) in select patients with presumed sepsis and a higher risk of fluid overload or harm; and be it further

RESOLVED, That ACEP affirm with CMS that the bedside emergency physician's judgement of potential harm be allowed withhold 30cc/kg crystalloid boluses in patients with presumed sepsis without penalty.

Background

This resolution requests ACEP work with the CMS to create a formal caveat allowing clinicians to withhold 30cc/kg crystalloid bolus(es) from patients with comorbidities that put them at a higher risk of fluid overload or harm and to affirm with the CMS that the bedside emergency physician may exercise clinical judgement to withhold 30cc/kg crystalloid bolus(es) without penalty in situations where administration could be potentially harmful to the patient.

ACEP has had numerous discussions with the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), and the measure stewards regarding the merits and deficiencies of the various components of the sepsis metrics. To support the highest quality of sepsis care, ACEP has worked closely with the CMS to develop our own quality measures as part of the Clinical Emergency Data Registry (CEDR). Specifically, the CEDR Qualified

Clinical Data Registry (QCDR) measures are CMS-approved entities that strive to improve healthcare quality. For year 2019, ACEP worked closely with CMS to develop CEDR QCDR measures, ACEP #30 and ACEP #48, that address septic shock, with ACEP #48 including exclusions specific to fluid resuscitation and lactate levels among sepsis patients with renal failure and/or heart failure.

In addition to the CEDR QCDR metrics, to support the highest quality of sepsis care, ACEP also developed the Emergency Quality (E-QUAL) Network Sepsis Initiative and the DART online point-of-care tool to assist members in the identification and treatment of patients who develop sepsis, severe sepsis, and septic shock. ACEP is also currently coordinating a multispecialty panel to develop consensus-based recommendations that address the underlying background, rationale, evaluation, and management of patients with sepsis who present to the emergency department. The deliverables of this project will be a manuscript containing the consensus-based recommendations and an update to the content of the DART online point-of-care tool.

Renowned emergency medicine experts specializing in the identification and treatment of patients with sepsis strongly encourage ACEP members to exercise their clinical judgement to provide care that is in the best interest of their patients regardless of quality measure score. This is true not only for patients with sepsis, but for patients with any condition.

In 2016, the Council and the Board of Directors adopted Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations, which directed ACEP to: 1) work with CMS regarding mandated reporting standards that require potential harm to patients without the recognition of evidence-based care of individual patients; and 2) communicate to members and hospitals the dangers that quality indicators could present to potential patients and the importance of physician autonomy in treatment. A similar resolution was submitted to the American Medical Association (AMA) from ACEP members. It was referred to the AMA Board of Trustees and adopted as policy.

> **Development of Quality Measures with Appropriate Exclusions and Review Processes H-450.927**
> 1. Our AMA will advocate for quality measures, including those in the Hospital Inpatient Quality Reporting Program, to have appropriate exclusions to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making, and for denominators of quality measures to be appropriately defined to ensure patients for whom the treatment may not be appropriate are adjusted for or excluded.
>
> 2. Our AMA will advocate for CMS to allow for any proposed quality measures to be reviewed by the appropriate medical specialty societies prior to adoption.

As a matter of principle, most ACEP subject matter experts recommend treating the most urgent life-threatening condition first and then manage other comorbid conditions. However, it is recognized there will be circumstances where comorbid conditions are exacerbated and become urgent and life threatening, as evidenced by the thousands of people who die in the United States each year from both heart failure and end stage renal disease. In most instances, it is only the examining and treating physician who can determine which condition is the most urgent and life threatening. More often than not, that condition would be septic shock.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted. Directed ACEP to: 1) work with CMS regarding mandated reporting standards that require potential harm to patients without the recognition of evidence-based care of individual patients; and 2) communicate to members and hospitals the dangers that quality indicators could present to potential patients and the importance of physician autonomy in treatment.

Prior Board Action

April 2019, supported appointing a Sepsis Task Force to develop consensus guidelines for the treatment of sepsis in the emergency department.

Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted.

October 2015, approved 2016 Sepsis Measures for CEDR.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 26(19)

SUBMITTED BY: Arjun Chanmugam, MD, FACEP
Maryland Chapter
New Jersey Chapter
Ohio Chapter

SUBJECT: EMTALA Professional Liability Coverage

PURPOSE: Support and advocate for federal liability protections when providing EMTALA-related services.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

WHEREAS, The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd)., and its original intent and goals are consistent with the mission of ACEP and the public trust engendered by emergency physicians; and

WHEREAS, EMTALA has become the de facto national health care policy for the uninsured as ninety-two percent of all hospitalizations for the uninsured are directly linked with an emergency department visit; and\

WHEREAS, EMTALA requires Medicare-participating hospitals with emergency departments to screen, stabilize, and manage patients with emergency medical conditions in a non-discriminatory manner, regardless of ability to pay, insurance status, national origin, race, creed, or color; and

WHEREAS, Healthcare Reform and the implementation of the Affordable Care Act (ACA) may affect access to emergency care; however, there have been no significant challenges to the current EMTALA law; and

WHEREAS, Several federal bills promoting professional liability (malpractice) relief for EMTALA related services have been promoted by ACEP; therefore be it.

RESOLVED, That ACEP support and advocate that all EMTALA related services have liability coverage commensurate with that which exists under the Federal Tort Claims Act for National Health Service members.

Background

This resolution calls for ACEP to support and advocate for federal liability protections when providing EMTALA-related services.

The nature of emergency medicine is providing care to patients who have serious injuries or illnesses, with whom the emergency physician has little or no relationship and, at best, a limited ability to access their medical history. For these reasons, emergency physicians and other on-call physicians have much higher liability exposure and subsequent premiums. Providing liability protection to physicians for the federally mandated EMTALA services rendered will help ensure emergency and on-call physicians remain available to treat patients in their communities. Otherwise, the nation will continue to see sharp declines in on-call specialist availability and the relocation of emergency physicians to areas of the country where the liability environment is more favorable.

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law enacted in 1986 that requires hospital emergency departments and its physicians to provide a medical screening exam for all patients, regardless of their insurance status or ability to pay. If an emergency medical condition is discovered, then medical treatment must be provided on-site or the patient is transferred to a facility that could provide the necessary treatment.

For the past several Congresses, ACEP has supported legislation, the "Health Care Safety Net Enhancement Act," which will encourage physicians and on-call specialists to continue their lifesaving work and ensure emergency medical care will be available for patients when and where it is needed. Specifically, the legislation addresses the growing crisis in access to emergency care by providing emergency and on-call physicians who perform EMTALA-related services with temporary protections under the Federal Tort Claims Act. It does so by temporarily deeming these physicians as federal employees covered under the Public Health Services Act for purposes of liability protection only. During the 112th (2012) Congress, the House version of this bill (H.R. 157) was approved by voice vote as an amendment to H.R. 5 in March 2012. The Senate did not take action on H.R. 5 before the end of the session.

As of September 9, 2019, ACEP has secured a House sponsor, Representative Bill Flores (R-TX), to reintroduce the legislation in the 116th Congress (H.R. 3984) and we are working on identifying a Senate sponsor as well.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective G – Pursue meaningful medical liability reform and other initiatives at the state and federal levels.

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials

Prior Council Action

Amended Resolution 22(14) EMTALA-Related Liability Reform adopted. Directed that ACEP support individual states in passing EMTALA-related liability reform that increases the burden of proof and evidentiary standard in cases against those providing EMTALA-related care.

Resolution 16(07) Compulsory Arbitration for EMTALA related medical liability torts not adopted. Called for ACEP to propose and seek support for a federal measure mandating binding arbitration in EMTALA related cases.

Resolution 31(04) Medical Liability Reform – Total Caps not adopted. Directed ACEP to support efforts to attain federal tort reform and support caps on economic and non-economic damages.

Resolution 27(01) Federal Tort Reform not adopted. Directed ACEP to support efforts to attain federal tort reform.

Amended Resolution 13(01) Emerging Professional Liability Crisis adopted. Directed ACEP to study causes and scope of professional liability crisis in emergency medicine and develop short- and long-term resolutions, including tort reform.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted. The resolution directed ACEP to take the position that meaningful medical malpractice reform be an essential component of any health care reform measures and directed ACEP's lobbyist to further that position with Congress and via its key contact system.

Amended Resolution 27(87) State Liability and Tort Reform adopted. Directed ACEP to encourage chapters to take an active role in their state medical societies'' liability reform efforts and to act independently where appropriate.

Amended Resolution 42(85) Malpractice Coverage Information adopted. The resolution called for ACEP to urge the membership, through national and state publications, to obtain documentation and information regarding their individual medical liability insurance.

Amended Resolution 27(85) Malpractice Premiums and Tort Legal Reforms adopted. ACEP was directed to cooperate closely with other medical organization in creating strong support for legal tort reforms.

Prior Board Action

June 2018, approved the policy statement "Interpretation of EMTALA in Medical Malpractice Litigation."

April 2017, approved revised policy statement "Reform of Tort Law;" revised and approved April 2011 and August 2009; reaffirmed October 1998; originally approved September 1985.

Amended Resolution 22(14) EMTALA-Related Liability Reform adopted.

Amended Resolution 13(01) Emerging Professional Liability Crisis adopted.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted.

Amended Resolution 27(87) State Liability and Tort Reform adopted.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 27(19)

SUBMITTED BY: Sean Ochsenbein, MD, MBA
Nathaniel Westphal, MD

SUBJECT: Ensuring Public Transparency and Safety by Protecting the Terms "Emergency Department" and "Emergency Room" as Markers of Physician-Led Care

PURPOSE: Oppose use of "emergency" or ER by a facility if a physician is not onsite at all times and draft state and federal legislation mandating that those terms indicate physician-led care.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The general public expects the highest standard of physician-led care when presenting to an emergency department or emergency room; and

WHEREAS, It is the consensus among the general public that when presenting to an emergency department or emergency room, they will be treated by a physician; and

WHEREAS, ACEP has the obligation to protect the public and ensure emergency departments and emergency rooms provide the high standard of care that patients expect to receive; and

WHEREAS, ACEP has the responsibility to honor this unwritten truth of physician-led care which the public has come to trust in emergency departments or emergency rooms; and

WHEREAS, ACEP's current policy states that any facility that does not meet the definition of an Emergency Department or Freestanding Emergency Department as defined by ACEP, and that advertises itself as providing unscheduled care should not use the word "emergency" or "ER" in its name in any way; and

WHEREAS, ACEP's current policy states that Freestanding Emergency Departments (FSED) including hospital outpatient departments (HOPD), satellite emergency departments (ED), and independent freestanding emergency centers (IFECs) should be staffed by appropriately qualified emergency physicians; and

WHEREAS, ACEP's current policy states that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care; and

WHEREAS, Across the United States advanced practice registered nurses or physician assistants are treating patients in designated sites under the term "emergency department" or "emergency room" without direct, in person, physician oversight; and

WHEREAS, The trend of advanced practice registered nurses or physician assistants may, over time, erode the public trust and expectations regarding the terms "emergency department" or "emergency room" and the care these terms signify; and

WHEREAS. It is ACEP's responsibility to protect the brand of emergency physicians and most importantly to honor the obligation that the public has bestowed upon the specialty of emergency medicine; and

WHEREAS, The branding of our specialty matters and ACEP must protect the terms "emergency department" and "emergency room" to ensure public safety and transparency of care; therefore be it

RESOLVED, That if a physician is not onsite at all times in a facility that otherwise meets the definition of an Emergency Department or Freestanding Emergency Department as defined by ACEP, and that facility advertises itself as providing unscheduled care, such facility should not use the word "emergency" or "ER" in its name in any way; and be it further

RESOLVED, That ACEP will consider it a top priority and will draft legislation for state and federal legislators and such legislation will mandate that the terms "emergency" and "ER" are indicative of physician-led care and should be regulated to ensure public safety and public transparency.

Background

The resolution calls for ACEP to oppose the use of the word "emergency" or "ER" by a facility if a physician is not onsite at all times and to draft state and federal legislation mandating that those terms indicate physician led care.

Recent years have witnessed the proliferation of delivery models and legislative proposals that would address perceived shortages of available board certified, residency trained emergency physicians by loosening requirements for onsite physician supervision and expanding the scope of practice of APRNs and PAs to permit either independent practice or lower levels of mandated supervision. These trends are not unique to emergency medicine and often reflect either efforts to reduce costs based on the argument that physician training is not always required in a practice environment or to expand the professional roles of non-physician health care practitioners. Additionally, proponents of these trends contend that in rural areas onsite physician care is not always available, meaning that the only choice is between nonphysician care and no care at all

ACEP's origins are rooted in the establishment of emergency medicine as a medical specialty, and the College's historical development coincides with the rising availability of residency training and board certification for physicians that would hold themselves out as emergency physicians. Whereas the early decades of ACEP are characterized by expansion of the specialty and of specialized care in contrast to nonspecialist physicians practicing in emergency departments, challenges are now increasingly arising from nonphysician practitioners arguing that their training suffices for an expanded scope of practice to include unsupervised practice. In contrast to this trend, ACEP policy for freestanding emergency departments, including those operated by hospitals, states that any such emergency department "that presents itself as an ED" should be "staffed by appropriately qualified emergency physicians." Given the array of emergent medical conditions that present at emergency departments, whether remote or rural, at any given time, the training and experience of an emergency physician is crucial for a viable, functioning emergency department team.

As stated in ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department," ACEP opposes the independent practice of emergency medicine by NPs and PAs. ACEP has assisted many state chapters as they confronted legislation that legalized the independent practice by NPs. While independent practice for NPs has passed in several states, efforts by National ACEP and the state chapters helped defeat legislation in many states.

Without question, NPs and PAs are valuable members of the emergency care team and are used effectively in many physician-led care models. However, ACEP has always believed that emergency care should be led by emergency physicians. ACEP has never supported the independent practice by NPs or PAs. In 2018, ACEP created a small workgroup composed of several members of the ACEP Board of Directors to discuss issues around the emergency medicine workforce. From the discussions of that group, two task forces were created: the NP/PA Utilization Task Force (NPUTF) and the EM Physician Workforce Task Force (EMPWTF).

ACEP's policy statement "Freestanding Emergency Departments" reinforces that any FSED facility that presents itself as an ED should be staffed by appropriately qualified emergency physicians. Additionally, the policy states that "ACEP encourages all states to have regulations regarding FSEDs that are developed in close relationship with the ACEP chapter in that state."

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted. Directed ACEP to explore the feasibility of setting minimum accreditation standards for FEC's.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted. Directed ACEP to study the emergence and proliferation of free-standing EDs and facilities including: applicable federal and state regulatory and accreditation issues; the potential impact on the emergency medicine workforce; the potential fiscal impact on hospital-based EDs; and provide informational resources to the membership.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Substitute Resolution 51(84) Advertising and Public Education of Free Standing Facilities adopted. This resolution called for ACEP to encourage physicians to emphasize in advertising their positive attributes rather than denigrate the capabilities of other providers or facilities.

Substitute Resolution 30(84) Acute Ambulatory Care Facility as Generic Term adopted. That ACEP develop definitions of various types of ambulatory and emergency care facilities and that these definitions be included in future revisions of the Emergency Care Guidelines.

Substitute Resolution 40(79) Hospital and Freestanding Emergency Care Facilities adopted. Called for ACEP to set standards of care for facilities that present themselves to be sources of emergency care.

Prior Board Action

April 2019, discussed two options from the task force regarding accreditation of Freestanding Emergency Centers. Approved partnering with the Center of Improvement in Healthcare Quality, which has deeming authority with CMS, to provide accreditation services for FECs.

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

September 28, 2018, discussed the feasibility for ACEP to proceed with implementing an accreditation program for freestanding emergency centers. The Board directed the task force to explore models and develop a business plan.

May 2018, accepted the report of the Freestanding Emergency Centers Accreditation Task Force, which included accreditation standards, and requested additional information about The Joint Commission's accreditation of FECs.

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted.

November 2015, reviewed the information paper “Freestanding Emergency Departments and Urgent Care Centers.”

June 2014, approved the policy statement “Freestanding Emergency Departments.”

July 2013, reviewed the revised information paper “Freestanding Emergency Departments;” originally developed in August 2009.

June 2013, revised the policy statement “Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;” originally approved as “Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department” January 2007 by replacing two policy statements: "Guidelines on the Role of Physician Assistants in the Emergency Department” and “Guidelines on the Role of Nurse Practitioners in the Emergency Department.”

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted.

Substitute Resolution 51(84) Advertising and Public Education of Free Standing Facilities adopted.

Substitute Resolution 30(84) Acute Ambulatory Care Facility as Generic Term adopted.

Substitute Resolution 40(79) Freestanding Ambulatory Care Centers adopted.

Background Information Prepared by: Harry J. Monroe, Jr.
Director, Chapter & State Relations

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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RESOLUTION: 28(19)

SUBMITTED BY: Darrell Calderon, MD
Ricardo Martinez, MD, FACEP

SUBJECT: Expanding the Benefits of EMTALA to Ensure the Safety of the Public

PURPOSE: Promote to policymakers that EMTALA should be expanded to urgent care and primary care clinics and further modify the law so that if a patient is required to be sent to the ED, the urgent care and primary care clinic must call ahead to facilitate a transfer, document that the patient is safe for transfer, and facilitate safe transportation or direct admission.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

WHEREAS, Members of the public deserve ease of access and rapid evaluation for acute, unscheduled conditions regardless of their ability to pay; and

WHEREAS, Urgent care and primary care clinics consistently assert that they can evaluate and treat a large number of the patients that are currently seen in emergency departments and at lower costs; and

WHEREAS, Urgent and primary care clinics routinely limit evaluation and care for patients based on the patient's financial status, leaving many patients unevaluated and with potentially unsafe conditions; and

WHEREAS, These practices do not ensure that patients are evaluated in a timely manner by a Qualified Medical Provider (QMP) to confirm that an emergency medical condition (EMC) does not exist; and

WHEREAS, EMTALA was put in place to ensure that patients are at least evaluated by a Qualified Medical Provider to ensure that the patient does not have an EMC and if an EMC is present, the provider needs to take steps to ensure the patient is given proper care; and

WHEREAS, EMTALA was put in place to prevent patient dumping, but current practices of urgent care and primary care clinics serve to overload hospital emergency departments, and create conditions that can affect patient safety and quality of care, and financially overburden emergency departments, hospitals, and the providers who dedicate themselves to care for patients in these facilities; therefore be it

RESOLVED, That in the interest of public health and safety, ACEP promote to policymakers that the benefits of EMTALA should be expanded to urgent care and primary care clinics so that they may contribute to ensuring that the unscheduled care needs of the public are met, better coordinate care with emergency departments, and lower overall costs to the health systems by evaluating and treating those patients that can safely be cared for in their clinics; and be it further

RESOLVED, That ACEP promote the expansion of EMTALA to include that if a patient is required to be sent to the emergency department, the urgent care and primary care clinic must call ahead to facilitate a transfer, document that the patient is safe for transfer, and facilitate safe transportation or direct admission.

Background

This resolution calls for ACEP to promote to policymakers that EMTALA should be expanded to urgent care and primary care clinics and further modify the law so that if a patient is required to be sent to the ED, the urgent care and primary care clinic must call ahead to facilitate a transfer, document that the patient is safe for transfer, and facilitate safe transportation or direct admission.

In 1986, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (42 U.S.C. §1395dd) to ensure public access to emergency services regardless of insurance status or ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

An emergency medical condition is defined as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."

EMTALA applies when an individual "comes to the emergency department." A dedicated emergency department is defined as "licensed by the State . . . as an . . . emergency department" or "is held out to the public . . . as a place that provides care for emergency medical conditions." This means that hospital-based outpatient clinics are not obligated under EMTALA unless they provide more than one-third of care as unscheduled AND those 1/3 visits are emergency medical conditions as defined by the statute. EMTALA applies to all aspects of emergency care, including specialists, all available tests and procedures, and anything else necessary to determine or stabilize an emergency medical condition.

Hospitals have three main obligations under EMTALA:

1. Any individual who comes and requests examination or treatment of a medical condition must receive a medical screening examination to determine whether an emergency medical condition exists. This cannot be delayed to inquire about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to a medical screening examination and stabilizing treatment.
2. If an emergency medical condition exists, treatment must be provided until it is resolved or stabilized. If the hospital does not have the capability to stabilize the emergency medical condition, an "appropriate" transfer to another hospital must be done in accordance with the EMTALA provisions.
3. Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

Additionally, a hospital must report any time it has reason to believe it may have received an individual who has been transferred in an unstable condition in violation of EMTALA.

EMTALA governs how unstable patients are transferred from one hospital to another. Under the law, a patient is considered stable for transfer if the treating physician determines that no material deterioration is reasonably likely to occur during or as a result of the transfer between facilities. EMTALA does not apply to the transfer of stable patients; however, if the patient is unstable, then the hospital may not transfer the patient unless: A physician certifies the medical benefits expected from the transfer outweigh the risks OR a patient makes a transfer request in writing after being informed of the hospital's obligations under EMTALA and the risks of transfer.

In addition, the transfer of unstable patients must be "appropriate" under the law, such that (1) the transferring hospital must provide ongoing care within it capability until transfer to minimize transfer risks, (2) provide copies of medical records, (3) must confirm that the receiving facility has space and qualified personnel to treat the condition

and has agreed to accept the transfer, and (4) the transfer must be made with qualified personnel and appropriate medical equipment.

Both CMS (hospitals) and the OIG (hospitals and physicians) have enforcement powers regarding EMTALA violations. There is a two-year statute of limitations for civil enforcement of any violation. Penalties may include:

- Termination of the hospital or physician's Medicare provider agreement.
- Hospital fines up to $104,826 per violation.
- Physician fines up to $104,826 per violation, including on-call physicians.
- The hospital may be sued for personal injury in civil court under a "private cause of action"

A receiving facility, having suffered financial loss as a result of another hospital's violation of EMTALA, can bring suit to recover damages. An adverse outcome does not necessarily indicate there is an EMTALA violation; however, a violation can be cited even without an adverse outcome. There is no violation if a patient refuses examination and/or treatment unless there is evidence of coercion.

In recent years, some courts, such as a Rhode Island federal court in the case Friedrich et al v. South County Hospital, have determined that certain urgent care centers (UCCs) must abide by EMTALA regulations. Since EMTALA only applies to Medicare-participating hospitals, for this to be valid, regardless of any other factors, the UCC must be operated by a hospital and use the hospital's Medicare provider number. Furthermore, the UCC must meet the definition of a "dedicated emergency department," which means it meets at least one of three requirements:

1. It is licensed by the state in which it is located as an ED.
2. It is presented to the public as a provider of care for emergency medical conditions (without requiring previously scheduled appointment).
3. During the previous calendar year, it provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions.

ACEP's the policy statement "Freestanding Emergency Departments" states that "ACEP believes that all FSEDs must follow the intent of the EMTALA statute…"

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

Prior Council Action

The Council has discussed and adopted many resolutions regarding EMTALA. However, no resolutions have been adopted that specifically relate to extending EMTALA requirements to primary care and urgent care settings.

Prior Board Action

June 2014, approved the policy statement "Freestanding Emergency Departments."

November 2015, reviewed the information paper "Freestanding Emergency Departments and Urgent Care Centers."

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 29(19)

SUBMITTED BY: Sarah Hoper, MD, JD, FACEP
Lisa Maurer, MD, FACEP
Rachel Solnick, MD
American Association of Women Emergency Physicians Section

SUBJECT: Extending Medicaid Coverage to 12-Months Postpartum

PURPOSE: Support the extension of Medicaid coverage to 12 months postpartum and work with relevant stakeholders to support the extension of Medicaid to 12 months postpartum.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The United States is the only industrialized nation with a rising maternal mortality rate[1]; and

WHEREAS, State maternal mortality review committees report an estimated 60% of maternal deaths may be preventable. A growing number of deaths are linked to emergency department (ED) treatable conditions such as cardiovascular disease, cardiomyopathy, and overdose and suicide, with many of these deaths occurring during the postpartum period[2]; and

WHEREAS, Medicaid is the largest payer of maternity care, covering 42.6% of births[3]; and

WHEREAS, States that have expanded Medicaid experienced a 50% greater reduction in infant mortality than non-expansion states[4]; and

WHEREAS, Pregnancy-related Medicaid eligibility ends 60 days postpartum, and over half [5] of Medicaid beneficiaries experience a coverage gap[6] in the 6 months following childbirth; and

WHEREAS, The postpartum period is a time of unmet maternal health needs[7]; and

WHERAS, A study on a Medicaid population of mothers found high use of the ED (34.9%) with associated hospitalization (6.6%) within 6 months of delivery[8]; and

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[1] MacDorman MF, Declercq E, Cabral H, Morton C. Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. Obstet Gynecol. 2016;128(3):447-55.

[2] Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs.

[3] Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. Births: Final Data for 2016. National vital statistics reports; vol 67 no 1. Hyattsville, MD: National Center for Health Statistics. 2018. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf

[4] https://ccf.georgetown.edu/2019/05/09/medicaid-expansion-fills-gaps-in-maternal-health-coverage-leading-to-healthier-mothers-and-babies/

[5] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1241

[6] https://www.ncbi.nlm.nih.gov/pubmed/?term=daw+churn

[7] Spelke B and Werner E. The Fourth Trimester of Pregnancy: Committing to Maternal Health and Well-Being Postpartum. R I Med J (2013). 2018 Oct 1;101(8):30-33. v Tully KP, Stuebe AM, and Verbiest SB. The fourth trimester: a critical transition period with unmet maternal health needs. Am J Obstet Gynecol. 2017 Jul;217(1):37-41.

[8] https://www.ncbi.nlm.nih.gov/pubmed/28691865

WHEREAS, Postpartum women experience a significantly increased risk (OR 2.2, 95%CI 1.5- 3.1) of thrombotic events (ischemic stroke, acute myocardial infarction, or venous thromboembolism) up to 12 weeks after delivery (past the 60 days covered by Medicaid)[9]; and

WHEREAS, 13% of pregnancy related maternal deaths occur 42-365 days after delivery[10]; and

WHEREAS, The American College of Obstetricians and Gynecologists is recommending a 3 week and 12 week postpartum follow up appointment rather than a onetime 6 week appointment[11]; and

WHEREAS, Conditions associated with pregnancy such as pregnancy-induced hypertension, gestational diabetes, post-partum depression may drive ED use for these conditions if postpartum mothers lose Medicaid insurance coverage; and

WHEREAS, Legislation in several states, including Texas, Illinois, California, and New Jersey, was introduced in 2019 to extend Medicaid coverage to 12 months postpartum; and

WHEREAS, The American Medical Association adopted a similar resolution at their 2019 annual meeting; therefore be it

RESOLVED, That ACEP support the extension of Medicaid coverage to 12 months postpartum; and be it further

RESOLVED, That ACEP work with relevant stakeholders to support the extension of Medicaid coverage to 12 months postpartum.

Background

The resolution calls upon the College to support the extension of Medicaid coverage to 12 months postpartum and work with relevant stakeholders to support such an extension.

Generally, Medicaid is required to cover pregnant women for 60 days following childbirth. Depending on economic circumstances of the mother, many do not have health insurance coverage beyond that point. Many mothers and newborns require health care for critical health related issues during this first year, and the lack of health care coverage arguably results in delaying access to necessary care.

In June 2019, the American Medical Association House of Delegates adopted Resolution 221 supporting enactment of legislation to extend Medicaid coverage to 12 months postpartum.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective D – Promote quality and patient safety, including development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources.

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[9] https://www.nejm.org/doi/full/10.1056/nejmoa1311485
[10] Creanga AA, Syverson C, Seed K, Callaghan WM. Pregnancy-related mortality in the United State, 2011-2013. Obstet Gynecol. 2017;130(2):366-73.
[11] https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care?IsMobileSet=false

Prior Council Action

The Council has discussed and adopted many resolutions related to Medicare, but none specific to extending coverage to 12-months postpartum.

Prior Board Action

None.

Background Information Prepared by: Harry J. Monroe, Jr.
Director, Chapter and State Relations

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 30(19)

SUBMITTED BY:
David Callaway, MD, FACEP
Eric Goralnick, MD, MS, FACEP
Richard Kamin, MD, FACEP
Gina Piazza, DO, FACEP
E. Reed Smith, MD, FACEP
Matthew Sztajnkrycer, MD, FACEP
Government Services Chapter
Disaster Medicine Section
EMS-Prehospital Care Section
Tactical Medicine Section

SUBJECT: High Threat Emergency Casualty Care

PURPOSE: That ACEP set as a legislative priority the drafting of and lobbying for legislative language that will enable the development and funding of both National Transportation Safety Board-style "Go Teams" and a database into which gathered information would be entered for research purposes; and, support the development processes of both a National Transportation Safety Board-style "Go Teams" and a database of gathered information for research purposes

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, High threat incidents, including mass shootings, mass stabbings, vehicle-borne attacks, bombings, and other acts of terror, continue to plague our nation and the world; and

WHEREAS, These events cause significant psychosocial, political, and economic impacts on our society and additional physical impacts on involved individual victims and represent disruptions of the public's health, safety, and security; and

WHEREAS, These types of events involve a high-threat incident response that is unique from day-to-day prehospital care and is inherently complex, involving multiple disciplines, acting under extreme stress; and

WHEREAS, Perpetrators have shown the ability to learn our response tactics and to evolve their threats to achieve maximal harm, and we have been continually challenged to make concomitant data-driven improvements in mitigation, preparedness, response, and recovery efforts due to the lack of a standardized, rapid, rigorous data-gathering mechanism and the lack of a data repository; and

WHEREAS, We must create a reliable mechanism(s) to allow us to study the injured and how we prepare for, respond to, and recover from high threat mass casualty incidents to inform and improve our health system and emergency services response from injury prevention throughout the chain of survival; and

WHEREAS, The Department of Defense has made great strides in reducing preventable battlefield deaths through their learning healthcare system and the process of focused empiricism "using the best data available in combination with experience to develop clinical practice guidelines that, through an iterative process, continue to be refined until high-quality data can be generated to further inform clinical practice and standards of care," a model which the National Academy of Sciences, Engineering, and Medicine has recommended be adopted as a best practice in creating a National Trauma Care System; and

WHEREAS, Preliminary work done in the U.S. and internationally by teams like the National Transportation Safety Board's (NTSB) "Go Teams" demonstrates that this nascent best practice is poised to enable improved and more rapid learning from these incidents, along with improved dissemination of lessons-learned; and

WHEREAS, ACEP's EMS Subcommittee on High Threat Emergency Casualty Care and the Disaster Preparedness & Response Committee recommend developing rapidly deployable, multidisciplinary teams of subject

matter experts, with the authority and ability to gather discipline and casualty-specific qualitative and quantitative data in furtherance of developing best practice guidelines based on the "Go-Team" model; and

WHEREAS, The subcommittee also recommends the establishment of a database to house gathered data to facilitate research and to enable rapid dissemination of lessons learned in a secure manner; and

WHEREAS, Both recommendations will require legislation and public-private partnerships; therefore be it

RESOLVED, That ACEP set as a legislative priority the drafting of and lobbying for legislative language that will enable the development and funding of both National Transportation Safety Board-style "Go Teams" and a database into which gathered information would be entered for research purposes; and be it further

RESOLVED, That ACEP support the development processes of both a National Transportation Safety Board-style "Go Teams" and a database of gathered information for research purposes.

Background

The resolution directs ACEP to set as a legislative priority the drafting of and lobbying for legislative language to enable the development and funding of both National Transportation Safety Board-style (NTSB) "Go Teams" and a database into which gathered information would be entered for research purposes. It further directs ACEP to support the development processes of both NTSB-style "Go Teams" and a database of gathered information for such purposes.

Several existing ACEP policies align with the purpose of this resolution. ACEP's policy statement, "Support for National Disaster Medical System and Other Response Teams," states "that every community needs a comprehensive plan for immediate emergency medical care in case its medical care system is overwhelmed or rendered ineffective in a disaster. As a component of this plan, ACEP supports the National Disaster Medical System (NDMS) and encourages further development and funding of the program. ACEP also supports its members who participate in the Disaster Medical Assistance Teams (DMAT), Urban Search and Rescue (USAR teams), or other federal or state-sponsored medical teams. ACEP encourages entities such as health care facilities/systems and EMS services and employers such as medical practice groups to allow, encourage, and support their employees to participate."

ACEP's policy statement, "Disaster Data Collection" also calls for the development of "real-time syndromic surveillance to capture a majority of clinical illnesses and injury patterns on a mass scale…ACEP further supports prospective and retrospective disaster data collection and research which is critical for future disaster preparedness and response."

Additionally, while specific to firearms-related injuries, ACEP's "Firearms Safety and Injury Prevention" policy statement calls for the creation of a confidential national firearm injury research registry while encouraging states to establish a uniform approach to tracking and recording firearm related injuries.

ACEP has also successfully advocated for legislation to help improve mass casualty response and other disaster response efforts, including the Pandemic and All-Hazards Preparedness and Advancing Information Act (PAHPAI) of 2018. PAHPAI also included ACEP-supported legislation, the Military Injury Surgical Systems Integrated Operationally Nationwide to Achieve ZERO Preventable Deaths Act, better abbreviated as the MISSION ZERO Act. Specifically, the MISSION ZERO Act authorizes the Assistant Secretary for Preparedness and Response (ASPR) to award grants that would enable military trauma care providers and trauma teams to provide trauma care and related acute care at civilian trauma centers. This training has the dual benefit of maintaining military surgical battle readiness between wars while at the same time improving civilian access to trauma care.

PAHPAI also authorized the Regional Health Care Emergency Preparedness and Response System. This program, developed by the Assistant Secretary for Preparedness and Response (ASPR) with input from the Trauma Coalition (a broad group of organizations representing the nation's frontline trauma care providers), will improve emergency response by creating regional systems of trauma centers, hospitals, and other public and private entities. Finally, the legislation also included increased funding for the Hospital Preparedness Program (HPP), which supports regional

collaboration by encouraging the development of health care coalitions. The HPP provides funding through cooperative agreements and grants to states, territories, and eligible municipalities to improve the capacity of the health care system to plan for and respond to medical surge events. HPP, the only source of federal funding for health care delivery system readiness, is intended to improve patient outcomes, minimize the need for supplemental emergency funding, and enable rapid recovery. By reauthorizing and the Hospital Preparedness Program with additional funding, Congress has improved the U.S. health care system's ability to save lives during emergencies and disaster events.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 20(13) Disaster Research adopted. Directed ACEP to work with other organizations to develop guidelines for evaluation of new or ongoing projects for disaster preparedness, response, and effectiveness of interventions and outcomes research to identify areas to focus funding. Additionally, work other organizations to increase disaster research funding until guidelines on appropriate funding for research on disaster preparedness, response, and effectiveness of interventions are established.

Prior Board Action

June 2019, approved the revised policy statement, "Support for National Disaster Medical System and Other Response Teams;" revised and approved June 2013 with the current title; revised and approved October 2006; originally approved March 1999 replacing two resolutions that were adopted in 1991 and 1985.

June 2016, approved the revised policy statement, "Disaster Data Collection;" revised and approved August 2007; originally approved October 2000.

Amended Resolution 20(13) Disaster Research adopted.

April 2013, approved the revised policy statement, "Firearm Safety and Injury Prevention;" replacing the "Firearm Injury Prevention" policy statement that was revised and approved in October 2012 and January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 31(19)

SUBMITTED BY: Missouri College of Emergency Physicians
New Jersey Chapter
Ohio ACEP

SUBJECT: Improving Emergency Physicians Utilization of Medication for Addiction Treatment

PURPOSE: Work with DEA and SAMHSA to minimize regulatory barriers for emergency physicians to enact meaningful OUD therapies, establish ED-specific OUD training, and advocate for the elimination of the X-waiver to initiate Medication Assisted Treatment from the ED.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP position to federal Executive and Legislative branch officials.

WHEREAS, The Emergency Department is the primary initial contact point for many individuals who are facing the health consequences of the opioid epidemic; and

WHEREAS, Many individuals present to the Emergency Department seeking some sort of formal assistance with breaking the cycle of addiction; and

WHEREAS, Medication Assisted Treatment has most recently demonstrated considerable benefit for the treatment of opioid addiction and prevention of the medical complications that might arise from continued opioid abuse; and

WHEREAS, Current ability to initiate Medication Assisted Treatment requires 8 hours of learning for qualified healthcare personnel to apply for the Drug Enforcement Agency (DEA) Waiver as mandated federally with oversight by Substance Abuse and Mental Health Services Administration (SAMHSA), directed under the Drug Addiction Treatment Act of 2000 (DATA 2000); and[2]

WHEREAS, ACEP has previously submitted positions opposing medical merit badges; and

WHEREAS, The American College of Medical Toxicology's position statement, endorsed by the American Academy of Clinical Toxicology, the American Academy of Emergency Medicine, and the American College of Emergency Physicians strongly recommend removing the waiver ("X-waiver") requirement for buprenorphine[3]; therefore be it

RESOLVED, That ACEP work directly with the Drug Enforcement Administration and the Substance Abuse and Mental Health Services Administration to minimize barriers for emergency physicians to enact meaningful therapy for patients in a time of opioid crisis in the unique environment in which we work; and be it further

RESOLVED, That ACEP advocate to the Drug Enforcement Administration and the Substance Abuse and Mental Health Services Administration for emergency department specific requirements and curriculum so as to reach the greatest number of patients safely and without onerous barriers; and be it further

RESOLVED, That ACEP advocate for our physicians in emergency department settings who are uniquely trained by our environment to recognize and respond to the complications of opioid addiction and furthermore that ACEP continue to advocate for patients seeking treatment for opioid addiction and/or dependence through the

elimination of X-waiver requirements for emergency physicians for treatment that is initiated from an emergency department setting.

References

1. Herring A et al. "Managing Opioid Withdrawal in the Emergency Department With Buprenorphine." *Annals of Emergency Medicine,* 73 (5). 481-7. 4 January 2019.
2. "Buprenorphine Waiver Management." *Substance Abuse and Mental Health Services Administration.* 16 July 2019. https://www.samhsa.gov/medication-assisted-treatment/training -material-resources/buprenorphine-waiver
3. "Coalition to Oppose Medical Merit Badges." American College of Emergency Physicians. 30 March 2017.

Background

This resolution calls for ACEP to work with the DEA and SAMHSA to minimize regulatory barriers for emergency physicians to enact meaningful OUD therapies, establish ED-specific OUD training, and advocate for the elimination of the X-waiver to initiate Medication Assisted Treatment from the ED.

Resolution 23(19) Allow Emergency Physicians to Prescribe Buprenorphine also requests ACEP to advocate for the removal of the X-waiver. The content of the background information is the same for both resolutions.

The immense scope of opioid use disorder and its associated public health impacts have become increasingly evident across all fields of medicine. The size of the crisis prompted the Department of Health and Human Services to declare the opioid crisis a public health emergency in October of 2017. Yet, despite the wide-ranging nature of this issue, nowhere are its impacts clearer than in the Emergency Department (ED). According to the National Survey on Drug Use and Health, in 2015 approximately 3.8 million people misused pain medications and 329,000 people used heroin. An estimated 135,000 of those people tried heroin for the first time during that year. Despite the scale of opioid misuse in this country, the consequences of that misuse are even more profound. Since 2001 there has been a 200% increase in the rate of death from opioids. In 2016 alone nearly two thirds (66.4%) of all drug overdose deaths involved prescription opioids, illicit opioids, or both, an increase of 27.7% from 2015. Put simply, opioid use disorder is widespread, and its associated mortality is getting worse.

Given the impact of opioid use disorder on ED patients, emergency medicine providers are taking the lead on addressing this crisis. Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. However, ED physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from opioid use disorder.

Medication for opioid use disorder refers to any addiction treatment that includes pharmacologic therapy. In the context of opioid use disorder this includes medications that act as opioid agonists, partial agonists, or antagonists. Popular examples are methadone, buprenorphine, and naltrexone. There is a growing body of literature showing that Medication Assisted Treatment (MAT) for opioid use disorder improves patient outcomes. Data suggest that patients receiving medication for opioid use disorder have decreased fatal overdose compared to with those who receive counseling alone. Additionally, patients maintained on buprenorphine for at least a year are noted to have less ED visits and inpatient hospital stays.

Yale University recently published a randomized controlled study evaluating the viability and efficacy of ED initiated buprenorphine. They determined that not only was it safe to administer buprenorphine to ED patients, but it also improved patient outcomes. Specifically, they found that compared to brief behavioral counseling or usual care, ED patients receiving buprenorphine where significantly more likely to be engaged in addiction treatment 2 months after their ED visit.

Despite the promise of this therapy they are currently significant barriers to ED administration of medication for opioid use disorder. The Drug Addiction Treatment Act of 2000 (DATA 2000) created a special licensing process for prescribing opioid-based addiction treatment. This special license, colloquially referred to as the X -Waiver, requires

physicians to complete an 8-hour training course before they can legally prescribe. This training includes information on identifying appropriate patients for buprenorphine treatment and how to best use this medications within addiction treatment programs. However, the training is not specifically designed with ED providers in mind. Furthermore, the 8-hour training provides a significant barrier for the widespread adoption of medication assisted therapy.

ACEP's policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department" supports all patients being treated appropriately for acute pain with prompt, safe, and effective pain management. The policy statement acknowledges that acute pain management is patient-specific and provides guidance on pharmacological and non-pharmacological pain interventions. This is a joint statement by ACEP, the American Academy of Emergency Nurse Practitioners, and the Emergency Nurses Association. ED physicians will continue to be on front lines of this public health emergency as the nation struggles with opioid use disorder. Given the scale of this problem it is incumbent upon us to use the best treatment available for our patients. While there are many potential solutions to this issue, medication for opioid use disorder is a promising tool, and is the only evidence-based treatment available for the treatment of opioid use disorder. It has proven to be both an effective and safe treatment for ED patients suffering from opioid addiction.

Most recently, ACEP met with the head of Substance Abuse and Mental Health Services Administration (SAMHSA), Assistant Secretary for Mental Health and Substance Use Dr. Elinore McCance-Katz, on May 15, 2019. During our meeting with Dr. McCance-Katz, we discussed issues that are extremely important to emergency physicians and our patients, including the ability to administer buprenorphine in the ED for patients with opioid use disorder and how to improve care for patients with mental health illnesses. ACEP mentioned the resources and tools that we have created to help our physicians and patients, highlighting the EM-specific DATA 2000/Medications for Addiction Treatment waiver training course that is now being offered to our members, as well as new web-based and mobile device applications around opioids and the management and treatment of suicidal patients. One of SAMHSA's major goals is to boost the community resources that are available to help clinicians across specialties treat patients with substance abuse disorders and mental illnesses. We expressed our commitment to helping SAMHSA achieve the goal and identified opportunities to work together going forward.

On July 16, 2019, ACEP member Dr. Eric Ketcham participated in a panel discussion sponsored by Pew Charitable Trusts focused on how to reduce barriers that impede the ability for providers to treat patients with Substance Use Disorder (SUD). Dr. Ketcham emphasized the need to remove the X-waiver training requirement. Dr. Ketcham also discussed the importance of initiating buprenorphine in the ED, and how the X-waiver requirement creates an unnecessary barrier that impedes access to this potentially life-saving medication. Finally, he and other panelists talked about other treatment barriers to SUD, including stigma and misperception, outpatient access issues, and insurance prior-authorization, and how policy makers can best address these impediments.

On July 16, 2019, ACEP member Dr. Eric Ketcham participated in a panel discussion sponsored by Pew Charitable Trusts focused on how to reduce barriers that impede the ability for providers to treat patients with Substance Use Disorder (SUD). Dr. Ketcham emphasized the need to remove the X-waiver training requirement. Dr. Ketcham also discussed the importance of initiating buprenorphine in the ED, and how the X-waiver requirement creates an unnecessary barrier that impedes access to this potentially life-saving medication. Finally, he and other panelists talked about other treatment barriers to SUD, including stigma and misperception, outpatient access issues, and insurance prior-authorization, and how policy makers can best address these impediments. Representative Paul Tonko (D-NY) also was present and kicked off the panel discussion. Representative Tonko is the sponsor of the ACEP-supported H.R. 2482, the "Mainstreaming Addiction Treatment Act," which would remove the X-waiver requirement as well as address other barriers to SUD treatment. ACEP also supports the Senate companion bill, S. 2074, sponsored by Senators Maggie Hassan (D-NH) and Lisa Murkowski (R-AK).

After the panel discussion, Dr. Ketcham and the other panelists met with Admiral Brett Giroir, the Assistant Secretary for Health at the U.S. Department of Health and Human Services (HHS). Adm. Giroir's office is looking into possibly reforming the restrictive "three-day" rule for administering buprenorphine. This rule allows non-waivered providers to administer (but not prescribe) buprenorphine to patients for a three-day period. However, the rule forces providers to administer buprenorphine one-day at a time, requiring patients to come back to the ED or other settings each day to

receive treatment. ACEP has long advocated for eliminating this unnecessary hurdle and allowing providers to provide the patient with three-days' worth of treatment during one session. We have previously met with Admiral Giroir and others at HHS to discuss this issue and are encouraged that the Department is considering a policy change.

On August 29, 2019, ACEP responded to an HHS request for information on ensuring appropriate access to opioid treatments. In the response, HHS is urged to do what is in their authority to reduce barriers to the treatment of patients with OUD. ACEP also issued a press release highlighting the major points contained in the letter.

In addition to advocating for Congress to remove the X-waiver and pushing for regulatory changes to the "three-day rule," ACEP also:

- Offers an emergency-medicine specific X-waiver training course (including one being held during *ACEP19* in Denver);
- Provides clinical tools for emergency physicians to improve decision making and clinical practices; and
- Operates the EQUAL Network Opioid Initiative, which engages emergency clinicians and leverages emergency departments to improve clinical outcomes.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP position to federal Executive and Legislative branch officials.

Prior Council Action

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The

resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Prior Board Action

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

February 2018, revised and approved the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012.

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.

June 2012, approved the Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 32(19)

SUBMITTED BY: Kyle Fischer, MD, FACEP
Maryland Chapter

SUBJECT: Legal and Civil Penalties for the Routine Practice of Medicine

PURPOSE: Oppose state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The routine practice of medicine encompasses nearly all aspects of human life; and

WHEREAS, The doctor-patient relationship frequently addresses complex and difficult medical and social situations; and

WHEREAS, Physicians are often required to address sensitive and controversial subjects with our patients; and

WHEREAS, Physician autonomy is frequently constricted by state and federal legislatures and regulators; and

WHEREAS, One state outlawed doctors' communication with patients regarding firearms (prior to the law being found unconstitutional); and

WHEREAS, Several states created legal penalties for physicians performing abortions; and

WHEREAS, Although physician assisted suicide has been legalized in many states, under most state laws helping someone commit suicide remains a felony; therefore be it

RESOLVED, That ACEP oppose any and all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

Background

This resolution calls for ACEP to oppose all state or federal legislation and/or regulation that creates criminal or civil penalties for the practice of medicine deemed to be within the scope of practice for a physician's representative specialty.

Physicians increasingly find themselves caught in the crossfire of highly divisive social issues like abortion, physician-assisted suicide, and gun control. In some cases, lawmakers not only dictate what physicians can and cannot do and say with their patients regarding these issues, but they are also imposing harsh penalties on physicians who do not comply.

Several states passed laws this year significantly restricting abortions. Most notably, the new Alabama law specifically makes it a felony for physicians to perform any abortion unless the mother's life is in jeopardy, punishable by up to 99 years in prison. The U.S. Senate considered a measure this year that would have punished

physicians who do not perform life-saving measures to save any infant born alive during an abortion. Failure to render the same degree of care provided during any birth could have resulted in fines and up to five years in prison. Participating in ending the life of a child born alive during an abortion could have brought federal murder charges. The bill failed to pass the Senate, after falling seven votes short of the 60 votes needed to prevent a filibuster. However, 26 states have enacted similar laws requiring physicians to provide medical care and treatment to born-alive infants at any stage of development. Texas passed such a law in June 2019, with physicians who fail to provide that level of treatment facing fines of at least $100,000 and third-degree felony charges that could lead to a prison term of two to ten years.

In 2011, Florida passed a law that prohibited doctors from asking patients about gun ownership unless it was medically necessary or from putting information about gun ownership in a patient's record. The law carried penalties for physicians of up to a $10,000 fine and discipline from the state medical board. The constitutionality of the law was challenged in court, and in 2017, the U.S. Court of Appeals overturned the law, saying it violated physicians' rights to equal protection and free speech.

In 2019, two more states passed laws legalizing physician-assisted suicide. New Jersey and Maine became the eighth and ninth states, respectively (along with the District of Columbia) to legalize the practice. Physicians cannot be prosecuted in these states for prescribing medications to hasten death, within certain parameters. In the vast majority of other states, however, physicians are under the same law as anyone else who assists someone in taking their own life and are subject to a felony prosecution.

ACEP does not have policy addressing laws that criminalize specific physician actions in such cases, but the College has addressed other examples of government interceding to restrict physician autonomy in determining what is best for their patients.

In response to state governments imposing limits on the amount of pain medication that can be prescribed to patients, the Council and the Board of Directors adopted Amended Resolution 17(12) Ensuring Patient Access to Pain Treatment, which directed, in part, that ACEP "work with government and regulatory bodies on the creation of evidence-supported guidelines for responsible emergency physician prescribing that takes into consideration lack of access while respecting the uniqueness of every individual doctor-patient encounter." Additionally, the resolution directed added that "ACEP oppose non-evidence based public or private limits on prescribing opiates, mandatory opioid-related documentation, and mandatory opioid-related CME."

ACEP's policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment" addresses physician autonomy by stating, in part, that ACEP:

- supports ACEP chapters having the autonomy to establish and coordinate evidence-based pain management guidelines that promote access to appropriate pain control within physician clinical judgment;
- supports limiting the initial prescription of an opioid to no more than a 7-day supply, unless in the judgment of the treating physician a longer duration is indicated and rationale is documented;

In 2016, the Council and the Board of Directors adopted Amended Resolution 18 Opposition to CMS Mandating Treatment Expectations that directed ACEP to work with CMS regarding mandated reporting standards that may result in harm to patients without the recognition of evidence-based care of individual patients, and that ACEP actively communicate to members and hospitals the dangers that quality indicators could present harm to potential patients, and the importance of physician autonomy in treatment.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 18(16) Opposition to CMS Mandatory Treatment Expectations adopted. The amended resolution directed ACEP to work with CMS regarding mandated reporting standards that may result in harm to patients without the recognition of evidence-based care of individual patients and that ACEP actively communicate to members and hospitals the dangers that quality indicators could present harm to potential patients, and the importance of physician autonomy in treatment.

Amended Resolution 17(12) Ensuring Patient Access to Pain Treatment adopted. Directed ACEP to work with government and regulatory bodies on the creation of evidence-supported guidelines for responsible emergency physician prescribing that takes into consideration lack of access while respecting the uniqueness of every individual doctor-patient encounter. It also directed that ACEP oppose non-evidence based public or private limits on prescribing opiates, mandatory opioid-related documentation, and mandatory opioid-related CME.

Prior Board Action

February 2018, approved the revised policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012 as "Ensuring Emergency Department Patient Access to Adequate and Appropriate Pain Treatment."

October 2016, Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted.

October 2012, Amended Resolution 17(12) Ensuring Patient Access to Pain Treatment adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 33(19)

SUBMITTED BY: Bret Frey, MD, FACEP
Nevada Chapter

SUBJECT: National Medical Tort Reform as a "CMS Best Practice"

PURPOSE: Work with CMS and other stakeholders to adopt and promulgate tort "best practices" for submission to Congress with a request for action and adopt principles that preserves CMS' budget viability and patients' legal rights.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

WHEREAS, The defensive practice of medicine in the U.S. is estimated at approximately $55 billion – $200 billion; and

WHEREAS, Medical liability direct and indirect costs are an additional estimated $50 billion annually; and

WHEREAS, Medical tort in the United States is adversarial, inefficient, and drives "cost without benefit;" and

WHEREAS, Medical cost control has become a centerpiece of numerous discussions on national healthcare value; and

WHEREAS, Adoption of CMS "best practices," following specialty specific "consensus guidelines" and adherence to "standards of care" have not conferred reliable liability protection; and

WHEREAS, ACEP's policy statement, "Reform of Tort Law," (originally adopted as Resolution 27(85), reaffirmed in 1998, revised in August 2009 and April 2011, and reaffirmed in April 2017) outlines the basics of medical tort reform essential to cost control, including but not limited to, a ceiling on non-economic damages, same-specialty expert witness standard, adoption of health courts, adoption of apology law protections, and safe harbors when adhering to "best practice" guidelines; and

WHEREAS, Medical tort reform is essential to the preservation and long-term viability of Medicare and Medicaid; therefore be it

RESOLVED, That ACEP work directly with CMS and other willing stakeholders to assist in the adoption and promulgation of tort "best practices" for submission to Congress with a request for action; and be it further

RESOLVED, That ACEP adopt principles of national medical tort reform that simultaneously preserves CMS budget viability and essential legal rights of patients.

Background

This resolution calls for ACEP to work with CMS and other stakeholders to adopt and promulgate tort "best practices" for submission to Congress with a request for action and adopt principles that preserves CMS' budget viability and patients' legal rights.

The Centers for Medicare & Medicaid Services (CMS) does not provide recommendations to Congress unless compelled to do so by a specific piece of legislation. Typically, CMS interacts with Congress by providing technical assistance on potential legislation. However, there is a history of legislation being introduced in Congress that would provide medical liability "safe harbor" protections when physicians follow established clinical practice guidelines.

The ACEP-supported legislative proposal, the "Saving Lives, Saving Costs Act," was introduced in the 113th, 114th, and 115th Congresses by Representative Andy Barr (R-KY) in the House and John Barrasso (R-WY) in the Senate. This bill establishes a framework for health care liability lawsuits to undergo review by independent medical review panels when health care professionals (practicing physicians or their agents or employees), providers, or organizations adhere to clinical practice guidelines. The Department of Health and Human Services (HHS) must publish these clinical practice guidelines provided and maintained by national or state medical societies or medical specialty societies designated by HHS. HHS must ensure that guidelines are developed in accordance with certain standards, including standards related to transparency, the composition of the panel, and the review of existing evidence. Professional organizations and participants in guideline development may not be held liable for injury allegedly caused by adherence to a guideline to which they contributed.

The legislative proposals have not advanced beyond introduction in their respective chambers, but their prospects for passing in the current political environment are unlikely.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective G – Pursue meaningful medical liability reform and other initiatives at the state and federal levels.

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative branch officials.

Prior Council Action

Resolution 31(04) Medical Liability Reform – Total Caps not adopted. Directed ACEP to support efforts to attain federal tort reform and support caps on economic and non-economic damages.

Resolution 27(01) Federal Tort Reform not adopted. Directed ACEP to support efforts to attain federal tort reform.

Amended Resolution 13(01) Emerging Professional Liability Crisis adopted. Directed ACEP to study causes and scope of professional liability crisis in emergency medicine and develop short- and long-term resolutions, including tort reform.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted. The resolution directed ACEP to take the position that meaningful medical malpractice reform be an essential component of any health care reform measures and directed ACEP's lobbyist to further that position with Congress and via its key contact system.

Amended Resolution 27(87) State Liability and Tort Reform adopted. Directed ACEP to encourage chapters to take an active role in their state medical societies'' liability reform efforts and to act independently where appropriate.

Amended Resolution 42(85) Malpractice Coverage Information adopted. The resolution called for ACEP to urge the membership, through national and state publications, to obtain documentation and information regarding their individual medical liability insurance.

Amended Resolution 27(85) Malpractice Premiums and Tort Legal Reforms adopted. ACEP was directed to cooperate closely with other medical organization in creating strong support for legal tort reforms.

Prior Board Action

April 2017, approved revised policy statement "Reform of Tort Law;" revised and approved April 2011 and August 2009; reaffirmed October 1998; originally approved September 1985.

Amended Resolution 22(14) EMTALA-Related Liability Reform adopted.

Amended Resolution 13(01) Emerging Professional Liability Crisis adopted.

Amended Resolution 70(94) Malpractice Reform as an Essential Element of Health Care Reform adopted.

Amended Resolution 27(87) State Liability and Tort Reform adopted.

Background Information Prepared by: Brad Gruehn
Congressional Affairs Director

Jeffrey Davis
Regulatory Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 34(19)

SUBMITTED BY: Illinois College of Emergency Physicians
Missouri College of Emergency Physicians
Pennsylvania College of Emergency Physicians
West Virginia Chapter

SUBJECT: Opposing Naloxone Addition to the Prescription Drug Monitoring Program

PURPOSE: Oppose legislation to add naloxone administration to the Prescription Drug Monitoring Program and work with chapters to develop strategies and supporting materials to stop such legislation.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The epidemic of opioid use disorders is a crisis in the United States that daily affects patients presenting to the emergency department; and

WHEREAS, Emergency physicians are leaders in addressing the opioid epidemic by advocating for effective solutions and opposing initiatives that have adverse unintended consequences; and

WHEREAS, Naloxone is a commonly used medication in both the pre-hospital setting and the emergency department to reverse the effects of opioids; and

WHEREAS, The therapeutic use of naloxone to address the effects of opioids extends beyond the resuscitation of patients with unintentional overdose of illicit drugs; and

WHEREAS, Co-prescription of naloxone with opioids is considered a best-practice, but not commonly done despite CDC recommendations; and

WHEREAS, State legislatures, including in Pennsylvania, are considering legislation to add naloxone administration to Prescription Drug Monitoring Program (PDMP) databases; and

WHEREAS, Such legislation to add naloxone administration to the PDMP will have the adverse unintended consequences of labeling patients as addicts based on incomplete or incorrect understanding of the circumstances under which they received naloxone and potentially discourage co-prescription of naloxone; and

WHEREAS, Leaving the decision of whether to report naloxone administration to the PDMP based on emergency physician judgement of the circumstance involved would inevitably lead to the application of biases and prejudices in patient assessments; and

WHEREAS, Widespread dissemination of naloxone has been shown to save lives in the opioid epidemic and should be encouraged; therefore be it

RESOLVED, That ACEP oppose legislation to add naloxone administration to the Prescription Drug Monitoring Program and work with chapters in developing strategies and supporting materials to stop such legislation.

References:

1. Follman et. al., "Naloxone Prescriptions Among Commercially Insured Individuals at High Risk of Opioid Overdose," JAMA Network Open, Volume, 2, Number 5, May 3, 2019:e193209

2. Abouk et. al., "Association Between State Laws Facilitating Pharmacy Distribution of Naloxone and Risk of Fatal Overdose," JAMA Internal Medicine, Published online May 6, 2019. doi:10.1001/jamainternmed.2019.0272

Background

The resolution asks ACEP to oppose legislative efforts to add the administration of naloxone to a Prescription Drug Monitoring Program (PDMP) and to work with chapters in developing strategies and supporting materials to stop such legislation.

Increased access to naloxone has proven to be an integral component in addressing the nation's opioid epidemic. According to CDC estimates, naloxone reversed more than 10,000 opioid overdoses between 1996-2010. The CDC also notes that the number of naloxone prescriptions dispensed doubled from 2017 to 2018.

As the resolution notes, there have been some initiatives at the state level to require naloxone administration to be reported to a respective PDMP. In some states, naloxone dispensation and administration are reported in different manners. Arizona, for example, requires pharmacists to report naloxone doses *dispensed* to the PDMP, but requires EMS and law enforcement to report naloxone doses *administered* to a separate database, the Arizona Prehospital Information and EMS Registry System, or AZ-PIERS. Such a policy is consistent with the joint ACEP/NAEMSP/ACMT policy statement, "Naloxone Access and Utilization for Suspected Opioid Overdoses," which states: "Programs should be developed to track and report distribution and usage of naloxone both by public safety/EMS personnel and bystander/public access individuals."

In Pennsylvania, legislation has been introduced to require naloxone administration to be reported in the state's PDMP, and further, would require reporting of the suspected/confirmed drug involved in the overdose to be reported within 72 hours of the initial reporting of the event. Proponents suggest that identifying controlled substance overdose events will help address the opioid epidemic, as they can inform a treatment plan and give a provider additional information that would otherwise not be available.

Others are concerned that mandatory reporting of naloxone administration to a PDMP would have an adverse effect on care because of potential stigma or bias, such as a patient being pre-judged as an "addict" if naloxone administration appears in their PDMP record without any context as to why naloxone may have been administered. For example, such a proposal could be overly broad and capture overdoses unrelated to the intent of addressing the opioid epidemic, such as accidental or mistaken ingestion of other medications, or could reduce the use or co-prescribing of naloxone to avoid stigma. Additionally, there are concerns that requirements like those in the Pennsylvania example would be burdensome on emergency physicians and EMS teams, as they would be required to provide information, such as a patient's identity or medical details (e.g., toxicology reports), that are often unavailable during the time that emergency care is being delivered.

Per ACEP's policy statement, "Electronic Prescription Drug Monitoring Programs," ACEP "…supports the use of electronic prescription drug monitoring programs (PDMP)…" but that use of these systems should be voluntary.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

The Council has discussed and adopted many resolutions related to PDMPs and Naloxone, but none specific to opposing legislation to add Naloxone administration to the PDMP.

Prior Board Action

January 2017, appoved the revised policy statement, "Electronic Prescription Drug Monitoring Programs;" originally approved October 2001 titled "Electronic Prescription Monitoring."

June 2016, approved the policy statement, "Naloxone Access and Utilization for Suspected Opioid Overdoses." This is a joint policy statement with the National Association of EMS Physicians (NAEMSP) and the American College of Medical Toxicology (ACMT)

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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RESOLUTION: 35(19)

SUBMITTED BY: Georgia College of Emergency Physicians
Missouri College of Emergency Physicians
Ohio Chapter

SUBJECT: Prudent Layperson Visit Downcoding

PURPOSE: Directs ACEP to develop and enact strategies, including legislative solutions, at the federal level to prevent negative clinical or financial impact caused by the lack of reimbursement for emergency medical services by third-party payers. Also calls for ACEP to create meaningful disincentives for third-party payers that disregard the Prudent Layperson Standard to ensure access to and subsequent reimbursement for emergency medical care regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care.

FISCAL IMPACT: Budgeted staff resources and potential unbudgeted costs for outside consultants and lobbyists to implement the advocacy agenda.

WHEREAS, The Prudent Layperson Standard guarantees patients the right to receive treatment in the emergency department if they feel they have a medical emergency; and

WHEREAS, Emergency providers have an unfunded mandate to provide a medical screening exam and evaluate for an emergency condition under the Emergency Medical and Labor Act (EMTALA); and

WHEREAS, Determining whether an emergent condition exists and stabilizing it as required by EMTALA requires a thorough evaluation that may include multiple diagnostics and treatment modalities; and

WHEREAS, The presenting, or chief complaint, is inadequate to determine if a patient has a medical emergency and does not consistently correlate with a non-emergent final diagnosis; and

WHEREAS, according to the Federal Register Final Rule, 2016, the final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis; and

WHEREAS, The Prudent Layperson Standard requires health insurance companies to cover a patient's emergency department (ED) evaluation based on the patient's symptoms and not their final diagnosis; and

WHEREAS, Insurance companies are arbitrarily downcoding ED charts based on a final diagnosis without reviewing the medical record or presenting symptoms or chief complaint; and

WHEREAS, Insurance companies are using both arbitrary diagnosis lists and tools developed for non-billing and coding purposes to downcode ED charts; therefore be it

RESOLVED, That ACEP develop and enact strategies (including legislative solutions) to prevent insurance companies from arbitrarily downcoding charts; and be it further

RESOLVED, That ACEP work to develop and enact policy at the federal level that prevents insurance companies from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Background

This resolution directs ACEP to develop and enact strategies, including legislative solutions, at the federal level to prevent any negative clinical or financial impact caused by the lack of reimbursement for emergency medical services by third-party payers. It also calls for ACEP to create meaningful disincentives for third-party payers that disregard the Prudent Layperson Standard (PLP) to ensure access to and subsequent reimbursement for emergency medical care regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care.

History of Prudent Layperson Federal and State Laws

The first PLP law was enacted in the state of Maryland in 1993. Three years later, the National Association of Insurance Commissioners (NAIC) drafted the Managed Care Provider Network Adequacy and Contracting Model Act (Model Act) which included the PLP standard. This step recognized the need to require the provision of coverage for emergency services based upon presenting symptoms rather than the ultimate diagnosis. The Model Act differs only slightly from the PLP in the Patient Bill of Rights, part of the 2010 Affordable Care Act (ACA) passed by the 111th Congress. The NAIC model includes the appropriate "concept" of a PLP that applies to patients with presenting symptoms rather than subsequent final diagnosis to the emergency department. As of July 1, 2019, 47 states and the District of Columbia have adopted a PLP law covering access to emergency medical care.

Federally, the Balanced Budget Act of 1997 originally implemented the PLP for Medicaid Managed Care and Medicare recipients and was the prequel to the ACA language standard subsequently adopted as the model for all health plans. However, this remains a source of legislative and regulatory controversy across many states. As previously mentioned, the 2010 ACA Bill of Rights adopted PLP language, however individual insurers have continued to try to reduce payments for emergency care they deem to be non-emergent.

Challenging Retrospective Denials and Down Coding

ACEP developed a toolkit in 2018 for third-party stakeholders to begin an ACEP-led outreach to all impacted groups to ensure a coordinated approach and encourage information sharing and a unified message. Congressional and state legislative activity has focused on identifying legislative champions to lead various efforts, such as Congressional pressure on the third-party payers that violate PLP in their state, Congressional pressure on the insurance commissioner within their state to limit enforcement, Congressional outreach to HHS or CCIIO to encourage their action, and a Hill briefing (featuring a panel of emergency physician(s), a consumer representative, and an impacted patient). The toolkit and Congressional pressure in 2018 led to the publication by Senator McCaskill (D-MO) of this report, "Coverage Denied: Anthem BCBS' Emergency Room Initiative," which included data ACEP had compiled and shared with the Senator's office.

ACEP provided data on specific retroactive denials collected from various emergency physician groups to several federal agencies to supplement any investigative work on PLP denials they might have had underway. ACEP continues to advocate for PLP strengthening in federal law as part of our surprise billing advocacy. Finally, ACEP has written letters to CMS and had calls with and sent letters to several states to address various issues with state Medicaid agencies and/or managed care plans' downcoding or retroactively denying claims.

ACEP is working with chapters to identify champions in the state legislatures and/or governors' offices who might have influence with insurance commissioners, develop op-eds in key markets to influence state lawmakers, and encourage impacted constituents to write to their legislators.

To support this work, ACEP staff internally tracks and collects payment denials by third-party payers in states where the policy has taken effect. Billing companies, ED groups, and Academic Chairs in those states were asked to report any data or observations of denials that violate the PLP. ACEP's DC office launched a website to collect patient stories of denials and is currently in the process of redesigning the site to publicize it more broadly.

ACEP will continue to explore legal options to prevent third-party payers from enforcing policies that violate PLP, including possible injunctions. ACEP has filed suit against Anthem Blue Cross Blue Shield of Georgia. The case is still pending.

Current AMA Policy on PLP

An AMA House of Delegates resolution adopted in June 2017 compels the AMA to work with state insurance regulators, insurance companies, and other stakeholders to immediately halt the implementation of policies that violate PLP of determining when to seek emergency care.

The AMA sent a letter in June 2017 asking Anthem to rescind the policy citing federal patient protections under PLP, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage.

ACEP Strategic Plan Reference

Goal 1 Reform and Improve the Delivery System for Acute Care
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system

Fiscal Impact

Budgeted staff resources and potential unbudgeted costs for outside consultants and lobbyists to implement the advocacy agenda.

Prior Council Action

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted. Directed ACEP to advocate for legislation and regulation to ensure that when authorized by the patient, A payer directly reimburses the provider for care.

Amended Resolution 34(02) Funding for EMTALA-Mandated Services adopted. Directed ACEP to collaborate with organizations whose members are affected by EMTALA to lobby Congress to fund EMTALA-mandated services not covered by current funding mechanisms; ask the AMA to make it a legislative priority to ensure that EMTALA-mandated physician services are funded; and provide a report to the 2003 Council on progress to date.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA for emergency departments and that the Board of Directors provide a report on these efforts at the 2001 Leadership/Legislative Issues Conference.

Amended Substitute Resolution 24(98) HMO Practices referred to the Board of Directors. Called for the College to support a requirement that when a patient calls their HMO with questions regarding medical care, that decisions are made by an appropriate licensed professional according to sound triage protocols developed by qualified individuals.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted. Directed ACEP to investigate and report back on the establishment of an ACEP office of EMTALA usage and compliance for the development of continuing programs for comprehensive regulatory monitoring, member and public education and the coordination of legal and regulatory advocacy for an environment which is conducive to appropriate emergency practice.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in state that have the definition in law. Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted. Directed ACEP to continue current efforts with appropriate government agencies and other interested parties regarding the following EMTALA issues: (1) the role that health care insurance entities have played in denying access to emergency care to their beneficiaries, and ensure that those entities come under the jurisdiction of the statute; (2) the distorted interpretation and misuse of the original intent of the statute; and (3) seeking relief from the onerous implications of the law in light of managed care; and report back to the Council at the 1997 meeting.

Resolution 52(95) Managed Care Plans - Access to Urgent/Emergent Care referred to the Board of Directors because of ongoing efforts in support of H.R. 2011. The resolution called for ACEP to urge managed care organizations to adopt a "prudent layperson" definition to ensure access to timely emergency care for all subscribers.

Substitute Resolution 39(90) Amendments to COBRA adopted. Directed the College to expand its position statement on the definition of bona fide emergency to include reference to the fact that medical evaluation is necessary to ascertain if a bona fide emergency exists and is mandated by federal patient transfer laws.

Substitute Resolution 49(86) Patient Transfer adopted. This resolution directed ACEP to develop and make available support materials for chapters to deal with the assessment, management, and transfer of patients and that the College continue to work toward resolution of those elements of COBRA that deal unfairly with emergency physicians.

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted. Directed that as government entities mandate statutory access to emergency services, such statutes ensure a mechanism for optimal physician payment.

Prior Board Action

February 2018, reaffirmed the policy statement "Assignment of Benefits;" reaffirmed April 2012; originally approved April 2006.

January 16, 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25). July 17, 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

June 2017, approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider.

April 2017, approved the revised policy statement "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005 with the title "Compensation When Services are Mandated;" originally approved September 1992.

April 2017, approved the revised policy statement "Prior Authorization;" revised and approved October 1998; originally approved November 1987.

May 2016, ACEP filed suit against the federal government. Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are "out of network" because of a medical emergency.

April 2016, approved the revised policy statement "Fair Payment for Emergency Department Services;" originally approved April 2009.

Referred Resolution 28(15) Standards for Fair Payment of Emergency Physicians assigned to the ACEP/EDPMA Joint Task Force on Reimbursement.

April 2014**,** revised and approved the policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Amended Substitute Resolution 15(00) EMTALA adopted.

Referred Amended Substitute Resolution 24(98) HMO Practices assigned to the Federal Government Affairs Committee and the Emergency Medicine Practice Committee.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted.

Resolution 43(97) Prudent Layperson Legislation adopted.

Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted.

Substitute Resolution 39(90) Amendments to COBRA adopted.

Substitute Resolution 49(86) Patient Transfer adopted

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted.

Background Information Prepared by: Adam Krushinskie, MPA
Reimbursement Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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RESOLUTION: 36(19)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence

PURPOSE: Work with stakeholders to raise awareness and advocate for research funding and legislation to curb gun violence and intimate partner violence.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Tamara O'Neal, MD, was a medical student, resident, and emergency medicine faculty in the state of Illinois and a member of the Illinois College of Emergency Physicians (ICEP); and

WHEREAS, After graduating from the University of Illinois Chicago (UIC) emergency medicine residency program, she remained in Chicago to give back to the community and work with residents at Mercy Hospital on the south side of Chicago; and

WHEREAS, On November 19, 2018, Dr. O'Neal was shot and killed by her former fiancé in the parking lot of the hospital where she worked; and

WHEREAS, Dr. O'Neal was dedicated to the betterment of her community, and was a strong advocate for diversity in medicine as well as the advancement of care for the most underserved patient populations; and

WHEREAS, The presence of a gun in a domestic violence situation increases the risk of homicide by 500% [1]; and

WHEREAS, 65 percent of all murder-suicides involved an intimate partner and of these 96 percent were females killed by their intimate partners and 94 percent involved a gun[2]; and

WHEREAS, A study of intimate partner homicides found that 20% of victims were not the intimate partners themselves, but family members, friends, neighbors, persons who intervened, law enforcement responders, or bystanders[3]; and

WHEREAS, ICEP, along with University of Illinois at Chicago faculty and alumni, helped to support the creation of a research fund in partnership with the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM); and

WHEREAS, Donations to the Dr. Tamara O'Neal Memorial Research Fund will go toward much-needed studies that address the intersectional issues of gun violence and intimate partner violence, especially as it affects people of color; and

[1] Campbell JC, Webster D, Koziol-McLain J, et al. Risk factors for femicide in abusive relationships: results from a multisite case control study. *Am J Public Health*. 2003;93(7):1089–1097. doi:10.2105/ajph.93.7.1089

[2] American Roulette: Murder Suicide in the United States. *Violence Policy Center.* Sixth Edition. June 2018. http://vpc.org/studies/amroul2018.pdf

[3] Smith SG, Fowler KA, Niolon, PH. Intimate Partner Homicide and Corollary Victims in 16 States: National Violent Death Reporting System, 2003–2009. *Am J Public Health.* 2014. 104, 461_466. doi:10.2105/AJPH.2013.301582

WHEREAS, ICEP successfully pledged to raise $50,000 in donations to the Dr. Tamara O'Neal Memorial Research Fund; therefore be it

RESOLVED, That ACEP work with stakeholders to raise awareness and advocate for research funding and legislation to curb gun violence and intimate partner violence.

Background

This resolution calls for ACEP to work with stakeholders to raise awareness and advocate for research funding and legislation to curb gun violence and intimate partner violence.

ACEPs legislative and regulatory priorities over the years have included working with members of Congress to promote efforts that may prevent firearm-related injuries/deaths and to support public/private initiatives to fund firearm research. ACEP has worked with the AMA and other stakeholders to address firearm injury prevention and research on this issue.

The College has addressed the issue of firearms multiple times over the years through Council resolutions and policy statements. A compilation of resources for physicians impacted by active shooter mass casualty incidents is available on the ACEP website.

The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on research grants. An Early Career Research Development Grant for $150,000 was awarded to Kristen Mueller, MD from Washington University in St. Louis in June 2019 for "Firearm Injuries and Recidivism at St. Louis Level 1 Trauma Hospitals." AFFIRM contributed $37,500 and EMF contributed $112,000 to fund this grant. A $5,000 Medical Student Research Grant was awarded in June 2019 to Henry Schwimmer, BA from Emory University School of Medicine for "Rural Emergency Department Firearm Assessment, Screening, and Treatment (FAST) Trial." AFFIRM contributed $2,500 and EMF contributed $2,500 for this award.

In June 2019, the Board of Directors approved a survey of the ACEP Council on the firearms research, safety, and policy. The survey is currently underway. It was sent to 432 councillors and 170 responses were received as of August 28, 2019. The survey will close on September 13, 2019. The results will be presented to the Board in October 2019 and at the 2019 Council meeting. The Board has not yet determined whether this survey will be sent to the entire membership.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP issuing public statements following a mass shooting event advocating for change consistent with the College's policies, 62.5% were in support of making public statements while 28.1% did not support such action.

ACEP's current policy statement "Firearm Safety and Injury Prevention" was developed by a task force that was appointed in 2013. ACEP policies are reviewed on a 5- to 7-year cycle as part of the policy sunset review process.

Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The resolution was assigned to the PHIPC. The committee drafted a revised policy statement. that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board discussed the revised policy statement in June 2019 and referred it back to the committee for further work.

During the 2017-18 committee year, the PHIPC developed an information paper, " Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

In March 2018, ACEP provided a letter of support for the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM.) The letter outlined ACEPs support of AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence. In January 2019, the Board of Directors approved a $20,000 donation to AFFIRM.

The Research Committee was assigned an objective in 2014-15 to "Convene a Technical Advisory Group (TAG) of firearm researchers and other stakeholders to develop a research agenda and to consider the use of available research networks (including ACEP's EM-PRN) to perform firearm research." TAG members determined the research agenda would be based on questions relating to suicides, unintentional injuries, mass violence, and peer violence. An article titled "A Consensus-Driven Agenda for Emergency Medicine Firearm Injury Prevention Research" was published in *Annals of Emergency Medicine* in February 2017 outlining this work.

During the 2013-14 committee year, the Research Committee was assigned an objective to make a recommendation to the Board regarding Referred Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs. In June 2014, the Board approved the following recommendations: 1) ACEP and EMF staff convene a consensus conference of firearm researchers and other stakeholders to develop a research agenda and to consider the use of available research networks (including the proposed EM-PRN) to perform firearm research; 2) ACEP and EMF staff to identify grant opportunities and promote them to emergency medicine researchers; 3) EMF to consider seeking funding for a research grant specifically supporting multi-center firearm research; and 4) ACEP to advance the development of the EM-PRN to create a resource for representative ED-based research on this topic and others.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 45(18) Support for Extreme Risk Protection Orders to Minimize Harm adopted. Directed ACEP to support Extreme Risk Protection Orders (ERPO) legislation at the federal level; promote and assist

chapters to enact ERPOs by creating a toolkit and other appropriate resources; and encourage and support further research of the effectiveness and ramifications of ERPOs and Gun Violence Restraining Orders (GVROs).

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted. Directed ACEP to revise the policy statement, "Firearm Safety and Injury Prevention" to reflect the current state of research and legislation.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. Directed ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence, devise strategies to help emergency physicians to work with stakeholders to mitigate patient risk of self-directed or interpersonal harm, investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes, and explore similar precedents currently in use.

Resolution 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for funding for research on firearm injury prevention and to work with the AMA and other medical societies to achieve this common cause.

Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs referred to the Board of Directors. Called for a task force to develop a research network of EDs to study the impact of firearm violence and invite interested stakeholders to participate in the network.

Amended Resolution 31(12) Firearm Violence Prevention adopted. Condemned the recent massacres in Aurora, CO and WI and the daily violence throughout the U.S. and reaffirmed ACEP's commitment against gun violence including advocating for public and private funding to study the health effects of gun violence.

Amended Resolution 41(04) Assault Weapon Ban adopted. ACEP deplores the threat to public safety that is the result of widespread availability of assault weapons and high capacity ammunition devices and urges the Congress and the President to enact and sign into law a comprehensive ban on all sales of assault weapons and high capacity magazines.

Resolution 14(00) Childhood Firearm Injuries referred to the Board of Directors. Directed ACEP to support legislation that requires safety locks on all new guns sold in the USA and support legislation that holds the adult gun owner legally responsible if a child is accidentally injured with the gun.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted. Sought to collaborate with other medical specialty organizations on firearms issues.

Resolution 22(96) National Center for Injury Prevention and Control adopted. Directed ACEP to continue supporting funding for Injury Prevention and Control in the CDC in which firearms research was included.

Amended Resolution 69(95) Firearm Legislation adopted. Sought to limit access to Saturday night specials.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. Advocated for increased taxes on handguns and ammunition with proceeds going to fund the care of victims and/or programs to prevent gun violence and to fund firearm safety education.

Resolution 47(94) Firearm Classification referred to the Board of Directors. Directed ACEP to support legislation classifying firearms into three categories: 1) prohibited; 2) licensed; and 3) unlicensed.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted. Directed ACEP to support legislation requiring photo identification and specific qualifications for firearm possession.

Substitute Resolution 45(94) Firearm Possession adopted. Supported legislation (as was passed in the crime bill) to make it illegal for persons under 21 and persons convicted of violent crimes, spousal and/or child abuse or subject to a protective order to possess firearms; illegal to transfer firearms to juveniles; and support legislation making it illegal to leave a loaded handgun where it is accessible to a juvenile.

Substitute Resolution 44(94) Firearm Legislation adopted. Support comprehensive legislation to limit federal firearms licenses.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted. Supported national safety regulations for firearms.

Amended Resolution 18(93) Firearm Injury Reporting System adopted. Explore collaboration with existing governmental entities to develop a mandatory firearm injury reporting system.

Amended Resolution 17(93) Firearm Injury Prevention adopted. Consider developing and/or promoting public education materials regarding ownership of firearms and the concurrent risk of injury and death.

Amended Resolution 16(93) Possession of Handguns by Minors adopted. Support federal legislation to prohibit the possession of handguns by minors.

Amended Resolution 11(93) Violence Free Society adopted. Develop a policy statement supporting the concept of a violence free society and increase efforts to educate member about the preventable nature of violence and the important role physicians can play in violence prevention.

Resolution 15(90) Gun Control not adopted. Sought for ACEP to undertake a complete review of all medical, legal, technical, forensic, and other pertinent literature regarding firearm-related violence with emphasis on the effects of firearm availability to the incidence of such violence, and that ACEP withhold public comment on gun control until such study is completed and an informed, unemotional, and unpolarized position on weapons can be formulated.

Amended Resolution 14(89) Ban on Assault Weapons adopted. Support federal and state legislation to regulate as fully automatic weapons are regulated, the sale, possession, or transfer of semi-automatic assault weapons to private citizens and support legislation mandating jail sentences for individuals convicted of the use of a semi-automatic assault weapon in the commission of a crime.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted. Support federal and state legislation to require 15-day waiting period for the sale, purchase, or transfer of any firearm to allow time for a background check on the individual and also support legislation mandating significant penalties for possession of a firearm while committing a crime.

Substitute Resolution 16(84) Ban on Handguns adopted. Deplored the loss of life and limb secondary to the improper use of handguns; supported legislation mandating significant penalties for possession of a handgun while committing a crime; support legislation mandating significant penalties for the illegal sale of handguns; support a waiting period for all prospective handgun buyers; supported successful completion of an education program on handgun safe for all prospective handgun buyers; support development of educational programs on the proper use of handguns for existing owners; support requiring screening of prospective handgun buyers for previous criminal records and mental health problems that have led to violent behavior.

Resolution 15(83) Handgun Legislation not adopted. Urged legislative bodies to enact legislation restricting the availability of handguns to the general public and to monitor the results.

Prior Board Action

June 2019, discussed proposed revisions to the statement “Firearm Safety and Injury Prevention.” The policy statement was referred back to the Public Health & Injury Prevention Committee for further revision.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

April 2019, approved the revised policy statement “Domestic Family Violence;” reaffirmed June 2013; originally approved October 2007 replacing seven rescinded policy statements.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

January 2019, approved $20,000 contribution to the American Federation for Firearm Injury Reduction in Medicine (AFFIRM).

Amended Resolution 45(18) Support for Extreme Risk Protection Orders to Minimize Harm adopted.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted.

June 2018, reviewed "Resources for Emergency Physicians" Reducing Firearm Violence and Improving Firearm Injury Prevention."

June 2014, approved the Research Committee's recommendations to convene a consensus conference of firearm researchers and other stakeholders to: 1) develop a research agenda and to consider the use of available research networks (including the proposed EM-PRN) to perform firearm research; 2) identify grant opportunities and promote them to emergency medicine researchers; 3) recommend EMF consider seeking funding for a research grant specifically supporting multi-center firearm research; and 4) advance the development of the EM-PRN so as to create a resource for representative ED-based research on this topic and others.

Substitute Resolution 21(14) Emergency Department Mental Health Exchange adopted.

Resolution 27(13) Studying Firearm Injuries adopted.

December 2013, assigned Referred Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs to the Research Committee to provide a recommendation to the Board of Directors regarding further action on the resolution.

April 2013, approved the revised policy statement, "Firearm Safety and Injury Prevention;" replacing the "Firearm Injury Prevention" policy statement that was revised and approved in October 2012 and January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

Amended Resolution 31(12) Firearm Violence Prevention adopted.

Amended Resolution 41(04) Assault Weapon Ban adopted.

November 2000, assigned Resolution 14(00) Childhood Firearm Injuries to the Public Health & Injury Prevention Committee.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted.

Resolution 22(96) National Center for Injury Prevention and Control adopted.

Amended Resolution 69(95) Firearm Legislation adopted.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Resolution 47(94) Firearm Classification referred to the Board of Directors.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted.

Substitute Resolution 45(94) Firearm Possession adopted.

Substitute Resolution 44(94) Firearm Legislation adopted.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted.

Amended Resolution 18(93) Firearm Injury Reporting System adopted.

Amended Resolution 17(93) Firearm Injury Prevention adopted.

Amended Resolution 16(93) Possession of Handguns by Minors adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Amended Resolution 14(89) Ban on Assault Weapons adopted.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted.

Substitute Resolution 16(84) Ban on Handguns adopted.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 37(19)

SUBMITTED BY: Larry Bedard, MD, FACEP
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SUBJECT: Single-Payer Health Insurance

PURPOSE: Support the adoption of a single-payer health insurance program and explore opportunities to partner with other organizations that favor the single-payer approach to providing universal health care to all Americans.

FISCAL IMPACT: Budgeted staff and consultant resources. Potential additional unknown costs to work with other partners or coalitions.

WHEREAS, Despite enactment of the Affordable Care Act (ACA) in 2010, approximately 24 million adult Americans still lack health insurance and approximately 44 million more are effectively underinsured, causing them to forego care or to receive care only at an advanced stage of disease;[1] and

WHEREAS, The ACA has created a complex and inefficient bureaucracy that works through private insurers with high administrative overhead; and

WHEREAS, Single-payer health insurance, often known as "Medicare-for-All", is simply an alternative method of financing the American health care system without disrupting the private practice of medicine; adds simplicity to billing and medical care administration resulting in lower overhead; and has the potential to help American businesses compete globally by reducing their financial obligations for their employees' health care; and

WHEREAS, Separate polls show that most of the general public[2,3] and a majority of physicians[4] support a national single-payer, Medicare-for-All health plan; and

WHEREAS, The ACEP Council adopted Resolution 15(99) Promotion of Health Care Insurance, stipulating that ACEP formulate and implement a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; and

WHEREAS, The ACEP Council adopted Substitute Resolution 31(14) Financing Health Insurance directing ACEP to create a Health Care Financing Task Force to study alternative financing models that foster competition and preserve patient choice, which met and deliberated with no policy having been proposed; and

WHEREAS, ACEP leadership created the Alternative Payment Models (APM) Task Force, which has focused on *payment* models (for physician reimbursement) rather than *financing* models (for American health care overall); therefore be it

RESOLVED, That ACEP support the adoption of a single-payer health insurance program that finances care for all Americans while fostering competition, preserving patient choice, and recognizing the essential value of emergency medicine; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations that favor the single-payer approach to providing universal health care to all Americans.

[1] Collins SR, Bhupal HK, Doty MM. Health insurance coverage eight years after the ACA: fewer uninsured Americans and shorter coverage gaps, but more underinsured (Commonwealth Fund, Feb. 2019), at: https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca.
[2] Keller M. Seventy percent of Americans support 'Medicare for all' in new poll. *The Hill* (August 23, 2018), at: https://thehill.com/policy/healthcare/403248-poll-seventy-percent-of-americans-support-medicare-for-all; Reuters/IPSOS poll, at https://www.reuters.com/investigates/special-report/usa-election-progressives/
[3] Kirzinger A, Muñana C, Lopes L, Hamel L, Brodie M. KFF Health Tracking Poll - June 2019: Health Care in the Democratic Primary and Medicare-for-all, at: https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-june-2019/; https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/
[4] Bluth R. Doctors warm to single-payer health care. *Kaiser Health News* (August 16, 2017), at: https://khn.org/news/doctors-warm-to-single-payer-health-care/

Background

This resolution requests ACEP to support the adoption of a single-payer health insurance program for financing health care and explore opportunities to partner with other organizations that favor the single-payer approach to providing universal health care to all Americans.

As the resolution notes, the Health Care Financing Task Force (HCFTF), established by Amended Resolution 19(16) to study alternative health care financing models, including single payer, delivered its report in Fall 2018. The report notes:

> Although the HCFTF cannot recommend a financing system at this time, a majority of the HCFTF agree that there are elements of [single payer] systems that strongly adhere to the '9 Principles' outlined. Therefore, if ACEP were to advocate for significant health care financing reform in the future, HCFTF members would want some elements of varied SP models to be considered and included in an ACEP-endorsed model.

The task force determined that ACEP should continue to advocate for and propose meaningful ideas for health care financing reform, but at the current time, no one system – single payer, two-tier, or the current health care system – could be espoused over another. The HCFTF concluded "ACEP shall focus on securing access to coverage for our patients and their families for, acute unscheduled care services in any health care financing model, including single payer."

For purposes of this discussion, it is important to recognize that single-payer is not equivalent to universal health care. Universal health care refers to a system in which all citizens have access to health care services, although payment for these services could derive from either a single source or multiple sources. Single-payer, on the other hand, is a health care financing system where all reimbursements derive from one entity.

Further, while the resolution states "Single-payer health insurance, often known as 'Medicare-for-All'…", it should be noted that "single-payer" and "Medicare-for-All" are also considered distinct proposals, even by many proponents. For example, a 2016 poll conducted by Kaiser Family Foundation (KFF) found significant variation in support among Democratic voters for various proposals, including Medicare-for-All (53% very positive), guaranteed universal health coverage (44% very positive), single-payer health insurance (21% very positive), and socialized medicine (22% very positive). However, those variations appear to have diminished within the past few years – according to a 2019 Morning Consult poll, a majority of voters support either Medicare-for-all (53%) or single-payer (51%). Regardless, as the Morning Consult notes, while the terms are often used interchangeably, "there are differences between the two: Single-payer is a sweeping term for a system in which the costs of essential care for all residents are covered by one public system, while a "Medicare for all" program could be single-payer but does not necessarily have to be."

The United States currently operates under a multi-payer system. Individuals and businesses pay taxes to the government, in the form of payroll taxes and income taxes, as well as paying premiums to private insurers. The government then reimburses health care providers who deliver care through one of the public programs, such as Medicare, Medicaid, CHIP or military health care (TRICARE or VA/CHAMPVA). For those who are privately

insured, health care providers seek reimbursement from the respective insurance company. Presently, there are dozens of private health insurance companies and thousands of private health insurance plans offered through state and federal insurance exchanges, public programs and in the private marketplace. Of those who had health insurance in 2010, government programs insured 95 million Americans while private insurance covered 196 million.

In the case of single-payer financing, individuals and businesses would pay taxes to the government. The government would then reimburse health service providers directly for care delivered through a national health insurance program. Although the collection of funds and the process of reimbursement are conducted by one entity, the delivery of care would be through both public and private sources. For example, under the terms of the single-payer system proposed by Physicians for a National Health Program (published in the *Journal of the American Medical Association* in 2003), all residents of the U.S. would be enrolled, and all medically necessary care would be covered. Obviously, the question of what is considered "medically necessary" could be contentious, especially given the recent developments in the State of Washington.

Financing the proposal would be achieved using existing sources of government funding (for public programs) and supplemented with new taxes. According to PNHP, businesses and individuals would pay more taxes, but those taxes would be offset because there would no longer be health insurance premiums.

Hospitals would receive a global budget for operating expenses every month. Medications and supplies would be purchased by the federal government according to a national formulary and using its bulk purchasing power to negotiate the lowest prices for medications and supplies. Physicians would have three reimbursement options: (1) fee-for-service (with a simplified, binding fee schedule); (2) salaried positions in facilities that receive global budget payments (i.e. hospitals); or (3) salaried positions within group practices or HMOs receiving capitation payments.

Two of the more common economic arguments in favor of single-payer are administrative simplification and the ability to control costs. According to a 2003 New England Journal of Medicine study, the U.S. spends more than $294 billion annually on administrative costs, which represents 31% of health expenditures in this country. However, not all administrative costs are harmful or inappropriate, thus diminishing the amount of savings generated by administrative simplification.

With regard to cost control, the U.S. has a fragmented, non-centrally coordinated system where different payers operate by different rules. Some argue that these variances have curtailed efforts to implement effective, systemic cost control measures, such as global budgeting (lump-sum monthly payments for all care provided); price controls; supply controls; reimbursement caps; and overall expenditure targets. Centrally administered plans, such as single-payer, provide policy makers who wish to institute cost controls with a substantial tool for obtaining that objective. Although, implementing that option would be largely dependent on public opinion. Additionally, if cost containment measures are too aggressive, it can lead to an underfunded system with significant wait times for elective procedures, insufficient resources and diminished research and development.

Some argue that the biggest disadvantage to a single-payer system is the threat of underfunding by the government (due to fiscal or policy determinations). A single-payer system is particularly reliant upon a government that is committed to high funding levels to ensure quality of care is not diminished. As the Medicare and Medicaid Trust Funds rapidly approach projected insolvency, questions arise about the federal government's ability to sufficiently provide benefits even under our current system. Another acknowledged disadvantage is that the transition from the current U.S. system to single-payer would be very difficult and disruptive. The ACEP HCFTF also notes several potential tradeoffs with regard to implementing a single-payer system. These include: "restricted availability and lengthy wait times for certain elective procedures, as well as the potential for capitation that could limit reimbursement for providers." Finally, it has been suggested that Americans would have to be willing to accept other certain sacrifices under a single-payer system, such as accepting less choice in their coverage options and a willingness to accept more government control, oversight, and regulations through a single-payer system.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care

Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted staff and consultant resources. Potential additional unknown costs to work with other partners or coalitions.

Prior Council Action

October 2018, the Health Care Financing Task Force report served as the foundation for the 2018 Council Town Hall Meeting.

Amended Resolution 19(16) Health Care Financing Task Force adopted. Directed ACEP to establish a Health Care Financing Task Force to study alternative health care financing models, including single-payer, and provide a report to the 2017 Council.

Substitute Resolution 31(14) Financing Health Insurance adopted. Directed ACEP to create a Health Care Financing Task Force to study alternative financing models that foster competition and preserve choice for patients and that the task force report to the 2015 ACEP Council regarding its investigation.

Resolution 20(12) Single Payer Universal Health Insurance not adopted. The resolution supported the adoption of single payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Resolution 26(11) Single-Payer Universal Health Insurance not adopted. The resolution supported the adoption of single-payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Substitute Resolution 21(10) Medicare-for-All Health Insurance referred to the Board. The original resolution Supported the adoption of Medicare for everyone and work with organizations that favor this approach to providing health insurance for all Americans. The substitute resolution directed the Board to appoint a taskforce to investigate alternative models of healthcare financing.

Resolution 18(09) Single-Payer Health Insurance not adopted. Directed ACEP to support the adoption of single payer health insurance and work with organizations that favor the single-payer approach.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted. Directed ACEP to support the adoption of single-payer health insurance and work with organizations that favor the single-payer approach. A substitute resolution was adopted, although the title of the resolution was not changed. The substitute resolution directed the Board of Directors to derive a list of essential components to be included in any new healthcare system and create a white paper.

Resolution 21(07) Single-Payer Health insurance referred to the Board of Directors.

Resolution 34(05) Single-Payer Health Insurance referred to the Board of Directors.

Resolution 11(00) Funding the Mandate referred to the Board.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted. Directed the College to develop a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; make a long-term commitment to work with federal, state, and private agencies to resolve the problem; and provide a progress report at the 2000 Council meeting. This resolution was linked to Resolution 12(99).

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted. It called for ACEP to continue working with the AMA and other leaders on developing and implementing an educational program, on the issue of the medically uninsured and underinsured.

Substitute Resolution 17(98) Responsibilities of On-call Physicians adopted. It called for a study on the ramifications of on-call physicians and EMTALA including reimbursement issues.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted. The resolution asked for swift action to identify any adverse effects on public health, safety, and access to emergency services resulting from the Act that could result in making many persons covered by Medicaid ineligible, thus increasing the number of uninsured, and to seek immediate government action if any of these are jeopardized.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. The resolution called for the increase of federal taxes on handguns and ammunition to support increased coverage for the uninsured.

Amended Resolution 38(94) Single-Payer System adopted. The resolution asked the board to endorse the concept of a single-payer system for the United States, saying it would reduce administrative costs, thereby offsetting the costs of providing expanded coverage to the poor and uninsured.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

Resolution 18(92) Effect of Transfer Legislation on Emergency Medical Care referred to the Board of Directors.

Prior Board Action

September 2018, accepted the final report from the Health Care Financing Task Force. The report was distributed to the Council.

Amended Resolution 19(16) Health Care Financing Task Force adopted.

June 2015, reaffirmed the policy statement, "Universal Health Care Coverage;" reaffirmed August 2009; originally approved December 1999.

Substitute Resolution 31(14) Single Payer Health Insurance adopted.

April 2014, approved the revised policy statement "Health Care Cost Assignments by Taxes," replacing the policy statement "Health Promotion Revenues ("Sin Taxes"); reaffirmed October 2006; revised and approved July 2000; originally approved in 1993.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted.

January 2008, discussed whether ACEP should have a more defined position on health care reform, including universal health care coverage. There was consensus that system reform and health care coverage were ACEP's primary goals in the health care debate.

August 2007, agreed with the assessment of the Federal Government Affairs Committee that support of reform principles and involvement in discussions regarding health care reform constitute sound approach to health care reform and thus took no action on Resolution 34(05).

January 2006, endorsed the "Principles of Reform of the U.S. Health Care System" developed by eleven physicians' organizations, including ACEP.

June 2005 discussed whether ACEP should take the lead in advocating for fundamental changes in public financing of health care to provide universal coverage of basic benefits.

Resolution 11(00) Funding the Mandate was assigned to the EMS Committee, Reimbursement Committee, Federal Government Affairs Committee, and the State Legislative/Regulatory Committee. ACEP addressed the resolution through ongoing legislative and regulatory activities, both nationally and at the state level.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted.

Substitute Resolution 17(98) Responsibilities of On Call Physicians adopted.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Amended Resolution 38(94) Single-Payer System adopted.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

Background Information Prepared by: Ryan McBride, MPP
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Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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RESOLUTION: 38(19)

SUBMITTED BY: Kerry Forrestal, MD, FACEP
Mark Goldstein, MD, FACEP
Maryland Chapter
New Jersey Chapter

SUBJECT: Standards for Insurance Denials

PURPOSE: Directs ACEP to work with legislators to enact legislation that 1) makes it illegal for third-party payers to engage in automatic denials of emergency department claims; 2) to deny a claim, a physician who reviews the claim must be ABEM or ABOEM certified and clinically active in a field related to the claim, and 3) work to establish written policies with third-party payers that uphold the legal rights of patients established by EMTALA.

FISCAL IMPACT: Budgeted staff resources and unbudgeted potential fees for outside consultants and lobbyists to implement the advocacy agenda.

WHEREAS, Roughly 278 million Americans rely on public and private health insurance to obtain healthcare for themselves and their families; and

WHEREAS, Patients who have healthcare insurance have a reasonable expectation that their policies will provide the care contracted for; and

WHEREAS, The Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd and provides the legal right to be provided a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC) at an accredited Emergency Department; and

WHEREAS, Insurance companies are engaging in an automated process for approval and denial for EMTALA based claims; and

WHEREAS, Insurance companies have also been found to be denying charts that have never been reviewed by a practicing physician; therefore be it

RESOLVED, That ACEP work with legislators to enact legislation that makes it illegal for an insurance company to engage in automatic denials; and be it further

RESOLVED, That in order to deny a claim, a physician (i.e., MD or DO) who is board certified and remains clinically active in a field related to the claim, carefully review the denial, and attest to the cause of the denial with their signature attached to the documentation that shall be provided to the patient; and be it further

RESOLVED, That patients have the legal right under EMTALA to seek emergency care and that their claims shall not be denied by insurance companies and that ACEP work towards getting an affirmation in writing from insurance companies that they will adopt this as policy.

Background

This resolution directs ACEP to work with legislators to enact legislation that makes it illegal for third-party payers to

engage in automatic denials of emergency department claims; to deny a claim, a physician who reviews the claim must be ABEM or ABOEM certified and clinically active in a field related to the claim; and establish written policies with third-party payers that uphold the legal rights of patients established by EMTALA.

History of Emergency Medical Treatment and Active Labor Act (EMTALA) and Prudent Layperson Standard (PLP)

The Emergency Medical Treatment and Active Labor Act (EMTALA) was originally enacted as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, and was subsequently amended in 1986, 1987, 1988, 1989 and 1990. The law requires that hospitals with emergency departments conduct an appropriate medical screening examination on all individuals seeking care in order to determine whether they are experiencing an emergency medical condition. If it is determined that an emergency medical condition exists, the hospital must stabilize the patient's condition if they are able or transfer the individual to another medical facility if they are not able to stabilize the patient's condition. A hospital may not delay the provision of the screening examination in order to inquire about the method of payment or insurance status. There are severe penalties for hospitals and physicians that violate the law, including substantial fines per violation and/or termination from Medicare/Medicaid programs.

The Prudent Layperson Standard (PLP) was first enacted into law in the state of Maryland in 1993. Three years later, the National Association of Insurance Commissioners (NAIC), which adopts model state legislation and regulations relating to virtually all areas of insurance, drafted the Managed Care Provider Network Adequacy and Contracting Model Act (Model Act) which included PLP. This step recognized the need to require the provision of coverage for emergency services based upon presenting symptoms rather than the ultimate diagnosis. The Model Act differs only slightly from PLP in the Patient Bill of Rights, part of the 2010 Affordable Care Act (ACA) passed by the 111th Congress. The NAIC model includes the appropriate "concept" of PLP that applies to patients with presenting symptoms rather than subsequent final diagnosis to the emergency department. Thus, while the language in the NAIC model law is not identical with the officially sanctioned ACEP PLP language that was developed later and incorporated into the definition in the Patient Bill of Rights, it contains the same substance.

Strategies to Uphold Legal Rights Established by EMTALA and PLP

Despite the longstanding legal precedence of protecting patients and physicians from unwarranted third-party payer denials established by EMTALA and PLP, significant numbers of denials as well as the use of non-emergency board certified physicians to conduct claim reviews continue to persist.

ACEP has continued to fight for the inclusion of the EMTALA provision in third-party payer policies, especially those from managed care plans, which have significantly increased their market share since EMTALA was mandated by law. Although PLP laws have largely eliminated the issue of prior authorization denials for emergency services, many third-party payers have continued to make after-the-fact decisions to deny payment for services resulting in loss of revenue for physicians and an unnecessary financial burden on patients.

ACEP also has continued tracking third-party payer denials and has successfully lobbied on behalf of members in states where policies were announced that would have led to a process of automatic denials. Letters have been sent to several third-party payers that make up a large percentage of total market share in the U.S. with varying degrees of success. Most recently, Anthem Blue Cross Blue Shield retracted a policy in 13 states that would have led to retroactive denials after a letter was submitted on behalf of ACEP demonstrating EMTALA and PLP violations.

The College has continued to monitor and influence both the legislative and regulatory process related to EMTALA and PLP. We have successfully lobbied both Congress and the Centers for Medicare and Medicaid Services (CMS) on several issues of importance to emergency medicine, including removing criminal penalties against physicians, adding on-call requirements to the law, instituting whistleblower protections, and PRO review requirements. ACEP regulatory affairs staff have submitted formal comments to CMS and met with them on numerous occasions over the years to discuss the law, the regulations, and enforcement issues.

ACEP has also spent significant financial resources to educate members about EMTALA through *ACEP Now*, *Annals of Emergency Medicine*, as well as educational sessions at ACEP meetings.

ACEP developed recommended legislative language for patient protections for emergency services in 1997 when the Prudent Layperson Standard (PLP) was adopted in the Balanced Budget Act of 1997. The document was significantly updated in 2017 to reflect the new challenges presented by third-party payers.

ACEP Strategic Plan Reference

Goal 1 Reform and Improve the Delivery System for Acute Care
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care

Fiscal Impact

Budgeted staff resources and unbudgeted potential fees for outside consultants and lobbyists to implement the advocacy agenda.

Prior Council Action

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted. Directed ACEP to advocate for legislation and regulation to ensure that when authorized by the patient, A payer directly reimburses the provider for care.

Amended Resolution 34(02) Funding for EMTALA-Mandated Services adopted. Directed ACEP to collaborate with organizations whose members are affected by EMTALA to lobby Congress to fund EMTALA-mandated services not covered by current funding mechanisms; ask the AMA to make it a legislative priority to ensure that EMTALA-mandated physician services are funded; and provide a report to the 2003 Council on progress to date.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed ACEP to solicit member input to formulate EMTALA recommendations to CMS' regulatory advisory committee including physician on-call responsibilities, greater consistency of enforcement, and more effective involvement of peer review organizations

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. Reaffirmed that Eds are an essential part of the health care safety net for all populations, including foreign nationals, and in advocacy efforts ACEP recognizes uncompensated care for foreign nationals as one example of the many factors that threaten the health care safety net.

Resolution 26(01) Emergency Care as an Essential Public Service adopted. Directed ACEP to champion the principle that emergency care is an essential public service.

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA for emergency departments and that the Board of Directors provide a report on these efforts at the 2001 Leadership/Legislative Issues Conference.

Amended Substitute Resolution 24(98) HMO Practices referred to the Board of Directors. Called for the College to support a requirement that when a patient calls their HMO with questions regarding medical care, that decisions are made by an appropriate licensed professional according to sound triage protocols developed by qualified individuals.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted. Directed ACEP to investigate and report back on the establishment of an ACEP office of EMTALA usage and compliance for the development of continuing programs for comprehensive regulatory monitoring, member and public education and the coordination of legal and regulatory advocacy for an environment which is conducive to appropriate emergency practice.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in state that have the definition in law. Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted. Directed ACEP to continue current efforts with appropriate government agencies and other interested parties regarding the following EMTALA issues: (1) the role that health care insurance entities have played in denying access to emergency care to their beneficiaries, and ensure that those entities come under the jurisdiction of the statute; (2) the distorted interpretation and misuse of the original intent of the statute; and (3) seeking relief from the onerous implications of the law in light of managed care; and report back to the Council at the 1997 meeting.

Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted. Directed ACEP to continue efforts with government agencies and other interested parties regarding EMTALA: 1) the role that insurance entities have played in denying access to emergency care to their beneficiaries and ensure those entities come under the jurisdiction of the statute; 2) the distorted interpretation and misuse of the original intent of the statute; and 3) seek relief from the onerous implications of the law in light of managed care.

Resolution 52(95) Managed Care Plans - Access to Urgent/Emergent Care referred to the Board of Directors because of ongoing efforts in support of H.R. 2011. The resolution called for ACEP to urge managed care organizations to adopt a "prudent layperson" definition to ensure access to timely emergency care for all subscribers.

Amended Resolution 11(92) Payment for Mandated Services adopted. Directed that any government agency, legislative body, insurance carrier, third-party payer, or any other entity that mandates that a service or product be provided by emergency physicians or other providers, also mandate an adequate source of funding to ensure appropriate compensation for those services or products; and support legislation to ensure that any governmental agency, legislative body, insurance carrier, third party payer, or any other entity that mandates the provision of medical services or products, also provides for appropriate compensation for that service or product.

Substitute Resolution 39(90) Amendments to COBRA adopted. Directed the College to expand its position statement on the definition of bona fide emergency to include reference to the fact that medical evaluation is necessary to ascertain if a bona fide emergency exists and is mandated by federal patient transfer laws.

Substitute Resolution 49(86) Patient Transfer adopted. This resolution directed ACEP to develop and make available support materials for chapters to deal with the assessment, management, and transfer of patients and that the College continue to work toward resolution of those elements of COBRA that deal unfairly with emergency physicians.

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted. Directed that as government entities mandate statutory access to emergency services, such statutes ensure a mechanism for optimal physician payment.

Prior Board Action

February 2018, reaffirmed the policy statement "Assignment of Benefits;" reaffirmed April 2012; originally approved April 2006.

January 16, 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25). July 17, 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court to compel the

insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

June 2017, approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider.

April 2017, approved the revised policy statement "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005 with the title "Compensation When Services are Mandated;" originally approved September 1992.

April 2017, approved the revised policy statement "Prior Authorization;" revised and approved October 1998; originally approved November 1987.

May 2016, ACEP filed suit against the federal government. Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are "out of network" because of a medical emergency.

April 2016, approved the revised policy statement "Balance Billing;" revised and approved 2009 with the current title; reaffirmed October 2008; originally approved October 2002 titled "Prohibition of Balance Billing."

April 2016, approved the revised policy statement "Fair Payment for Emergency Department Services;" originally approved April 2009.

Referred Resolution 28(15) Standards for Fair Payment of Emergency Physicians assigned to the ACEP/EDPMA Joint Task Force on Reimbursement.

April 2014, revised and approved the policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted.

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Amended Substitute Resolution 15(00) EMTALA adopted.

Referred Amended Substitute Resolution 24(98) HMO Practices assigned to the Federal Government Affairs Committee and the Emergency Medicine Practice Committee.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted.

Resolution 43(97) Prudent Layperson Legislation adopted.

Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted.

Amended Resolution 11(92) Payment for Mandated Services adopted.

Substitute Resolution 39(90) Amendments to COBRA adopted.

Substitute Resolution 49(86) Patient Transfer adopted

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted.

Background Information Prepared by: Adam Krushinskie, MPA
Reimbursement Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 39(19)

SUBMITTED BY: Joseph J. Calabro, DO, FACEP
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SUBJECT: Work Requirements for Medicaid Beneficiaries

PURPOSE: Oppose mandatory work requirements that force Medicaid beneficiaries to prove or keep employment to keep their health insurance benefit.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, 36 states and the District of Columbia have expanded their Medicaid programs under the provisions of the Affordable Care Act; and

WHEREAS, Expanded Medicaid coverage has increased overall access to healthcare, expanded preventive services, improved prescription drug coverage and boosted employment, while creating less financial stress for beneficiaries, increasing reimbursement for hospitals, and improving state tax revenue;[1,2,3,4] and

WHEREAS, The Centers for Medicare and Medicaid Services (CMS) has granted Section 1115 demonstration waivers to nine states (Kentucky, Indiana, Arkansas, New Hampshire, Wisconsin, Michigan, Arizona, Ohio and Utah) to test the effect of mandatory work requirements (with pre-specified exemptions) on the ability to attain and maintain Medicaid eligibility; and

WHEREAS, CMS is reviewing additional Section 1115 proposals submitted by seven other states; and

WHEREAS, There is no evidence to date that Medicaid work requirements have a significant impact on employment or poverty for Medicaid beneficiaries;[5,6,7] and

WHEREAS, Early evidence from Arkansas suggests that Medicaid work requirements have adversely effected coverage, particularly due to confusion about eligibility and reporting requirements;[5,7,8] and

WHEREAS, Medicaid work requirements have the potential to impact states' budgets because of monitoring and enforcement activities, which are not reimbursable by CMS;[9] and

WHEREAS, Any policy that denies or disrupts insurance coverage, and thus creates a barrier to healthcare access outside the Emergency Department (ED), could lead to poor health outcomes for affected individuals and more uncompensated care in the ED;[10,11] therefore be it

RESOLVED: That ACEP oppose mandatory work requirements that force Medicaid beneficiaries to prove they are employed, or seeking employment, to get or keep health insurance.

[1] Rudowitz R, Antonisse L. Implications of the ACA Medicaid expansion: A look at the data and evidence. Kaiser Family Foundation Issue Brief, May 2018. (http://files.kff.org/attachment/Issue-Brief-Implications-of-the-ACA-Medicaid-Expansion-A-Look-at-the-Data-and-Evidence).
[2] Koorstra K. Fiscal Brief: Healthy Michigan Plan savings and cost estimates. Lansing, MI: Michigan House Fiscal Agency, October 30, 2018. (https://www.house.mi.gov/hfa/PDF/Alpha/Fiscal_Briefing_HMP_Savings_and_Cost_Estimates.pdf).
[3] Ayanian JZ, Ehrlich GM, Grimes DR, Levy H. Economic effects of Medicaid expansion in Michigan. *N Engl J Med* 2017; 376:407-410. (https://www.nejm.org/doi/full/10.1056/NEJMp161398).
[4] Sommers BD, Blendon RJ, Orav EJ. Both the 'private option' and traditional Medicaid expansions improved access to care for low-income adults. *Health Affairs* 2016; 35:96-105. (http://content.healthaffairs.org/content/35/1/96.full.html).
[5] Musumeci M, Rudowitz R, Lyons B. Medicaid work requirements in Arkansas: Experience and perspectives of enrollees. Kaiser Family Foundation Issue Brief, December 2018. (http://files.kff.org/attachment/Issue-Brief-Medicaid-Work-Requirements-in-Arkansas-Experience-and-Perspectives-of-Enrollees).
[6] Pavetti L. Work requirements don't cut poverty, evidence shows. Center on Budget and Policy Priorities, Updated June 7, 2016. ("*The large majority of individuals subject to work requirements remained poor, and some became poorer.*") (https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows)
[7] Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Special Report: Medicaid work requirements – results from the first year in Arkansas. *New Engl J Med* 2019 (published online June 19, 2019) (*..in its first six months, work requirements in Arkansas were associated with a significant loss of Medicaid coverage and rise in the percentage of uninsured persons. We found no significant changes in employment associated with the policy…Many Medicaid beneficiaries were unaware of the policy or were confused about how to report their status to the state…"*)
[8] Solomon J. Medicaid work requirements can't be fixed: unintended consequences are inevitable result. Center on Budget and Policy Priorities, January 10, 2019. ("*Paperwork and red tape cause eligible people to lose coverage*.") (https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed).
[9] Randolph M, Udow-Phillips M. Proposed Medicaid work requirements in Michigan. Ann Arbor, MI: Center for Healthcare Research & Transformation, 2018. (https://www.chrt.org/wp-content/uploads/2018/06/FINAL-Work-Req-Fact-Sheet-FINAL-.pdf).
[10] Pines JM, Ladhania R, Black BS, Corbit C, et al. Changes in reimbursement to emergency physicians after Medicaid expansion under the Patient Protection and Affordable Care Act. *Ann Emerg Med* 2019; 73:213-224. ("…*we found that full Medicaid expansion resulted in a more than 6% increase in emergency physician reimbursement per visit in full-expansion states compared with nonexpansion ones."*) (https://www.annemergmed.com/article/S0196-0644(18)31374-X/fulltext)
[11] Haught R, Dobson A, Luu P-H. How will Medicaid work requirements affect hospitals' finances? Commonwealth Fund Issue Brief, March 2019. ("*In states that impose work requirements, fewer covered Medicaid beneficiaries means hospitals will see reduced revenues, increased uncompensated care costs, and smaller operating margins.*") (https://www.commonwealthfund.org/sites/default/files/2019-03/Haught_medicaid_work_requirements_hosp_finances_ib_v2.pdf)

Background

The resolution calls upon the College to oppose mandatory work requirements that force Medicaid beneficiaries to prove or keep employment to keep their health insurance benefit.

Eight states have been approved by the Center for Medicare and Medicaid Services (CMS) for a waiver to permit them to mandate work and reporting requirements as a condition for ongoing Medicaid eligibility, though only Indiana has implemented such a program. Arkansas had implemented a work and reporting mandate in June of 2018, but the state's program was set aside by a federal court in March 2019. Waivers for Kentucky and New Hampshire have also been set aside by the courts. The remaining approved states have not yet implemented their waivers. In addition to the eight approved states, another seven states have waiver applications pending before CMS. Some of these waivers/applications for waiver apply only to the Medicaid expansion population, although 11 would apply to traditional Medicaid.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted staff resources and resources.

Prior Council Action

The Council has discussed and adopted many resolutions related to Medicare, but none specific to opposing mandatory work requirements for Medicaid beneficiaries.

Prior Board Action

July 2018, reviewed the information paper "Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine."

Background Information Prepared by: Harry J. Monroe, Jr.
Director, Chapter and State Relations

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
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Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2019 Council Meeting
Reference Committee Members

Reference Committee C
Emergency Medicine Practice
Resolutions 40-54

Michael A. Turturro, MD, FACEP (PA) Chair
Sara A. Brown, MD, FACEP (IN)
Angela P. Cornelius, MD, FACEP (LA)
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American College of Emergency Physicians®
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RESOLUTION: 40(19)

SUBMITTED BY: Rural Emergency Medicine Section
Florida College of Emergency Physicians
Idaho Chapter
Nebraska Chapter
West Virginia Chapter

SUBJECT: Advancing Quality Care in Rural Emergency Medicine

PURPOSE: Directs ACEP to: 1) work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; 2) identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; 3) develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and 4) encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

FISCAL IMPACT: Estimated $15,000 to convene meeting of stakeholder organizations to develop strategies, promote collaborative practice delivery models, and develop a paper.

WHEREAS, All patients, regardless of setting, deserve prompt access to high-quality emergency care, and ACEP emphasizes that emergency care is best provided by physicians who are residency trained in emergency medicine; and

WHEREAS, Data suggests that emergency medicine residency trained/board certified emergency physicians may never be able to fully meet workforce demands in rural areas; and

WHEREAS, The ED workforce in many rural areas may by necessity differ from that in urban areas and is diverse; and

WHEREAS, ACEP supports innovative approaches to raise the level of care, as well as the cognitive and technical skills of all emergency providers; and

WHEREAS, ACEP supports initiatives to improve the quality of emergency care in rural areas and expand the size of the rural emergency care workforce; and

WHEREAS, The recommendations from the Institute of Medicine (IOM) report and the Future of Emergency Medicine Summit include the need for increased collaboration between emergency medicine and primary care specialties and increased links between academic medical centers and rural hospitals; therefore be it

RESOLVED, That ACEP work with identified stakeholder groups and professional organizations, including the American Academy of Family Physicians and the National Rural Health Association, to create effective strategies and to promote emergency medicine practice delivery models that encourage collaboration, increase quality, and reduce costs in rural health care settings; and be it further

RESOLVED, That ACEP identify and promote a variety of existing training opportunities, such as procedural skills, simulation labs, and continuing medical education, to be available to maintain physician and non-physician clinicians' skills and to improve rural emergency medicine care; and be it further

RESOLVED, That ACEP work collaboratively with organizations to develop a rural emergency medicine white paper that identifies best practices, site criteria, supervision requirements, and studies funding mechanisms to

promote the development and uniform availability of rural emergency medicine electives within emergency medicine residency training programs; and be it further

RESOLVED, That ACEP encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine and rural healthcare.

Background

This resolution directs the College to: 1) work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; 2) identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; 3) develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and 4) encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

According to the 2017 ACEP information paper "Delivery of Emergency Care in Rural Settings," approximately 42% of emergency departments in the U.S. are located in rural counties, accounting for about 17% of all emergency department visits. The unique challenges facing rural emergency medicine are significant and, in many areas, worsening. With low patient volumes and often serving largely impoverished areas, many rural EDs and hospitals face severe financial difficulties. According to the University of North Carolina Center for Health Services Research, 113 rural hospitals have closed since 2010, 16 of them in this year alone.

Rural EDs must also deal with workforce challenges that include a limited number of board-certified emergency physicians choosing to work in rural settings. A 2018 study in the *Annals of Emergency Medicine* showed that emergency physicians make up less than 45% of emergency department clinicians in rural counties, compared to almost 64% in urban counties. 28.3% of rural ED clinicians were non-emergency physicians and 26.8% were advance practice providers (compared to 12% and 24.1%, respectively, in urban EDs.)

These challenges exacerbate the fundamental problem of relatively poor outcomes for rural patients compared to other practice settings. Prolonged transport times to the hospital and typically sicker patient populations than those seen in other settings undermine the effort to save lives in rural America. According to one report, 60% of all U.S. trauma deaths occur in rural areas, even though only 15% of the population lives there.

ACEP has been working on the ongoing problems plaguing rural emergency medicine for many years. In 2003, the ACEP Board of Directors convened a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs and make recommendations as to ACEP's role in the effort. Recommendations from the summit addressed residency training, academic medical centers, advocacy, distribution of the EM workforce, research, and educational programs.

Subsequent actions related to some of the recommendations from the summit included:

- The Residency Review Committee for EM approved program requirements for rural training.
- The American Board of Emergency Medicine and the American Board of Family Medicine developed a combined EM/FM training program.
- ACEP's federal advocacy efforts were successful in obtaining rural GME funding for redistribution of unused GME residency slots via the Medicare Modernization Act; this effort resulted in establishment of new emergency medicine residency programs in rural states such as Nebraska, Utah, and Iowa.

In July 2009, ACEP convened the Future of Emergency Medicine Summit. The summit included representatives from all emergency medicine organizations and other key stakeholders. The purpose of the summit was to build consensus on issues facing emergency medicine, most notably workforce realities, and specifically including rural emergency care.

Following additional discussion on educational opportunities for rural emergency medicine providers, a new Rural Emergency Medicine Task Force was convened in 2014. The task force's recommendations included better defining rural emergency medicine, identifying non-ACEP rural emergency medicine providers, addressing education gaps in rural emergency medicine, supporting and enhancing the development of scientific articles related to rural emergency medicine, and adopting a policy statement supporting the Comprehensive Advanced Life Support program.

In 2017, ACEP developed the policy statement "Definition of Rural Emergency Medicine," which reads: "Rural emergency medicine is urgent or emergent medicine practiced in geographic areas with low population densities and resource constraints, including ready access to more specialized care facilities. Rural emergency departments provide critical services for their communities, including facilitating earlier evaluation and entry into the healthcare system, stabilization and initiation of treatment, and coordinated transfer to a tertiary care facility."

While opposing the required completion of any short course, including Advanced Cardiac Life Support or Advanced Trauma Life Support for board-certified emergency physicians, ACEP has endorsed voluntary use of the Comprehensive Advanced Life Support (CALS) course as an "equally acceptable alternative to other advanced life support and/or trauma life support courses. CALS may be of particular value to those who practice rural emergency medicine as it is more comprehensive than other life support courses." ACEP initiated a pilot project to help expand CALS training opportunities in one rural state.

ACEP's information paper (mentioned previously) "Delivery of Emergency Care in Rural Settings" provides an overview of the challenges facing rural emergency medicine, legislative and funding efforts to support rural hospitals, and the prospect of freestanding emergency departments and telehealth helping to fill the void in better meeting the needs of rural emergency patients. In addition, ACEP's policy statement "Emergency Medicine Telemedicine" states that "ACEP further supports efforts to keep small and rural hospital EDs operational via use of appropriately trained and supervised NPs and PAs with telemedicine support."

For the last several years, including 2019, *Scientific Assembly* has offered educational courses of particular relevance to rural providers. The courses are also available on Virtual ACEP.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety

Fiscal Impact

Estimated $15,000 to convene meetings of stakeholder organizations to develop strategies, promote collaborative practice delivery models and develop a white paper.

Prior Council Action

Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States referred to the Board of Directors. The resolution called in part for ACEP to advocate for the creation of a Critical Access Emergency Center Designation where critical access hospitals no longer exist due to natural disasters or cannot be feasibly maintained.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. The resolution called for ACEP to analyze the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where emergency departments in critical access and rural hospitals have closed.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for inclusion of emergency medicine in the National Health Service Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organizations to encourage the development and promotion of rural clerkships/ rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas." Reaffirmed in April 2012 and October 2006. Originally approved in June 2000.

January 2018, assigned Referred Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States to the Federal Government Affairs Committee for action.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

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June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

October 2005, adopted Amended Resolution 37(05) Rural Emergency Medicine Workforce.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Substitute Resolution 20(01) Medical Education Debt adopted.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 41(19)

SUBMITTED BY:
Rural Emergency Medicine Section
Young Physicians Section
Alaska Chapter
Florida College of Emergency Physicians
Idaho Chapter
Missouri College of Emergency Physicians
Montana Chapter
Nebraska Chapter
Nevada Chapter
New Mexico Chapter
West Virginia Chapter
Wyoming Chapter

SUBJECT: Establish a Rural Emergency Care Advisory Board

PURPOSE: Establish an advisory board to monitor, coordinate, and advocate for clinical initiatives and health policies that would improve the delivery of emergency care in rural areas.

FISCAL IMPACT: Unbudgeted costs to include up to one FTE in excess of $100,000 in salary and benefits for identifying and monitoring the impacts of health policy on rural EDs and advocating for improvements to rural health care. Travel and meeting costs for any in-person advisory board meeting. Potential additional advocacy-related costs depending on the level and degree of new advocacy efforts (such as additional lobbying, policymaker education campaigns, meetings in DC, etc.)

WHEREAS, Emergency medicine was founded to improve the access by and delivery of care to the acutely ill wherever and whenever needed; and

WHEREAS, ACEP's mission is to promote the highest quality of emergency care and is the leading advocate for emergency physicians, their patients, and the public; and

WHEREAS, The economics of health care delivery in the United States is rapidly evolving, including drastic shifts within both urban and rural settings; and

WHEREAS, Rural communities are struggling to preserve dwindling access to basic and specialty health care services, including emergency services; and

WHEREAS, Federal legislation can dramatically affect the well-being of communities across the country, especially those in rural areas; and

WHEREAS, ACEP does not have an institutionalized system and resources to monitor the effects of health care legislation in rural areas; and

WHEREAS, Supporting policies for emergency patients in rural environments will improve advocacy and care for all emergency patients; therefore be it

RESOLVED, That ACEP establish an advisory board to monitor, coordinate, and advocate for clinical initiatives and health policies that would improve the delivery of emergency care in rural areas.

Background

This resolution directs the College to establish an advisory board to monitor, coordinate, and advocate for clinical initiatives and health policies that would improve the delivery of emergency care in rural areas.

According to the 2017 ACEP information paper "Delivery of Emergency Care in Rural Settings," approximately 42% of emergency departments in the U.S. are located in rural counties, accounting for about 17% of all emergency department visits. The unique challenges facing rural emergency medicine are significant and, in many areas, worsening. With low patient volumes and often serving largely impoverished areas, many rural EDs and hospitals face severe financial difficulties. According to the University of North Carolina Center for Health Services Research, 113 rural hospitals have closed since 2010, 16 of them in this year alone.

Rural EDs must also deal with workforce challenges that include a limited number of board-certified emergency physicians choosing to work in rural settings. A 2018 study in *Annals of Emergency Medicine* showed that emergency physicians make up less than 45% of emergency department clinicians in rural counties, compared to almost 64% in urban counties. 28.3% of rural ED clinicians were non-emergency physicians and 26.8% were advance practice providers (compared to 12% and 24.1%, respectively, in urban EDs.)

These challenges exacerbate the fundamental problem of relatively poor outcomes for rural patients compared to other practice settings. Prolonged transport times to the hospital and typically sicker patient populations than those seen in other settings undermine the effort to save lives in rural America. According to one report, 60% of all U.S. trauma deaths occur in rural areas, even though only 15% of the population lives there.

For many years, ACEP has advocated for federal legislation and regulation to improve rural emergency care. Following the ACEP Rural Workforce Summit in 2003, ACEP's federal government affairs efforts were successful in obtaining rural GME funding for redistribution of unused GME residency slots via the Medicare Modernization Act; this effort resulted in establishment of new EM residency programs in rural states such as Nebraska, Utah, and Iowa.

For the past several years, ACEP has led the effort to pursue Congressional support for the REACH (Rural Emergency Acute Care Hospital) Act, which would create a rural emergency hospital classification that would allow endangered critical access hospitals to voluntarily convert to rural emergency hospitals and continue providing emergency care. In May 2018, ACEP met with the Centers for Medicare & Medicaid Services (CMS) to discuss innovative payment approaches that would improve access to care in rural areas. ACEP staff provided an overview of a data analysis ACEP prepared on Medicare ED utilization in rural areas, and discussed how ACEP's alternative payment model, the Acute Unscheduled Care Model (AUCM), could be implemented in these areas. Since that meeting, ACEP's federal affairs staff have continued to follow up with CMS and provide additional information to help inform their work in this area.

A separate advisory board as contemplated by the resolution would be unique within the ACEP organizational structure. The proposed advisory board's charge to "monitor, coordinate and advocate for clinical initiatives and health policies" would require effective coordination with existing bodies within the College working on rural health care issues, in particular the federal affairs staff and the Federal Government Affairs Committee.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Unbudgeted costs to include up to one FTE in excess of $100,000 in salary and benefits for identifying and monitoring the impacts of health policy on rural EDs and advocating for improvements to rural health care. Travel and meeting costs for any in-person advisory board meeting. Potential additional advocacy-related costs depending on the level and degree of new advocacy efforts (such as additional lobbying, policymaker education campaigns, meetings in DC, etc.)

Prior Council Action

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Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

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Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Substitute Resolution 20(01) Medical Education Debt adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 42(19)

SUBMITTED BY: Zach Jarou, MD
John Rogers, MD, FACEP
Emergency Medicine Informatics Section

SUBJECT: Artificial Intelligence in Emergency Medicine

PURPOSE: 1) Develop an information paper on the role and future impact of emergency medicine artificial intelligence (EMAI) through convening a summit or creation of a task force. 2) Add EMAI to ACEP's Strategic Plan. 3) Incorporate a presentation on EMAI as part of the 2020 Leadership & Advocacy Conference 2020 and/or ACEP20.

FISCAL IMPACT: Cost for a summit approximately $25,000 plus staff labor. Cost for a task force approximately $15,000 plus staff labor (depending on the number and site of meetings). Cost for an educational offering approximately $5,000 (estimated speaker fee and travel costs).

WHEREAS, Applications using artificial intelligence (AI) are being developed and implemented for emergency medicine; and

WHEREAS, Emergency physicians should be the principal leaders and stakeholders of new technologies being applied to the practice of emergency medicine; and

WHEREAS, Applications using AI may alter the workforce needs both in terms of number and type of providers; and

WHEREAS, The use of these applications may require specific training before, during, and after residency; and

WHEREAS, These applications may alter physician workflow, and the practice of emergency medicine itself; and

WHEREAS, The general principles, scientific evidence, ethics, liability, and legal questions regarding the use of AI in emergency medicine have yet to be elucidated; and

WHEREAS, Identifying applications that emergency physicians would find helpful would guide the development of these applications; and

WHEREAS, Research and funding to support directed research questions on AI in emergency medicine may be of benefit to the Emergency Medicine Foundation and the academic community; therefore be it

RESOLVED, That ACEP convene an Emergency Medicine Artificial Intelligence (EMAI) Summit and/or a task force; and be it further

RESOLVED, That the purpose of convening an Emergency Medicine Artificial Intelligence (EMAI) Summit is to produce an information paper to include recommendations based on the best available knowledge or opinion on the issues and concerns surrounding artificial intelligence and make recommendations for how the College will continue to be informed and advised on matters related to EMAI; and be it further

RESOLVED, That the Board of Directors consider updating the College's Strategic Plan to include artificial

intelligence; and be it further

RESOLVED, That during the Leadership & Advocacy Conference 2020 and/or ACEP20, a presentation on artificial intelligence in emergency medicine, panel discussion, town hall, or similar session on emergency medicine artificial intelligence be offered.

Background

This resolution calls for ACEP to develop an information paper on the role and future impact of artificial intelligence in Emergency Medicine through convening a summit or creation of a task force, the information paper should contain recommendations for the College to keep informed and advised on matters related to emergency medicine artificial intelligence (EMAI), EMAI to be addressed in ACEP's Strategic Plan, and incorporate a presentation on EMAI as part of the 2020 Leadership & Advocacy Conference and/or ACEP 2020.

Artificial Intelligence (AI) is a term used to describe a computer or similar device that can perform complex tasks generally associated with intelligent beings. These processes may include learning (acquisition of information and rules for using that information), reasoning (using rules to reach conclusions) and self-correction. Often included as AI, machine learning (ML) is somewhat different and is the ability of computers to rapidly analyze large quantities of data and draw relationships that might not be apparent after human analysis. The AMA prefers the term Augmented Intelligence, recognizing that it is not "artificial" but rather the ability of today's computers to analyze an immense amount of data and filter out unnecessary or duplicative information rapidly. In addition, AI can use this data analysis to make connections that might escape the human brain.

AI is already impacting our world outside of medicine. In fact, medicine may be lagging behind other industries. For example, your online buying habits are filtered and analyzed almost instantaneously, and you are provided with additional options that reflect those purchases. In addition, you may be prompted for future purchases based on prior patterns.

AI is part of medicine today. In the 1970s and 80s, physicians at the University of Pittsburgh attempted to design a computer program that would establish a differential diagnosis for patients based upon their presentation and some laboratory input. Their aim was to ensure that all possible causes, common and rare, of a patient's illness were considered, and to provide direction for physicians caring for particularly difficult cases. Their product, INTERNIST-1 took decades of literature review and establishing ranking algorithms for each symptom/sign/laboratory finding as it related to each disease (an effort requiring approximately 15 person-years). While INTERNIST-1 proved to be accurate when a patient had a single disease, it did not work well on complex cases and involved the manual entry of a large amount of data for each patient, making it far too cumbersome to be useful.

AI has many applications for medicine and for emergency medicine. Many of these are demonstration projects but show promise for future widespread applications. AI can do a lot to improve physician performance and efficiency but will never replace the physician.

AI can handle well-defined repetitive tasks, especially when those tasks have defined inputs and binary (yes/no) outputs. There are now AI products that analyze photos of skin lesions and determine malignancy with greater specificity and sensitivity than dermatologists. For the ED there are applications for AI interpretation of rashes.

AI is excellent at predictive modeling. Numerous systems exist to predict readmissions, and the quantity and physical location of EMS calls. They can predict the need for admission for infants with bronchiolitis, adults with cervical spine injury, renal colic, and patient mortality in sepsis. It can be trained to interpret x-rays and images, often with greater accuracy than a radiologist.

AI has proven superior to humans in patient monitoring. Computers do not get "alarm fatigue" or take breaks. They may also assist with decision making, by making decision trees and care algorithms available at the appropriate "just in time" moment.

AI can also help with staffing and flow in the ED. Using years of data, it can predict patient influx and staffing shortages. It can provide more accuracy to triage decisions and deployment of staff/beds in the ED and hospital. Future applications of AI may reduce medication errors and reduce the incidence of falls and other patient safety concerns. AI shows promise in diagnosing and predicting mental illness, providing counseling via a robot and connecting individuals to services and resources.

Physicians will never be replaced by AI; it is there to augment our practice and patient care. AI cannot provide empathy or compassion. It cannot learn the Art of Medicine. It cannot be a doctor. It also takes a learned doctor to make sense of the data derived by AI. AI also relies on aggregated data, which may or may not apply to a specific patient. However, clearly AI will change the role of a physician.

ACEP currently does not have any policy statements or information papers addressing the role or future development and integration of AI in the emergency setting. The AMA has both policy and information papers on AI.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in the different environments across the acute care continuum.

Fiscal Impact

Cost for a summit approximately $25,000 plus staff labor.
Cost for a task force approximately $15,000 plus staff labor (depending on the number and site of meetings).
Cost for an educational offering approximately $5,000 (estimated speaker fee and travel costs).

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Sandy Schneider, MD, FACEP,
Associate Executive Director, Clinical Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 43(19)

SUBMITTED BY: Illinois College of Emergency Physicians
Maryland Chapter
Missouri College of Emergency Physicians
Pennsylvania College of Emergency Physicians
South Carolina College of Emergency Physicians
West Virginia Chapter

SUBJECT: Droperidol is Safe to Use in the ED

PURPOSE: Develop a policy statement and a clinical policy to guide members on the safe and effective use of droperidol for various indications in the ED based on existing medical evidence.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency physicians have encountered barriers in incorporating droperidol into their practice, including severe restrictions and overt prohibition; and

WHEREAS, Patients who present with agitated delirium to the emergency department (ED) can be undergoing life-threatening medical or psychiatric concerns; and

WHEREAS, Treatment of these patients can be challenging for the emergency physician; and

WHEREAS, There is growing evidence that the use of droperidol for the treatment of agitated delirium is safe and efficacious; and

WHEREAS, There is a wealth of literature on the safe use of droperidol for other indications in the ED including, but not limited to nausea, vomiting, and migraine headache; and

WHEREAS, Other emergency medicine organizations have published clinical policies on the safe use of droperidol in the ED; therefore be it

RESOLVED, That ACEP create a policy statement regarding the safety and effectiveness of the use of droperidol for various indications in the ED; and be it further

RESOLVED, That ACEP develop a clinical policy to guide its members on the safe and effective use of droperidol for various indications in the ED based on existing medical evidence.

References

1. https://www.acepnow.com/article/a-5-step-approach-to-the-agitatedpatient/?singlepage=1
2. Calver L, Page CB, Downes MA, et al. The Safety and Effectiveness of Droperidol for Sedation of Acute Behavioral Disturbance in the Emergency Department. Annals of EM. 2015; 66: 3. 230–238
3. AAEM Clinical Policy: Safety of Droperidol Use in the Emergency Department. Accessed 6/11/19. https://www.aaem.org/UserFiles/file/Safety-of-Droperidol-Use-in-the-ED.pdf

Background

This resolution calls for ACEP to develop a policy statement and a clinical policy to guide members on the safe and effective use of droperidol for various indications in the ED based on exiting medical evidence.

On December 5, 2001, the FDA issued a “black box” warning on droperidol. Droperidol had previously been used in

EDs for a variety of reasons, including for patients experiencing acute psychotic illnesses. The warning was issued because of a risk of torsades de pointes induced by QT prolongation.[2] Many experts, both in the ED and in other specialties, believe that the black box warning was issued based on poor evidence and effectively removed a safe and effective drug from use.

Much of the recent literature points to droperidol being safe and effective, with instances of arrythmia and/or other adverse effects being low. The Cochrane Database of Systematic Reviews updated a 2004[1] systematic review in 2016. Looking only at randomized controlled trials, the authors found that droperidol demonstrated a reduced risk of needing additional medications and there was no evidence that droperidol caused cardiovascular arrhythmia[3]. The authors concluded that the evidence against use of droperidol in the ED was based on personal experience rather than the evidence in the current literature[3].

A 2014 study in *Prehospital Emergency Care* looked at the data for 532 agitated patients, 289 receiving haloperidol and 132 receiving droperidol. The authors found there was no significant difference found in adverse events between haloperidol and droperidol.[5]

As recently as 2018, a study in *Tzu-Chi Medical Journal* found that droperidol is effective and safe to use to treat patients with nausea/vomiting, acute psychosis, and migraine in the ED.[4]

ACEP has a clinical policy on Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department and an information paper Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature. However, because of the black box warning, neither goes into detail regarding droperidol.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None.

Prior Board Action

January 2017, approved the revised clinical policy "Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department;" originally approved September 2005.

October 2014, reviewed the information paper "Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature."

Background Information Prepared by: Mandie Mims, MLS
Clinical Practice Manager

Margaret Montgomery, RN, MSN
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 44(19)

SUBMITTED BY: Indiana Chapter
New Jersey Chapter
Missouri College of Emergency Physicians
Ohio Chapter

SUBJECT: Independent ED Staffing by Non-Physician Providers

PURPOSE: 1) Review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

FISCAL IMPACT: Budgeted staff resources and up to $20,000 (unbudgeted) for dissemination of materials to communities and governmental agencies.

WHEREAS, There is a continued nationwide trend to expanding the scope of non-physician providers[i], specifically nurse practitioners (NP) and physician assistants (PA), to include independent practice of medicine; and

WHEREAS, There exists significant education and training differences between board certified emergency physicians and non-physician provider training;[ii,iii] and

WHEREAS, Some emergency departments have implemented staffing models with independent practicing, non-physician providers without the oversight of a board certified emergency physician or any emergency physician; and

WHEREAS, This creates a patient safety issue due to the lack of training, experience and oversight of these practitioners;[iv] and

WHEREAS, Emergency medicine deals with time critical disease processes that requires rapid intervention and procedures to prevent loss of life, which cannot be provided via off site supervision; and

WHEREAS, ACEP values the contributions by NP and PA practitioners to the care of emergency patients in a team-based environment, with direct supervision by physicians; therefore be it

RESOLVED, That ACEP review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" and be it further

RESOLVED, That ACEP develop tools and strategies to identify and educate communities, local, state, and the federal government regarding the importance of emergency physician staffing of emergency department; and be it further

RESOLVED, That ACEP oppose the independent practice of emergency medicine by non-physician providers; and be it further

RESOLVED, That ACEP develop and enact strategies, including legislative solutions, to ensure that the practice of emergency medicine includes mandatory on-site supervision by an emergency physician.

Background

This resolution calls on ACEP to review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." In addition, it asks for ACEP to develop tools and strategies to identify and then educate communities and government at all levels on the importance of emergency physician staffing of emergency departments. It asks that ACEP oppose the independent practice of emergency medicine by non-physician providers and develop strategies including legislative solutions to require on-site supervision of non-physicians by an emergency physician.

ACEP is already reviewing the 2013 policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." The revisions to the policy statement will be presented to the ACEP Board of Directors for approval at their meeting on October 24, 2019. ACEP already opposes the independent practice of emergency medicine by NPs and PAs (policy since 2001). ACEP already has a task force (details below) that is making recommendations for scope of practice and supervision requirements for NPs and PAs.

ACEP has assisted many state chapters as they confronted legislation that legalized the independent practice by NPs. While independent practice for NPs has passed in several states, efforts by National ACEP and the state chapters helped defeat legislation in many states.

Without question, NPs and PAs are valuable members of the emergency care team and are used effectively in many physician-led care models. However, ACEP has always believed that emergency care should be led by emergency physicians. ACEP has never supported the independent practice by NPs or PAs. In 2018, ACEP created a small workgroup composed of several members of the ACEP Board of Directors to discuss issues around the emergency medicine workforce. From the discussions of that group, two task forces were created: the NP/PA Utilization Task Force (NPUTF) and the EM Physician Workforce Task Force (EMPWTF).

The EMPWTF is examining the physician workforce supply and demand for the future. The EMPWTF is supporting a comprehensive study by Ed Salsberg, a noted national authority on physician workforce. ACEP invited all major emergency medicine organizations to participate and support this study. ABEM, AOBEM, ACOEP, EMRA, and SAEM chose to participate. AACEM, AAEM, AAEM/RSA, SAEM/RAMS declined. Although the focus of the EMPWTF is physician workforce, AAENP and SEMPA are participating.

The NPUTF is also multiorganizational, with all major emergency medicine organizations participating including AACEM, AAEM, AAEM/RSA, AAENP, ACEP, ACOEP, CORD, EMRA, ENA, SAEM, SAEM/RAMS, and SEMPA. The primary purpose of the NPUTF is to define the scope of practice and need for supervision for NPs and PAs who practice in the emergency setting. The NPUTF objectives are:

- *Objective 1: Overview of Current NP/PA Training* – The group is conducting an extensive review of current training requirements and options. This includes new options for on-line training (primarily for NPs) with special emphasis on the amount of general and emergency care specific exposure.
- *Objective 2: State of EM/APP Supervision* – The group is initially looking at current levels of supervision, including what is legally permitted and what is done in practice. They have prepared a survey and are attempting to obtain policies from various institutions.
- *Objective 3: Reimbursement Issues Surrounding the Use of NPs and PAs* – They plan a brief paper on the incentives, costs, and productivity data of PAs and NPs vs MDs. They are examining the cost of onboarding and retention patterns of the various providers. They will also cover requirements for chart co-signing and the medical-legal exposure associated with that practice.
- *Objective 4: EM/NP/PA Workforce Issues – The group is examining the distribution of the APP* workforce.
- *Objective 5: ACEP Policies* – The group is reviewing all ACEP's policies and positions regarding the use of NPs and PAs and determining if these should be recommended for revision. They are also reviewing policies of other organizations. They have noted that all policies are silent on the use of telehealth.
- *Objective 6: Current/Existing Policies/Procedures/Guidelines from Outside Groups* – USACS has provided their extensive guidelines; however, the group reports resistance by other large employers to release their policies. They are reaching out to the medical directors through ACEP's sections.

For the past year, the NPUTF has been preparing their report and recommendations. The report and recommendations will be provided to the ACEP Board of Directors for approval at the October 24, 2019 Board meeting. Once approved by the ACEP Board, it will be distributed to the other participating organizations for approval and endorsement. The report will then be submitted to *Annals of Emergency Medicine* for publication consideration.

ACEP's current policy statement, first created in 2001, "Providers of Unsupervised Emergency Department Care," clearly states that ACEP believes that the independent practice of emergency medicine is best performed by specialists who have completed American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) certification, or have successfully "completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited emergency medicine residency, and is in the process of completing ABEM or AOBEM examinations." Additionally, the policy includes the statement that "ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care" and ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists." The NPUTF is reviewing the policy statement and will provide their recommendations to the Board in October.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." In that policy statement, ACEP asserted that:

- PAs and APRNs do not replace the medical expertise and patient care provided by emergency physicians.
- PAs and APRNs working in EDs should have or acquire specific experience or specialty training in emergency care and should receive continuing education in providing emergency care.
- Credentialing procedures for PAs and APRNs in the ED must be specifically stated and approved by the facility governing body with input from the medical staff and must meet the requirements of the federal or state jurisdictions in which they practice.
- PAs and APRNs must be appropriately certified by their respective certifying bodies.
- Due to variations in state laws and regulations, it is imperative that emergency physicians, PAs and APRNs are aware of their scope of practice as well as physician supervision responsibilities and requirements.
- The PAs and APRNs scope of practice must be clearly delineated and must be consistent with federal and state laws and regulations.
- PAs and APRNs working in EDs should participate in a supervised orientation program, including demonstrating knowledge of specific ED policies and procedures and the requisite knowledge base to function safely and appropriately in the ED.
- The medical director of the ED or a designee has the responsibility of providing the overall direction of activities of the PA or APRN in the ED. In EMS, this is the role of the physician EMS medical director.
- PAs may function in various capacities and with varying degrees of supervision. However, as dependent practitioners, they must always function with a supervisory agreement with a physician.
- APRNs supervisory requirements (collaborative agreements) vary and independent practice is authorized in some states.
- ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care.
- Each supervising physician should retain the right to determine his/her degree of involvement in the care of patients provided by PAs and APRNs in accordance with the defined PA or APRN scope of practice, state laws and regulations, and supervisory or collaborative agreement. When such is required, the supervising physician for each PA or APRN encounter should be specifically identified.
- The ED medical director should define the number of PAs and/or APRNs whose clinical work can be simultaneously supervised by one emergency physician, guided by ED clinical needs and state laws.
- ED medical directors are encouraged to develop guidelines for PAs and APRNs outlining the types of conditions PAs and APRNs may or may not routinely evaluate and treat:
  - With indirect supervision: Verbal supervising physician consultation and/or chart review/signature.
  - With direct supervision: In conjunction with a supervising physician physically attending to the patient, providing face-to-face time.
- PAs and APRNs must be aware of and participate in performance improvement activities of the ED or EMS agency.

- The ED medical director should be responsible for ongoing professional practice evaluation of each PA and APRN utilizing focused professional practice evaluation, as appropriate.
- PAs and APRNs may fulfill clinical and administrative roles in which they will supplement and assist emergency physicians.
- Multiple staffing models utilizing PAs and APRNs exist. It is the responsibility of the ED medical director to identify the most appropriate staffing model to achieve operational efficiency, while maintaining clinical quality.

Over the past decade, there has been tremendous growth in the number of NPs and PAs, both in the ED and in medicine in general. Often used and referred to as a single group (Advanced Practice Providers or APPs), their background and training are very different, and their skill set, at least initially in the ED, may vary. NPs are required to be RNs first and then complete a master's degree in nursing (depending on the program, this may take 1.5-4 years). In general, 500 hours of faculty-supervised clinical hours are required. Some programs permit some of the curriculum to be taken on line. There is no specific emergency medicine NP; most are family nurse practitioners, although some may have a focus on acute care. Physician assistants generally are required to have two years of college coursework, with emphasis in the sciences, although most have a bachelor's degree. Most programs are three years and include 2,000 hours of clinical rotation.

Both NPs and PAs have the option of certification in emergency medicine. Specific post-graduate courses exist for both groups to get additional training in emergency medicine. However, all NPs and PAs can work in any area of healthcare by their license, and can, and often do, move from specialty area to specialty area with no requirement by the state for additional training. Certification in emergency medicine is a valuable credential but should never be used to support independent practice. The Society for Emergency Medicine Physician Assistants (SEMPA) was created in 1990. It is currently managed as an independent organization by ACEP. The American Academy of Emergency Nurse Practitioners (AAENP) is a newer and smaller organization. Both provide educational opportunities for their members and have a certification program to demonstrate competence in emergency medicine. To sit for the exam, AAENP requires an initial family NP program, with an additional 2,000 hours of emergency practice in the past five years, with at least 100 hours of continuing education in emergency medicine, with 30 of those hours specifically on procedural skills. Alternatives to these requirements include completion of a graduate or post-graduate training program in emergency medicine or an emergency medicine fellowship. SEMPA has a similar program.

NPs are considered licensed independent practitioners by the Health Resources and Services Administration (HRSA); however, state law determines whether they can practice independently. Many states recognize them as independent licensed practitioners (AK, AZ, CO, CT, HI, ID, IA, ME, MD, MT, NE, NV, NH, NM, ND, OR, RI, SD, VT, WA, WY, and Washington, DC). In all other states, NPs must work under the supervision of or in collaboration with a physician. PAs are required to have a formal connection to physicians; however, there is movement within the American Academy of Physician Assistants to advocate for more autonomy. SEMPA does not support the independent practice of PAs.

There are about 250,000 NPs and 140,000 PAs in the US. There are no good data on the number of NPs and PAs who practice in the ED. Many may practice in the ED for part of their work and then in an office or clinic setting. However, from the Clinical Emergency Data Registry and E-QUAL data, we know that about 10% of providers' participants are either PAs or NPs. That number appears to be similar in urban and rural areas. In general, most APPs in EDs work adjacent to or directly supervised by physicians but there is increasing use of APPs independently staffing EDs, with or without telemedicine oversight.

It should be noted that several other "non-physicians"' practice in the ED. This diverse group includes dentists, oral surgeons, psychologists, podiatrists, psychiatric social workers, and many more. Many of these provide consultation and direct patient care in the ED. Sexual Assault Nurse Examiners are trained RNs who provide services in some settings as well as collect forensic specimens. Increasingly, consultations in the ED are provided by NPs and PAs who work for other specialties. Some may direct patient care in the ED. Practice by these non-physicians is governed by local hospital policy. ACEP has not created a specific policy statement for these individuals when they provide services in the ED.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted staff resources and $20,000 to convene a task force (already appointed and in progress). Up to $20,000 (unbudgeted) for dissemination of materials to communities and governmental agencies.

Prior Council Action

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care and survey states and hospitals on where independent practice by NPs is permitted.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. Directed ACEP to work with NP and PA organizations to establish a curriculum and clinically-based ED educational training program and encourage certifying bodies to develop certifying examinations for competencies in emergency care.

Prior Board Action

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

September 2018, accepted the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations to proceed with the NP/PA Utilization Task Force and the Emergency Medicine Workforce Task Force.

June 2013, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements: "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

June 2011, adopted a motion to take no further action on referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development. In January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. A task force was appointed to review the available information and provide a recommendation to the Board regarding ACEP's potential involvement in the development of specialized training curricula for PAs and NPs that work in the ED.

May 2001, accepted the report of the Staffing Task Force.

The MLP/EMS Task Force recommendations were presented to the Board September 1999. The Board approved dissemination of the results of the surveys.

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Clinical Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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[i] Scope of Practice Policy: Nurse Practitioners Overview. http://www.scopeofpracticepolicy.org/practitioners/nurse-practitioners/
[ii] American Association of Family Physicians: Scope of Practice Kit: What is a Physician? https://www.aafp.org/dam/AAFP/documents/advocacy/workforce/scope/Restricted/ES-statescopeofpracticekit-051513.pdf
[iii] Primary Care Coalition: Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners. https://www.tafp.org/Media/Default/Downloads/advocacy/scope-education.pdf
[iv] McCleery E, Christensen V, Peterson K, et al. Evidence Brief: The Quality of Care Provided by Advanced Practice Nurses. 2014 Sep. In: VA Evidence Synthesis Program Evidence Briefs [Internet]. Washington (DC): Department of Veterans Affairs (US); 2011-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK384613/

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 45(19)

SUBMITTED BY: International Emergency Medicine Section
Social Emergency Medicine Section

SUBJECT: Medical Neutrality

PURPOSE: Make a public statement in support of medical neutrality.

FISCAL IMPACT: Budgeted committee, section, and staff resouces.

WHEREAS, Medical neutrality describes the ethical obligation of medical professionals to treat the sick and injured without discriminating on the basis of religion, race, or political affiliation; and

WHERAS, Medical neutrality is a universal principle which applies in both times of armed conflict, as enshrined in international humanitarian law, and in times of peace, as enshrined in the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social, and Cultural Rights (ICESCR), and the Convention Against Torture (CAT); and

WHEREAS, Emergency physicians and our prehospital colleagues, being uniquely situated to provide life-saving care in times of conflict, have a special responsibility to defend medical neutrality; therefore be it

RESOLVED, That ACEP make a public statement in support of medical neutrality.

Background

This resolution calls on ACEP to make a public statement in support of medical neutrality. Medical neutrality primarily refers to a principle of noninterference with medical services in times of armed conflict and civil unrest. Medical neutrality is often interpreted as practicing medicine impartially and with immunity from attack, for both providers and patients, during times of conflict. Medical neutrality has drawn its tenets from international law, medical professional codes of ethics, as well as humanitarian law. The 1864 Geneva Convention established principles of neutrality for medical personnel, establishments and units providing relief to the wounded. It stated: "Inhabitants of the country who bring help to the wounded shall be respected and shall remain free," and that "Wounded or sick combatants, to whatever nation they may belong, shall be collected and cared for." The later 1949 Geneva Convention, which replaced the Convention of 1864, also established rules for the protection of people not participating in fighting as well as those unable to fight; specifically calling for provisions that would give protection to the wounded and sick, as well as to medical and religious personnel. Additional protocols were added to address non-international armed conflicts as well as wars of national liberation. Currently, there are 194 nations that have ratified the Geneva Conventions. The International Covenant on Economic, Social, and Cultural Rights (ICCPR) and the International Covenant on Civil and Political Rights were both signed and ratified during the United Nations (UN) 1966 General Assembly. The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment was signed and ratified by the UN in 1984. In 2016, the UN adopted Resolution 2286, which condemned attacks and demanded compliance with the Geneva Convention.

In 2012, the World Health Assembly (WHO) adopted Resolution 65.20 that called on WHO to provide global leadership in collecting and reporting information on healthcare attacks. The WHO created the Attacks on Health Care Initiative to collect evidence on attacks and promote best practices for preventing them. As part of the initiative, they

monitor secondary internet sources for attacks and work with partners on the ground in conflict and emergency-affected countries to gather relevant information.

The United States Medical Neutrality Protection Act of 2013, referred to the House Foreign Affairs and Judiciary Committees, required the Secretary of State to annually compile a list of foreign governments that the Secretary determined to have engaged in violations of medical neutrality. Some examples of violations included: militarized attacks on health care facilities, health care service providers or individuals receiving medical treatment; destruction of medical supplies; and deliberate blocking of access to health care professionals. The bill prohibited assistance to governments that violated medical neutrality and also directed diplomatic and consular missions to investigate all reports of violations. After its introduction to the House on May 16, 2013, it was referred to the Subcommittee on Immigration and Border Security.

The World Medical Association (WMA) policy on international ethics states that a "physician shall give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care," and "always bear in mind the obligation to respect human life." The AMA policy statement, *Medical Neutrality H-520.998*, supports global medical neutrality for all health care workers, the sick and wounded. The ACEP *Code of Ethics for Emergency Physicians* calls on emergency physicians to "respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care." ACEP adopted the revised policy statement "Non-Discrimination and Harassment" in June 2018. In February of 2019, ACEP signed on to the Colombo Declaration, which condemned attacks on health care facilities, workers, and vehicles in conflict zones.

Documented violations of medical neutrality have occurred, and continue to occur, throughout the world. One study found that while the likelihood of violence against health care workers increased as conflict increased, there was no correlation between attacks on civilians and health/aid workers thus suggesting that health care workers are overtly targeted. According to WHO data, there were a total of 388 attacks on health care workers, resulting in 322 deaths and 425 injuries, in 19 countries across the globe in 2018 alone. The International Committee of the Red Cross (ICRC) conducted a two-and-a-half-year analysis looking at reports of violations in countries where they had operations and found 655 violent incidents in 16 countries. While the short-term consequences of violations of medical neutrality have been cited (i.e. lack of access to essential health services, reduced capacity to address infectious disease, loss of facilities, large-scale exodus of health care workers from a conflict area), the WHO states that the full extent of the impacts of attacks on health care is not yet known. Attacks on health care are increasingly used strategically during times of conflict but are rarely prosecuted nationally. Additionally, some governments might also criminalize the provision of medical care to those injured and seen as the opposition.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted. Directed the College to oppose all forms of discrimination against patients and that ACEP oppose employment discrimination in emergency medicine.

Prior Board Action

June 2018, approved the revised policy statement "Non-Discrimination and Harassment";" revised and approved April 2012 with the current title; originally approved October 2005 titled "Non-Discrimination."

January 2017, approved the revised policy statement "Code of Ethics for Emergency Physicians;" revised and approved June 2016 and June 2008; reaffirmed October 2001; revised and approved with the current title June 1997; originally approved January 1991 titled "Ethics Manual."

October 2015, approved the revised policy statement "Emergency Physicians Rights and Responsibilities;" revised and approved April 2008 and July 2001; originally approved September 2000.

April 2014, reaffirmed the policy statement "Cultural Awareness and Emergency Care;" approved April 2008 with the current title; originally approved October 2001 titled "Cultural Competence and Emergency Care.

Substitute Resolution 41(05) Sexual Orientation Non-Discrimination adopted.

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 46(19)

SUBMITTED BY: Kerry Forrestal, MD, MBA, FACEP
Erik Schobitz, MD, FACEP
Maryland Chapter
New Jersey Chapter

SUBJECT: Mental Health Care for Vulnerable Populations

PURPOSE: Support increasing the capacity of mental health facilities to provide care for children with special needs and support policies that allow pediatric patients to be admitted to a conventional mental health facility to receive treatment while also remaining in the queue for a bed at a neuropsychiatric facility.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Children with special needs, such as those who have lower functioning autism or other neurological impairments plus mental health issues will, on occasion, require hospitalization for medication stabilization; and

WHEREAS, There are extremely limited neuropsychiatric beds available to place these children: in Maryland, as an example, there is one hospital with four beds that will care for adults and children with combined neurological and psychiatric issues, this in a state with a population of over 6 million residents; and

WHEREAS, These vulnerable children are forced to wait in Emergency Departments after being medically cleared for admission for placement in one of these scarce beds; and

WHEREAS, This boarding situation puts patients, families, and staff at risk of assault; therefore be it

RESOLVED, That ACEP support increasing the capacity of current conventional mental health facilities to provide care for children with special needs; and be it further

RESOLVED, That ACEP support policies that allow a pediatric patient to be admitted to a conventional mental health facility and receive treatment while remaining "on the list" for a bed at a neuropsychiatric facility.

References

1. According to Becker's Hospital Review 8/2016 – Total US psychiatric inpatient beds declined 13% from 2010-2016.
2. Becker's Hospital Review also notes that according to some estimates, the US needs 123,300 more inpatient psychiatric beds to alleviate the current shortage.
3. The CDC in 2018 noted a 15% increase in prevalence of autism nationally over the previous biannual review. Autism Speaks notes the prevalence is now 1/59 children by age 8 will be diagnosed as autistic.

Background

This resolution calls for ACEP to support increasing the capacity of mental health facilities to provide care for children with special needs and to support policies that allow pediatric patients to be admitted to a conventional mental health facility to receive treatment while also remaining in the queue for a bed at a neuropsychiatric facility.

The nation's dwindling mental health resources present significant challenges for emergency department (ED) physicians. Over the past several decades, there has been a movement towards treating patients with mental illness or

intellectual and developmental disabilities (I/DD) in the community instead of in inpatient facilities. Several factors, such as advacements in therapeutic and pharmacologic treatments (i.e., development of first-generation antipsychotics in the late 50s and early 60s), political and federal priorities (i.e., NIMH's push for community health centers under Dr. Robert Felix), as well as societal pressures and outcry over the conditions of state run facilities in the 40s and 50s precipitated the de-institutionalism of mental health care that occurred during most of the 60s. The National Association of State Mental Health Program Directors report notes a decline of 77.4% beds for inpatient psychiatric patients since 1970. The Agency for Healthcare Research and Quality states that "From 1970 to 2000, public psychiatric hospital beds dropped from 207 to 21 beds per 100,000 persons." Unfortunately, to this day, the availability of psychiatric beds is limited and community care remains fragmented and difficult to access.

Patients with mental health complaints and/or intellectual and developmental disabilities (I/DD) are increasingly presenting to EDs for care. The prevalence of U.S. children with diagnosis of a developmental disability is 6.99%, according to the CDC. Approximately 7% of pediatric emergency department visits are for mental health or behavioral emergencies. However, little is known about patients with I/DD presenting to the ED because the patient population with intellectual or developmental disabilities is rarely studied in emergency departments. Additionally, there are state-to-state variations in statutes directing the treatment of individuals with I/DD.

Psychiatric bed availability varies widely. Beds exist in a variety of settings, from specialized private or public hospitals, units in general hospitals, psychiatric-specific inpatient units, VA centers and more. Each of these facilities might have different admission and insurance requirements or other restrictions, such as acuity, age, uncertainty with "medical clearance," etc. Insurance authorization allowing psychiatric patients to be admitted to the hospital from the ED can often take extensive amounts of time, contributing to boarding and further burdening the ED. Additionally, many psychiatric facilities do not fall under EMTALA and can, therefore, legally refuse admission. One study found that out of seven psychiatric hospitals available for pediatric patients in Houston, Texas, none would accept patients with severe intellectual disabilities or autism. As noted previously, with the decrease in available beds and increasing demand, psychiatric facilities are frequently at capacity and often have no place for additional patients. Some facilities might exclude patients because of inadequate staffing, or lack of advanced equipment/training needed for care (i.e., tracheostomy care, etc.). Many psychiatric facilities may also lack the ability to provide basic medical care for patients with insulin-dependent diabetes, dialysis-dependent renal failure, unresolved cellulitis, or pregnancy. Without the ability to care for such patients, facilities may refuse transfer even if they have capacity. While some states have instituted real-time, psychiatric bed registries, this is not a common practice across the U.S.

Compounded with a shortage of available beds is a severe shortage of mental health care providers in the workforce. In 2016, the US Department of Health and Human Service (HHS), the Health Resources and Services Administration (HRSA), the Bureau of Health Workforce, and the National Center for Health Workforce Analysis produced a report addressing the supply and demand of behavioral health practitioners. It projected a shortage of behavioral health workers by 2025 along with an increasing national demand from patients. Another study looking at national trends in ED visits for youth with mental health concerns found that only 16% of patients in the ED were seen by a mental health provider during their visit. According to the American Academy of Child and Adolescent Psychiatry (AACAP), as of April 2019 there are 8,300 practicing child and adolescent psychiatrists in the United States with an estimated 15 million children and youth in need of services. A 2015 workforce study done by the American Academy of Pediatrics (AAP) and the Child Neurology Society (CNS) found that of the child neurologists surveyed, the majority of division directors believed that their current staffing levels were inadequate and they perceived an increasing volume and complexity of referrals. A growing subspecialty of pediatrics, developmental-behavioral pediatrics (DBP), had less than 800 AAP board-certified DBPs by the end of 2016.

Emergency departments can be overwhelming for children with autism. Additionally, children with autism might have unusual reaction to medication and elevated behavioral responses to routine procedures. ACEP's policy statement "Pediatric Mental Health Emergencies in the Emergency Department" states that, "The American College of Emergency Physicians supports the following actions: advocacy for increased community mental health resources and linking them to the medical home, EDs, and inpatient psychiatric hospitals, as well as improved pediatric mental health tools for the ED, increased mental health insurance coverage, adequate reimbursement at all levels; acknowledgment of the importance of the child's medical home and their role in managing crisis events, development of community paramedicine programs for accurate assessment and triage of behavioral health crisis, and promotion of education and research for mental health emergencies." It also says that, "EDs should safely, humanely, and in a

culturally sensitive manner manage patients with exacerbations of known diagnosed mental illnesses as well as those with developmental delay, autistic spectrum disorders, ADHD, or those in behavioral crisis," and that, "Pediatric mental health emergencies are best managed by a skilled, multidisciplinary team approach, including specialized screening tools, pediatric-trained mental health consultants, the availability of pediatric psychiatric facilities when hospitalization is necessary, and an outpatient infrastructure that supports pediatric mental health care, including communication back to the primary care physician and timely and appropriate ED referrals to mental health professionals."

ACEP's policy statement "Boarding of Pediatric Patients in the Emergency Department" states, "Recognizing that a major contributor to boarding admitted pediatric patients in the ED is the delay in transfer of care and placement to inpatient units after the decision to admit, hospital and inpatient processes must be improved to speed transfer of admitted patients out of the ED." Additional policy statements, such as "The Role of Emergency Physicians in the Care of Children" call for "...optimal access to facility and specialists," while the policy statement "Pediatric Readiness in the Emergency Department" (joint policy statement with the American Academy of Pediatrics and the Emergency Nurses Association) calls for written policies, procedures and protocols in the ED for: social and behavioral health issues; children with special health care needs including developmental disabilities; written pediatric interfacility transfer procedures and/or agreements that include psychiatric emergencies. ACEP conducted an all-member poll in April 2014 on ED trends and the poll included questions on psychiatric patients. Another membership poll on psychiatric boarding was disseminated in 2016.

ACEP frequently collaborates with the American Academy of Pediatrics (AAP) on joint policy statements and development of resources and tools for emergency physicians. One such tool is the Emergency Information Form (EIF) for Children with Special Health Needs. This form is intended to summarize a child's complicated medical history when they present with an acute health need without their pediatrician or parent. Along with the EIF, ACEP and AAP developed a fact sheet and policy statements to better help physicians treat and manage children with special needs, such as those with ASD. ACEP is also developing a bedside, point-of-care tool that will outline evidence-based clinical content for the care of patients with autism spectrum disorder. The tool will be submitted to the ACEP Board of Directors in October 2019 for review.

Recent efforts to address mental health have also occurred. During the 2019 Leadership & Advocacy Conference, ACEP advocated on the Hill for mental health policy changes, calling for innovations within mental health care itself and improved access to care. ACEP members urged lawmakers to co-sponsor the "Improving Mental Health Access from the Emergency Department Act." In 2017, ACEP called on lawmakers to express support for H.R. 3931, the "Excellence in Mental Health and Addiction Treatment Expansion Act," which would provide outpatient services and make inpatient psychiatric beds more readily available. In 2016, ACEP advocated for legislation that provided additional resources for patients with serious mental illness. H.R. 2646, the "Helping Families in Mental Health Crisis Act of 2015," called for expansion of the mental health workforce and for mental health parity in health plans. Later, the 21st Century Cures Act, passed into law in December 2016, included a number of provisions around mental health, including Section X "Strengthening Mental and Substance Use Disorder Care for Children and Adolescents" as well as language from the H.R. 2646 bill that ACEP had promoted.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Goal 2 Enhance Membership Value and Member Engagement
Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 40(18) Care of Individuals with Autism Spectrum Disorder in the ED adopted. Directed ACEP to develop educational materials for emergency physicians to improve the treatment and management of patients with Autism Spectrum Disorder in the ED.

Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient adopted. The resolution directed ACEP to develop a psychiatric boarding toolkit.

Amended Resolution 14(16) Development and Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs adopted. Called for the development and application of throughput quality data measures and dashboard reporting for behavioral health patients boarded in EDs.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted. Directed ACEP to work with the US Department of Health and Human Services, US Public Health Service, The Joint Commission and other appropriate stakeholders to determine action steps to reduce ED boarding and crowding.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to seek out and work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Additionally directed ACEP to promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted. Directed ACEP to convene a work group of appropriate stakeholders to explore and identify additional resources, technologies, and best practices that promote quality patient care for timely evaluation and disposition of behavioral health patients and provide a report to the 2013 Council.

Amended Resolution 26(10) Determining Medical Clearance for Psychiatric Patients in Emergency Departments adopted. Directed ACEP to meet with the American Psychiatric Association and other stakeholders to create a standard for the medical stability of psychiatric patients that includes the conclusions from the 2006 ACEP "Clinical Policy: Clinical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department."

Substitute Resolution 28(06) Psychiatric Bed Availability adopted. Directed that ACEP work with appropriate organizations to study the impact of psychiatric bed availability on emergency departments and EMS, seek solutions to problems identified, and bring the issue to the AMA House of Delegates at the 2007 annual meeting.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted. This resolution called on ACEP to develop talking points to respond to issues related to psychiatric and substance use patients in the ED.

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted. This resolution called on ACEP to support legislation around psychiatric involuntary transfers.

Prior Board Action

Resolution 40(18) Care of Individuals with Autism Spectrum Disorder in the ED adopted.

Amended Resolution 39(18) Care of the Boarded Behavioral Health Patient adopted.

September 2018, approved the revised policy statement, "Pediatric Mental Health Emergencies in the Emergency

Department;" reaffirmed April 2012; originally approved April 2006 titled, "Pediatric Mental Health Emergencies in the Emergency Medical Services System."

September 2018, approved the revised policy statement, "Boarding of Pediatric Patients in the Emergency Department;" originally approved January 2012.

June 2018, approved the revised policy statement "Pediatric Readiness in the Emergency Department" with the current title; revised and approved April 2009; originally approved December 2000 titled "Guidelines for Care of Children in the Emergency Department."

June 2017, approved the Quality & Patient Safety Committee's recommendation to develop a toolkit for reporting of behavioral health patients that can be implemented independently in Emergency Departments. The Clinical Emergency Department Registry (CEDR) currently has dashboard functionality and the ED throughput measures are included in the registry and reportable to CMS for the Quality Payment Program (QPP). CMS currently collects data on CMS OP-18c measure for arrival to ED departure time for psychiatric and mental health patients and CMS ED-2c measure for admit decision to ED departure time for psychiatric and mental health patients.

January 2017, approved the "Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department." Replaced the 2006 clinical policy with the same title. The 2006 clinical policy replaced the 1999 "Clinical Policy for the Initial Approach to Patients with Altered Mental Status."

June 2016, reviewed the updated the information paper "Emergency Department Crowding High-Impact Solutions."

Amended Resolution 14(16) Development and Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs adopted.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted October 2015.

October 2015, reviewed the information paper "Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department."

October 2014, reviewed the information paper, "Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature."

June 2013, reaffirmed the policy statement, "The Role of Emergency Physicians in the Care of Children;" reaffirmed October 2007; revised and approved June 2001 and January 1996; originally approved September 1989.

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted.

Amended Resolution 26(10) Determining Medical Clearance for Psychiatric Patients in Emergency Departments adopted.

January 2008, approved the survey on Psychiatric Bed Availability for distribution to the Emergency Department Directors Academy e-list.

Substitute Resolution 28(06) Psychiatric Bed Availability adopted.

Amended Resolution 20(06) Psychiatric and Substance Abuse Patients in the Emergency Department adopted.

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted.

June 1984, approved the policy statement "The Emergency Physician's Role in Behavioral Emergencies."

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING.RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 47(19)

SUBMITTED BY: Indiana Chapter

SUBJECT: Prevention of Self -Harm & Accidental Injury by Internet Challenges and Social Media Posts

PURPOSE: Work with the CDC to study, track, and trend statistical data about accidental self-harm promoted by social media posts, develop guidelines for recognition of self-harm content, develop programs to advance awareness among adolescents, and promote legislation that protects patients from self-harm and prohibits posting of self-harm challenge content and videos on social media sites and the internet.

FISCAL IMPACT: Undetermined amount of staff resources.

WHEREAS, The American College of Emergency Physicians represents the interests of emergency physicians who provide healthcare access for all persons residing in America; and

WHEREAS, The American College of Emergency Physicians advocates for measures to protect the patients we serve and promote wellness and harm prevention; and

WHEREAS, The American College of Emergency Physicians understands the powerful influence and easy accessibility of information posted on the internet and social media sites which promote self-harm and pose challenges; and

WHEREAS, The American College of Emergency Physicians realizes the dangerous and potentially fatal effects of mimicking these challenges resulting in self-harm and death, especially for our most vulnerable adolescent population; and

WHEREAS, Social media sites have a moral obligation to monitor posts which could be harmful to their viewers; therefore be it

RESOLVED, That ACEP study, track, and trend statistical data regarding accidental self-harm promoted by social media posts in collaboration with the Centers for Disease Control; and be it further

RESOLVED, That ACEP develop guidelines for the recognition of self-harm content and develop programs to advance awareness amongst adolescents; and be it further

RESOLVED, That ACEP promote legislation that protects patients from self-harm materials and prohibits the posting of self-harm challenge content and videos on social media sites and the internet.

Background

This resolution calls for ACEP to work with the CDC to study, track and trend statistical data regarding accidental self-harm promoted by social media posts, develop guidelines for recognition of self-harm content, develop programs to advance awareness among adolescents, and promote legislation that protects patients from self-harm and prohibits posting of self-harm challenge content and videos on social media sites and the internet.

To date, ACEP has not addressed self-harm and accidental injury caused by internet challenges and social media posts.

An article in Archives of Disease in Childhood, "Prevalence and associated harm of engagement in self-asphyxial behaviors ("choking game") on young people: a systematic review" notes that this behavior is not new and was described in the British Medical Journal in 1951. The CDC defines the "choking game" as "self-strangulation or strangulation by another person with the hands or with a noose to achieve a brief euphoric state caused by cerebral hypoxia." The "choking game" is most frequently related to a social media challenge, fitting in with a social group and experimentation.

A 2008 CDC Morbidity and Mortality Weekly Report, "Unintentional Strangulation Deaths from the 'Choking Game' Among Youths Aged 6-19 Years- United States, 1995-2007" noted that death certificates lack the detail necessary to distinguish choking-game deaths from other unintentional strangulation deaths and utilized LexisNexis to search newspaper reports and choking-game-awareness websites to identify deaths. This report was the first attempt to assess the incidence of deaths as a result of the "choking game" in the US. It is difficult to track statistics because cases can be reported as suicides.

YouTube and other websites provide information and songs about the choking game. A 2014 Lifetime Movie titled "The Choking Game" was based on a young adult novel, "Choke," published in 2012. There are websites and webpages focused on providing information (the choking game has a variety of names), describing the "game" and identifying signs and symptoms that could indicate that an adolescent is participating in this risky behavior.

There are numerous social media challenges including: The Blue Whale challenge that persuades teens to accept 50 challenges over 50 days that can include self-mutilation, running away from home, a last challenge to commit suicide to end the game; car surfing where the teen "surfs" on the roof, bumper, or hood of a moving vehicle; Tide pod ingestions; and the cinnamon challenge that dares participants to swallow a tablespoon of cinnamon in one minute without drinking any liquid to wash it down.

The Public Health & Injury Prevention Committee (PHIPC) was assigned an objective for the 2017-18 committee year to "review the literature and research on contagion-related suicide risk for teens." The committee developed the information paper "Suicide Contagion in Adolescents: The Role of the Emergency Department."

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Undetermined amount of staff resources.

Prior Council Action

The Council has discussed and adopted resolutions related to suicide, but none on the subject of self-harm and accidental injury as a result of internet challenges and social media posts.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. Directed that ACEP research the feasibility of identifying and risk-stratifying patients at high risk for violence; devise strategies to help emergency physicians work with stakeholders to mitigate patients' risk of self-directed or interpersonal harm; and investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes and explore similar precedents currently in use.

Prior Board Action

September 2018, reviewed the information paper ""Suicide Contagion in Adolescents: The Role of the Emergency Department"

November 2015, reviewed the information paper, "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED."

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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RESOLUTION: 48(19)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: Promotion of Maternal and Infant Health

PURPOSE: Collaborate with ACOG to promote maternal and infant health in rural areas and provide educational materials for emergency physicians on how to provide care consistent with best practices for these vulnerable populations.

FISCAL IMPACT: Budgeted staff resources and $20,000 for creation of a point of care tool.

WHEREAS, Many hospitals across the country have inadequate or no obstetric coverage and the percentage of rural counties with hospital-based obstetric services declined from 55% to 46% between 2004 and 2014,[1,2] with less-populated rural counties experiencing more rapid declines[3,4]; and

WHEREAS, Pregnant patients in rural settings may need to travel long distances for obstetric care; and

WHEREAS, Pregnant patients may present to an emergency department with an obstetrical complaint or complication; and

WHEREAS, These rural patients are more likely to have a preterm delivery; therefore be it

RESOLVED, That ACEP attempt to collaborate with the American College of Obstetricians and Gynecologists to promote maternal and infant health; and be it further

RESOLVED, That ACEP work with the American College of Obstetricians and Gynecologists and other stakeholders to provide educational materials, such as toolkits, to emergency physicians regarding how to provide care that is up-to-date and consistent with best clinical practices for these vulnerable populations.

References

[1]Access to Obstetric Services in Rural Counties Still Declining with 9 percent losing services 2004-14
Health Affairs, September 2017
[2]Eroding Access and Quality of Childbirth care in Rural US Counties, JAMA 2018
[3]The neglected challenge: Saving America's rural ob care
https://www.contemporaryobgyn.net/maternal-mortality-special-reports/neglected-challenge-saving-americas-rural-ob-care
[4]Kozhimannil KB, Hung P, Henning-Smith C, Casey MM, Prasad S. Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States [published online March 8, 2018.] *JAMA* . doi: 10.1001/jama.2018.1830.

Background

This resolution calls for the College to collaborate with the American College of Obstetrics and Gynecology to promote maternal and infant health in rural areas and to provide educational materials such as toolkits for emergency physicians regarding how to provide care consistent with best practices for these vulnerable populations.

ACEP is already working on educational materials with the American College of Obstetrics and Gynecology (ACOG). ACOG has recently received a grant from the CDC to develop educational materials for non-OB physicians to reduce maternal morbidity and mortality. ACOG reached out to ACEP as their initial organization and we will be

working with them over the next one to two years to create appropriate content. Additionally, ACOG has expressed interest in ACEP creating a point of care tool for the website and app that would cover maternal and post-partum complications.

The American Academy of Family Physicians has created a course on Advanced Life Support in Obstetrics that is available to all physicians. Several emergency physicians who practice in a rural or low-resourced setting have taken this course

Many rural healthcare facilities have been under pressure for many years to keep their doors open. Disparities in healthcare for rural versus urban communities is reflected in national-level data. ACOG noted in their Committee Opinion in February 2014 titled "Health Disparities in Rural Women" that "In 2008, only 6.4% of obstetrician-gynecologists practiced in a rural setting. By 2010, 49% of the 3143 U.S. counites (home to 10.1 million women or 8.2% of all women), lacked an obstetrician-gynecologist." The report outlines recommendations to reduce rural health disparities but notes that rural communities are diverse and local solutions are needed to address local issues. In 2015, CDC data showed a maternal mortality rate of 18.2 per 100,000 live births in a metropolitan area versus 29.4 deaths per 100,000 live births in most rural areas. CDC figures reflect the same trend for infant mortality rates.

ACOG developed a Committee Opinion on Hospital-Based Triage of Obstetric Patients but these recommendations are for collaboration of hospital-based obstetric units and the emergency department within the same facility.

At *ACEP19* there are several courses that address pregnancy and trauma in pregnancy. Two sessions of "Emergency Vaginal Delivery Lab" are offered with one session each of these two courses: "Late Pregnancy and Postpartum Emergencies" and "Trauma in Pregnancy." The lab on vaginal deliveries will discuss the management of the complications associated with an emergency delivery, identifying necessary equipment, and identifying patients who cannot be transferred to labor & delivery.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Goal 2 Enhance Membership Value and Member Engagement
Objective C – Provide robust communications and educational offerings, including novel delivery models.

Fiscal Impact

Budgeted staff resources and $20,000 for creation of a point of care tool.

Prior Council Action

None.

Prior Board Action

January 2019, reaffirmed the joint policy statement, "Death of a Child in the Emergency Department." A joint policy statement of the ACEP, American Academy of Pediatrics (AAP), and the Emergency Nurses Association (ENA.) Revised by AAP April 2014, ENA October 2012 and ACEP March 2013. Reaffirmed in October 2008 by ACEP and AAP. Approved June 2002 by AAP. Originally approved February 2002.

April 2018, approved the policy statement "Interpretation of EMTALA in Medical Malpractice Litigation."

October 2016, approved clinical policy "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy."

April 2014, approved revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved October 2007, June 2004, and June 2001 with current title; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

April 2012, approved the revised Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy. Originally approved September 2002.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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RESOLUTION: 49(19)

SUBMITTED BY: Arizona College of Emergency Physicians
District of Columbia Chapter
Idaho Chapter
Illinois College of Emergency Physicians
Maryland Chapter
New Jersey Chapter
Pennsylvania College of Emergency Physicians
West Virginia Chapter

SUBJECT: Protecting Emergency Physician Compensation During Contract Transitions

PURPOSE: Adopt a new policy statement addressing continuity of fair compensation including monetary payments and malpractice coverage during times of contract transitions.

FISCAL IMPACT: Budgeted staff and committee resources to develop and disseminate a policy statement.

WHEREAS, Emergency physicians providing medical services in hospitals may be employed by separate corporate entities or staffing groups who contract with the said hospital for those services; and

WHEREAS, Emergency physicians may not have input into the contract negotiations between the said hospital and staffing group; and

WHEREAS, During times of transitions in staffing group contracts, emergency physicians have been asked to work unpaid to complete their professional responsibilities; and

WHEREAS, The ACEP policy statement "Emergency Physician Rights and Responsibilities"[2] states that emergency physicians "should be accorded due process before any adverse final action with respect to employment or contract status" and "both independent contractors and physician employees should be represented in the contract negotiation process between hospitals and those payers providing reimbursement for emergency services;" and

WHEREAS, The ACEP policy statement "Compensation Arrangements for Emergency Physicians"[3] states "Exploitation of emergency physicians by other emergency physicians or health care entities is improper;" therefore be it

RESOLVED, That ACEP adopt the following statement and disseminate its content to its members and other parties: "It is the position of the American College of Emergency Physicians that emergency physicians who provide services to patients during a time of contract transitions should be fully compensated for their professional efforts without delay, barrier, or requirement to continue employment with a specific party. This compensation should include monetary compensation as well as uninterrupted provision of malpractice coverage. Parties involved in contract transitions, including contract management groups and the hospitals and health systems involved, have a responsibility to meet these obligations immediately and not use such a transition as leverage in the contract process."

References

1. https://www.phillytrib.com/metros/montgomery_county/er-doctors-go-unpaid-atroxborough-other- hospitals-in-changeover/article_9f25e8f2-a33d-5f4e-97377a812ff0cc7b.html
2. ACEP Policy: Emergency Physician Rights and Responsibilities. Accessed on 6/10/19. https://www.acep.org/patient-care/policy-statements/emergency-physician-rights-andresponsibilities/
3. ACEP Policy: Compensation Arrangements for Emergency Physicians. Accessed on 6/10/19. https://www.acep.org/patient-care/policy-statements/compensationarrangements-for-emergency- physicians/

Background

This resolution calls for ACEP to adopt a new policy statement specifically addressing continuity of fair compensation, including monetary payments and malpractice coverage, during times of contract transitions. It further speaks against using the transition period for leverage in negotiating new contract terms. The authors cite two examples from 2018 to support the need for this policy statement. The concepts addressed in the proposed policy can be found in other ACEP resources, but not stated as succinctly as in this language.

ACEP's policy statement "Emergency Physician Rights and Responsibilities" explains that emergency physicians typically work under a contractual arrangement to provide staffing. Relevant points include:

- Emergency physicians should be reasonably compensated for clinical and administrative services and such compensation should be related to the physician's qualifications, level or responsibility, experience, and quality and amount or work performed.
- Emergency physicians should be accorded due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges. Emergency physicians' medical and/or clinical staff privileges should not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law.
- Emergency physicians, both independent contractors and physician employees, should be represented in the contract negotiation process between hospitals and those payers providing reimbursement for emergency services. Emergency physicians are entitled to fair rights and reimbursement pursuant to such contract agreements.
- Emergency physicians should not be required to agree to any unreasonable restrictive agreement that limits the right to practice medicine for a specified period of time or in a specific area after the termination of employment or contract to provide services as an emergency physician. Such restrictions are not in the public interest.

ACEP's policy statement "Compensation Arrangements for Emergency Physicians" includes two relevant points:

- Regardless of the compensation method or practice arrangement, emergency physicians are entitled to fair and equitable compensation, taking into account their experience and added value to the practice, market conditions, and other appropriate circumstances.
- Exploitation of emergency physicians by other emergency physicians or health care entities is improper.

ACEP's policy statement (not referenced in the resolution) "Emergency Physician Contractual Relationships" also contains a relevant point:

- The contracting parties should be ethically bound to honor the terms of any contractual agreement to which it is a party and to relate to one another in an ethical manner.

The "Emergency Physician Contractual Relationships" policy statement has an associated Policy Resource & Education Paper (PREP) that explains some of the background and foundation of the policy statement.

In 2017, the Contract Transitions Task Force developed the information paper "Emergency Department Physician Group Staffing Contract Transition" that includes this information:

> "The contract should have clear language detailing the rights and responsibilities of the party after the decision to terminate is made. Typically, both parties have the same obligations and rights until the termination date. Contracts should specify an orderly transition, and both parties should agree to work collaboratively towards that future transition. Whether there are certain ethical obligations on all parties (beyond the contract) is perhaps debatable, but continuity of patient care, patient safety and community safety, and any medical student/resident vital patient care or educational programs should be paramount.

> There are certain rights and obligations that must continue after termination. For example, sharing billing information, HIPAA compliance, and addressing final payments and/or accounts receivable should be specified in the contract."

The information paper also references malpractice coverage in the event of contact termination.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective E.5. – Monitor and support chapter efforts to pursue legislative and regulatory initiatives that ensure fair payment.

Objective G.6. – Review and update as needed ACEP resources, including educational offerings that provide information to members to help minimize their liability risks. Collate the resources and promote to members.

Goal 2 Enhance Membership Value and Member Engagement
Objective H.3. – Develop a collection of resources for each of the stages in a physician's career – first job, moving, maternity, leadership and advancement, planning for retirement, retirement.

Fiscal Impact

Budgeted committee and staff resources to develop and disseminate a policy statement.

Prior Council Action

The Council has discussed and adopted many resolutions regarding ED contracts. Resolutions relevant to this resolution are:

Resolution 45(17) Group Contract Negations to End-of-Term Timelines referred to the Board of Directors.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans and contract groups.

Amended Resolution 49(94) Information on Contract Issues adopted. Directed ACEP to continue efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Prior Board Action

July 2018, reviewed the Policy Resource and Education Paper (PREP) "Emergency Physician Contractual Relationships. The PREP is an adjunct to the policy statement "Emergency Physician Contractual Relationships."

June 2018, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1982 titled "Contractual Relationships Between Emergency Physicians and Hospitals."

May 2018, reviewed the revised "Emergency Department Physician Group Staffing Contract Transition" information paper. First draft reviewed June 2017, second draft reviewed March 2018. The final version of the information paper also included the tenets of Referred Resolution 45(17) Group Contract Negotiations to End-of-Term Timelines.

January 2017, issued a public statement on rapid transitions of ED contracts.

January 2017, discussed concerns regarding the residency program at Summa Health.

April 2015, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" reaffirmed October 2008; revised and approved April 2002; revised and approved June 1997; reaffirmed April 1992; originally approved June 1988.

October 2015, approved the revised the policy statement "Emergency Physician Rights and Responsibilities;" revised April 2008, July 2001; originally approved September 2000.

Resolution 45(17) Group Contract Negations to End-of-Term Timelines assigned to the Contract Transitions Task Force.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted.

Amended Resolution 49(94) Information on Contract Issues adopted.

Background Information Prepared by: David A. McKenzie, CAE
Reimbursement Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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RESOLUTION: 50(19)

SUBMITTED BY: Social Emergency Medicine Section
New York Chapter

SUBJECT: Social Work in the Emergency Department

PURPOSE: 1) Promote the inclusion of social workers and/or care managers within the ED team. 2) Educate hospitals on the need to include social workers in team-based care. 3) Compile best practices on ED care models that include social workers and care managers and create resources to assist members in implementing these models.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

WHEREAS, Social determinants including, among many others, food insecurity, substance use disorders, homelessness, and socioeconomic status, greatly impact patients' health and the outcomes of their ED care; and

WHEREAS, Optimal care of Emergency Department (ED) patients mandates attention to social determinants of health; and

WHEREAS, Payment models are transforming to consider patient outcomes and these outcomes are intrinsically tied to their social determinants; and

WHEREAS, Centers for Medicare and Medicaid Services Conditions of Participation discharge planning rules have been updated to reflect the need to consider discharge planning for patients treated in the emergency department; and

WHEREAS, Emergency physicians are tasked with focusing on the prompt evaluation and medical treatment of ED patients; and

WHEREAS, A holistic approach to patients and their social determinants requires a team-based approach including, but not limited to, social workers and care managers; therefore be it

RESOLVED, That ACEP promote the consistent inclusion of social workers and/or care managers in the team of clinicians caring for patients in the ED; and be it further

RESOLVED, That ACEP educate hospitals on the need to include social workers and/or care managers on ED care teams; and be it further

RESOLVED, That ACEP compile information on best practices related to ED care models that include social workers and care managers and create resources to assist members in implementing multidisciplinary care models.

Background

This resolution requests ACEP to promote the inclusion of social workers and/or care managers within the ED team, educate hospitals on the need to include them in team-based care, compile best practices on ED care models that include social workers and care managers, and create resources to assist members in implementing these models.

Emergency departments are often referred to as the "front porch" of the medical system or called the "safety net/de facto" system for the medically underserved. As a result of EMTALA, EDs provide care for all individuals, regardless of socioeconomic status. EDs also see a growing demand for serving lower socioeconomic patients with unmet social needs. The ICD-10-CM codes (Z55-Z65) now include categories of potential health hazards related to a patient's socioeconomic or psychosocial environment, and other factors that can influence their health status.

Team-based, multi-disciplinary care is becoming increasingly common within health care as more emphasis is placed on improving patient quality and outcomes. Since the Institute of Medicine report, *To Err is Human*, stimulated discussion on how to improve patient safety and quality across the delivery system, the need for better coordination and collaboration has continued to drive the conversation. Multi-disciplinary teams and collaborative care models often include clinicians, nurses, and social workers or care managers. Emergency department social workers are typically tasked with facilitating linkages and identifying resources across organizational systems to improve the care of an individual. They might also provide mental health services, serve as a cultural liaison, educator, discharge planner, assessor, or crisis intervention specialist. They also frequently work with vulnerable populations, such as child/elder abuse victims or victims of sexual assault. The Bureau of Labor Statistics states that there were 707,400 social workers in the US in 2018. Of those, approximately 180,000 were involved in the health care setting. Job growth for social workers is expected to outpace other occupations, particularly in the health care setting, partially due to the aging populations. Demand for mental health and substance use disorder social workers is also expected to increase as more people seek treatment or are diverted into treatment programs. Case management services might also be carried out by a community health worker, nurse or care coordinator. Case management typically includes assessing for unmet needs and aiding in delivering or coordinating services with other agencies.

Despite the movement towards more multi-disciplinary teams, and the inclusion of social workers as part of many ED-care teams, not all hospitals have social workers available. The Deloitte Center for Health Solutions surveyed 300 hospitals and health systems and found that while the majority (88%) were committed to addressing social determinants of health and were screening patients for social needs, 72% of hospitals had not made any investments into meeting these needs, with the limited activity that was occurring fragmented and ad hoc. The U.S. spends less on social services than other developed nations, ranking 22 out of 37 nations. The American Hospital Association launched The Value Initiative in 2017 to address population health and social determinants of health to reduce cost and improve the quality of care provided by hospitals and health systems in the future.

Some argue that including social workers in the ED may reduce overall hospital costs by reducing unnecessary admissions or reducing the length of stay. One study examining ED visit reduction programs found that only case management consistently reduced ED use when compared to other strategies, such as patient education, etc. Other arguments for the use of social workers are for: improving quality of communication, increased patient satisfaction, and less burden on ED physicians to address social needs or services. One study found that social workers reduced the demands on clinicians to arrange for home health care, nursing home placement, and other social-services. Some argue that the costs of providing social work might eventually be met with ED efficiency gains (reduced admissions, clinician time, etc.). One literature review found that interventions in care coordination, income support, nutrition, housing, and community outreach had positive impacts on health improvements or health care spending reductions.

Some argue that the inclusion of social workers in the ED detracts from the overall mission of the emergency care system in treating the acute and critically ill or injured. Barriers to including social workers as part of the ED team could include the prohibitive cost to the hospital or institution, but also other challenges, such as lack of local or community resources, limited workforce, narrow scope of practice, and reduced coverage and access (e.g., M-F, 9:00 am – 5:00 pm hours).

ACEP's policy statement "Emergency Department Planning and Resource Guidelines," states that emergency departments "must provide the staff and resources necessary to evaluate all individuals presenting to the emergency department" and that ED personnel must establish effective working relationship with other health care providers and entities with whom they must interact, such as social service resources. It also states that emergency medical care must be available to all members of the public and that a smooth continuum should exist between prehospital and ED providers to follow up care.

ACEP's policy statement "Optimizing the Treatment of Pain the Patients with Acute Presentations" states that in

addition to contemporaneous pharmacologic intervention, "other pathways such as referral for long term pain management, case management or referral to social service for clinicals and/or center" should be considered." Additionally, it encourages the use of "social service interventions" for patients at risk of addiction.

The ACEP website includes many Transitions of Care Resources, including a Rapid Integration of Care Toolkit.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective A – Promote/Advocate for efficient, sustainable and fulfilling clinical practice environments.

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted. Directed ACEP to pursue reimbursement strategies to promote coordination of care, effective ED information sharing, and performance incentives for case management of high utilizers.

Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted. Directed that ACEP develop a rapid integration of care toolkit to focus on transitions of care and care coordination, provide best practices based upon hospital type and location, tools/resources for the design and implementation of rapid integration of care programs, and measures to report success of efforts.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted. Directed ACEP to define the role of emergency medicine in transitions of care for emergency medicine patients; to participate in all significant forums of discussion with regulatory entities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, The Joint Commission, National Quality Forum, related to performance parameters and proposed standards for emergency medicine transitions of care; to monitor and have input into any reimbursement issues tied to transitions of care, including performance incentives and accountable care organization collaboration; and to identify resources and educational materials to improve transitions of care for emergency patients.

Substitute Resolution 34(07) Patient Support Services Addressing the Gaps adopted. Stated that the College supports that hospitals develop resources to improve emergency department patients' access to outpatient community health and support services.

Prior Board Action

June 2019, approved the policy statement "Safe Discharge from the Emergency Department."

April 2019, approved the revised policy statement "Patient Support Services;" reaffirmed June 2013; originally approved October 2007.

January 2019, reaffirmed the policy statement "EMTALA and On -call Responsibility for Emergency Department Patients;" revised and approved June 2013, April 2006 replacing policy statements titled "Hospital, Medical Staff, and Payer Responsibility for Emergency Department Patients" (1999), "Medical Staff Responsibility for Emergency Department Patients" (1997), and "Medical Staff Call Schedule" (1987).

April 2017, approved the revised policy statement "Optimizing the Treatment of Pain the Patients with Acute Presentations;" replaced the 2009 policy statement with the same title.

January 2017, approved the revised policy statement "Code of Ethics for Emergency Physicians;" revised and approved June 2016 and June 2008; reaffirmed October 2001; revised and approved with the current title June 1997; originally approved January 1991 titled "Ethics Manual." Part II D defines the role of the emergency physicians with society.

April 2016, approved the policy statement "Human Trafficking." States that EDs include approaches to interfacing with outside entities such as social service organizations to care for patients.

October 2015, Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted.

October 2014, reviewed the Rapid Integration of Care Toolkit.

April 2014, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved October 2007, June 2004, and June 2001 with current title; reaffirmed September 1996; revised

Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted.

October 2012, reviewed the information paper, Transitions of Care Task Force Report. The information paper recommended strategies for emergency medicine. The 2012 Council Town Hall meeting focused on Transitions of Care and highlighted aspects of the task force report.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted.

Substitute resolution 34(07) Patient Support Services Addressing the Gaps adopted.

Background Information Prepared by: Loren Rives, MNA
Senior Manager, Academic Affairs

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 51(19)

SUBMITTED BY:

Alexander Chiu, MD, MBA, FACEP	Hawaii Chapter
Mark E. Escott, MD, MPH, FACEP	Iowa Chapter
Adam Ash, DO, FACEP	Nebraska Chapter
Joo Yup Shaun Chun MD, FACEP	New Jersey Chapter
David Ernst, MD, FACEP	New York Chapter
Alina Ershova BA	Virginia College of Emergency Physicians
Hartmut Gross, MD, FACEP	West Virginia Chapter
William Holubek, MD, FACEP	Critical Care Section
Nizar Kifaieh, MD, MBA, FACEP	EMS-Prehospital Care Section
Arkansas Chapter	Wilderness Medicine Section
District of Columbia Chapter	

SUBJECT: Stimulating Telemedicine Researchers and Programs

PURPOSE: 1) Promote telehealth research, maintain a database of telehealth programs and interested researchers; 2) allocate lobbying resources to increase federal funding for telehealth research in emergency medicine; and 3) work with outside organizations to coordinate research awareness and lobbying efforts to increase the number of quality research studies in emergency telehealth.

FISCAL IMPACT: Budgeted staff resources for advocacy activities and maintenance of a database of telehealth programs and researchers. Additional dedicated lobbying efforts could be needed for telehealth research funding and coordinating telehealth lobbying efforts with other organizations, depending on the workload. May require an additional staff person or increased costs for consultant lobbying activity, which could exceed $100,000. Any additional costs are not currently included in the budget.

WHEREAS, ACEP represents emergency physicians practicing in all emergency care environments; and

WHEREAS, Telemedicine is currently a valuable tool for providing patient care by emergency physicians under a variety of circumstances that include consultant access and direct-to-patient care; and

WHEREAS, ACEP represents emergency physician's equitable reimbursement and evidence-based practice for providing patient care through its lobbying and public awareness; and

WHEREAS, Reimbursement policies for telemedicine services provided by emergency medicine providers created by CMS and third-party payers are developed primarily based on research data centered around outcomes, quality, access, and cost; and

WHEREAS, In 2016, the ACEP Emergency Telemedicine Section, having been awarded an ACEP Section Grant to develop a Telehealth Focused Practice Guideline document, performed a systematic review of two bibliographic databases (PubMed/Medline and EMBASE) from 1974 to September 2016 which revealed that the quality of studies suffered from small patient populations and were underpowered, showing low number of relevant studies and a lack of patient outcomes in the realm of emergency physicians as providers of telemedicine; and

WHEREAS, ACEP telehealth literature search found a lack of both unbiased, high-quality literature and low-quality literature involving the use of telemedicine in emergency medicine; and

WHEREAS, In 2019 the Agency for Healthcare Research and Quality (AHRQ) published a systematic review to

identify and summarize the evidence of telehealth consultations, found telehealth evidence insufficient, and called for further telehealth research emphasizing rigor and standardized outcome comparisons; and

WHEREAS, A grant search was performed using resources and medical librarians at NYITCOM and Health/ Hospitals System and search engines www.AHRQ.org, www.spin.infoedglobal.com, www.Grants.gov, and other relevant search engines and the search included both new grant funding opportunities and projects which were funded; and

WHEREAS, A total of 417 grant funding opportunities were selected for review of possible restriction (examples of restriction include telehealth and veteran patients or telehealth and breast cancer) and 413 of the 417 funding opportunities were found to have restrictions on telehealth research; and

WHEREAS, Per clinical policies, ACEP requires thousands of high-quality studies and meta-analyses to produce Level A Clinical Recommendations and Level B Clinical Recommendations for a high or moderate degree of clinical certainty; and

WHEREAS, given the grant search and clinical policy literature requirement, there is a *lack* of dedicated federal and other financial resources available to support research in emergency telehealth to reach generally accepted principals for emergency telehealth patient care that reflect a high or moderate degree of clinical certainty; and

WHEREAS, A simple database of high-quality researchers interested in telemedicine research and telemedicine programs would create no material cost to ACEP and would be a cost-effective way to coordinate experienced researchers with emergency telehealth programs delivering care to large samples of patients; and

WHEREAS, The American Telemedicine Association (ATA), in their 2019 strategy statement, has agreed to work with other organizations in the improvement of telemedicine; and

WHEREAS, The ATA Health, Technology, and Distance Learning SIG has agreed during its 2019 strategic goals meeting to promote telehealth research awareness, increase telehealth quality research studies, and increase funding opportunities in telehealth with the same methods presented in this resolution; therefore be it

RESOLVED, That ACEP promote telehealth research awareness to its members, maintain a database of telehealth programs and interested researchers, and make introductions between interested parties; and be it further

RESOLVED, That ACEP allocate lobbying resources at the federal level for promoting the increase of federal funding toward telehealth research in emergency medicine; and be it further

RESOLVED, That ACEP work with outside organizations, such as the American Academy of Emergency Medicine, the Society for Academic Emergency Medicine, American Telemedicine Association, Healthcare Information and Management Systems Society, and others to coordinate research awareness and lobbying efforts to increase the number of quality research studies in emergency telehealth.

*Additional authorship by: Ummul Asfeen, BS; Edward Cho, DO, MPH; Meaghan Donnelly MS BS; Brianna Ferrarie; Mark Kindschuh, MD, MBA; John Rimmer, DO; Jonathon Savage, DO, FAAEM; Christian Daniel Espana Schmidt, MD; Wehbeh, MD; and Tucker Woods, DO.

Background

This resolution calls for ACEP to promote telehealth research, maintain a database of telehealth programs and interested researchers, allocate lobbying resources to increase federal funding for telehealth research in emergency medicine, and work with outside organizations to coordinate research awareness and lobbying efforts to increase the number of quality research studies in emergency telehealth.

The rapid development and deployment of telehealth services is significantly impacting various aspects of the U.S. healthcare system. According to a 2016 report by the U.S. Department of Health and Human Services (HHS), more than 40% of hospitals in the U.S. and more than 60% of all healthcare institutions were using telemedicine.

While the growth of telehealth has been impressive, it has nonetheless been slowed by reimbursement and interstate licensing issues. State laws regulating private payer reimbursement for telemedicine vary, but the majority now have parity laws that require insurers to reimburse for care provided via telemedicine in the same way it reimburses for in-person care. While Medicare reimburses for some telehealth services, it does not pay for telehealth services provided for emergency care.

Despite these reimbursement challenges, the use of telehealth in emergency care is growing as well through a variety of applications, including remote consults with psychiatrists and other specialists, providing rural patients access to emergency physicians when their hospital has none available, and health systems conducting centralized virtual visits for lower acuity patients presenting to their EDs.

Research of some applications of telehealth demonstrates that telehealth can enhance access to care, reduce costs, and/or improve outcomes. A 2019 report by the Agency for Healthcare Research and Quality (AHRQ) reported that "results vary by setting and condition, with telehealth consultations producing generally either better outcomes or no difference from comparators in settings and clinical indications studied." Regarding emergency care, the report noted that:

- "Specialty telehealth consultations likely reduce patient time in the emergency department."
- "Telehealth consultations in emergency services likely reduce heart attack mortality."

However, the AHRQ report also noted limitations in available research that preclude a more thorough examination of the impacts of telehealth, stating that "more detailed telehealth consultation costs and outcomes data would improve modeling assumptions." The limited amount of research on telemedicine was also noted in an information paper developed by members of the ACEP Emergency Telehealth Section. The purpose of the 2016 project was to review currently available literature that reported on emergency telehealth or telehealth applied in acute unscheduled care "to evaluate current research and to suggest the future directions of telehealth research. It was discovered that there is a lack of established specialty guidelines or evidence to support reaching certain conclusions in the reviewed literature."

ACEP has supported efforts to increase funding for emergency telehealth research. In response to a request for information from the Congressional Telehealth Caucus earlier this year, ACEP submitted a comment letter specifically requesting additional federal funding for telehealth research in emergency medicine. The comment letter stated in part that "additional data on quality, cost, access, and outcomes are needed to help both CMS and third-party payers evaluate and establish appropriate reimbursement for these services." ACEP has lobbied for increased federal funding for additional research to support emergency medicine. ACEP's efforts were instrumental in the 2012 creation of the Office of Emergency Care Research (OECR) within the National Institutes of Health. While OECR does not fund research projects, its mission includes coordinating emergency care research funding opportunities within the National Institutes of Health, matching researchers with funding opportunities, and helping to train new emergency care researchers.

Additional recent ACEP advocacy efforts related to telehealth include a comment letter this year to the Federal Communications Commission (FCC) regarding its proposed Connected Care Pilot Program, in which ACEP encouraged the FCC to expand the scope of the project to support high quality, cost-effective telehealth programs in the emergency department setting that allow greater access to an emergency physician in inner city or rural EDs. Over the past two Congresses, ACEP has promoted the CONNECT for Health Act to expand the use of telehealth and remote patient monitoring services in Medicare. In 2017, ACEP advocated (unsuccessfully) through the Current Procedural Terminology (CPT) Editorial Panel Process to get ED evaluation and management (E/M) codes, observation codes, and critical care codes added to the list of recognized telehealth codes.

ACEP has also developed an alternative payment model called the Acute Unscheduled Care Model, in which participating emergency physicians would become eligible to receive reimbursement for providing telehealth services under the model. The model was recommended for implementation by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and awaits further action by the HHS Secretary.

ACEP's Emergency Telehealth Section established a task force of section members to work, in part, on telehealth research issues. Through the work of the task force, the section applied for an ACEP section grant this year to develop an emergency telehealth research repository that would include a library of citations to published literature on

emergency telehealth and a searchable database of ongoing research in the field. The project would also provide a mechanism to facilitate connections between researchers interested in finding collaborators. The section's proposed project was not selected for a grant. Members of the section task force are working on a potential proposal to the Society for Academic Emergency Medicine about the possibility of creating a joint online emergency telehealth research repository with ACEP.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted staff resources for advocacy activities and maintenance of a database of telehealth programs and researchers. Additional dedicated lobbying efforts could be needed for telehealth research funding and coordinating telehealth lobbying efforts with other organizations, depending on the workload. May require an additional staff person or increased costs for consultant lobbying activity, which could exceed $100,000. Any additional costs are not currently included in the budget.

Prior Council Action

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Prior Board Action

June 2016, approved the policy statement "Ethical Use of Telemedicine in Emergency Care"

January 2016, approved the policy statement "Emergency Medicine Telemedicine."

Amended Resolution 45(15) Telemedicine Appropriate Support and Control adopted.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

Resolution 36(14) Development of Telemedicine Policy for Emergency Medicine adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 52(19)

SUBMITTED BY: Edward Shaheen, MD, FACEP
Emergency Telehealth Section

SUBJECT: Telehealth Emergency Physician Inclusion

PURPOSE: Specifies that all ACEP policies apply to all emergency physicians regardless of whether their services are provided in-person or remotely unless specifically stated that they only apply to in-person emergency services.

FISCAL IMPACT: None

WHEREAS, ACEP has established policies to apply to the practice of emergency medicine in many settings; and

WHEREAS, The practice of medicine changes with time and advancements in medicine and technology; and

WHEREAS, Technology has enabled emergency physicians to provide their services in ways not predicted or envisioned in the past and it is important to consider these technological advancements; and

WHEREAS, Many emergency physicians currently provide telehealth services; and

WHEREAS, ACEP leaders recognize that more emergency medicine will be provided outside of the traditional emergency department and much of this via telehealth; and

WHEREAS, The wording of ACEP policies do not specifically identify emergency physicians who provide their services remotely via telehealth, electronically, drones, or other means known today or that will come in the future and it is important for there to be no misinterpretation as to whom ACEP policies apply; and

WHEREAS, One such example of how current ACEP policy may be interpreted as not applicable to emergency physicians who provide their services and/or expertise via telehealth is the "Disaster Medical Response" policy statement that states "the American College of Emergency Physicians (ACEP) supports a national credentialing mechanism and up-to-date database of available physicians and medical volunteers who could be *deployed* as needed in the face of a national emergency. A policy and program must be in place to provide these responders with workers' compensation and medical liability protection when *deploying* to a disaster at the request of the federal or state government.;" and

WHEREAS, ACEP current and future policies could be interpreted to not include services provided by emergency physicians that are not performed or provided in-person; and

WHEREAS, Emergency physicians who provide their services, regardless of whether in-person or not in-person, should be treated equally, held to appropriate standards, and given equal protection; therefore be it

RESOLVED, That unless a policy statement specifically indicates that it only applies to in-person emergency services, ACEP extend all ACEP policies that include or refer to emergency physicians to specifically apply to all emergency physicians regardless of whether their services are provided remotely or in-person.

Background

This resolution calls for all ACEP policies that apply to emergency physicians to apply to all emergency physicians regardless of whether their services are provided in-person or remotely unless specifically stated that they only apply to in-person emergency services.

The rapid development and deployment of telehealth services is significantly impacting various aspects of the U.S. healthcare system. According to a 2016 report by the U.S. Department of Health and Human Services (HHS), more than 40% of hospitals in the U.S. and more than 60% of all healthcare institutions were using telemedicine. Use of telehealth in emergency care is growing as well through a variety of applications, including remote consults with psychiatrists or other specialists not available on site, providing rural patients access to emergency physicians when their hospital has none available, and health systems conducting centralized virtual visits for lower acuity patients presenting to their EDs.

ACEP's policy statement "Emergency Medicine Telemedicine," addresses several issues regarding telemedicine in the emergency department setting, and states that "the use of telemedicine is quickly increasing in emergency departments throughout the United States, and emergency physicians are well suited to the provision of this care."

ACEP's policy statement "Definition of an Emergency Physician" does not distinguish by site of service or other practice differences, stating only that "an emergency physician is defined as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians."

The policy statement "Definition of Emergency Medicine" addresses different practice settings, including telemedicine, stating that "emergency medicine is not defined by location, but may be practiced in a variety of settings including hospital-based and freestanding emergency departments (EDs), urgent care clinics, observation medicine units, emergency medical response vehicles, at disaster sites, or via telemedicine."

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

None

Prior Council Action

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Prior Board Action

April 2017, reaffirmed the policy statement "Definition of an Emergency Physician;" originally approved June 2011.

June 2016, approved the policy statement "Ethical Use of Telemedicine in Emergency Care"

January 2016, approved the policy statement "Emergency Medicine Telemedicine."

Amended Resolution 45(15) Telemedicine Appropriate Support and Control adopted.

June 2015, approved the revised policy statement "Definition of Emergency Medicine." Revised April 2008, April 2001. Reaffirmed October 1998. Revised April 1994 with current title. Originally approved March 1986 as "Definition of Emergency Medicine and the Emergency Physician."

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

Resolution 36(14) Development of Telemedicine Policy for Emergency Medicine adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 53(19)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Supporting Vaccination for Preventable Diseases

PURPOSE: Support the elimination of non-medical exclusions for vaccines and make a public statement of support for the safety and efficacy of vaccines in preventing disease.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Vaccination has proven to be a safe and effective public health measure decreasing and reducing the burden of disease on patients and communities; and

WHEREAS, Anti-vaccination groups have grown in resources, prominence and influence; and

WHEREAS, The World Health Organization has listed vaccine hesitancy and pandemic flu as two of its top 10 global health threats in 2019[1]; and

WHEREAS, Emergency physicians are uniquely positioned to interact with a wide variety of patients and vulnerable populations; and

WHEREAS, Emergency physicians are equipped to serve as educators, advocates, and facilitators for those best served by vaccinations; therefore be it

RESOLVED, That ACEP support the elimination of non-medical exclusions for vaccines; and be it further

RESOLVED, That ACEP make a public statement of support for the safety and efficacy of vaccines in preventing disease.

Background

This resolution calls for the College to support the elimination of non-medical exclusions for vaccines and to make a public statement of support for the safety and efficacy of vaccines in preventing disease. This resolution is similar to Resolution 53(19) Vaccine Preventable Illnesses Toolkit. Much of the background information is the same for both resolutions.

ACEP has long had policies recognizing that vaccines effectively and significantly reduce the spread of vaccine-preventable infectious diseases, including the 2015 policy statement "Immunization of Adults and Children in the Emergency Department" and the 2019 policy statement "Reporting of Vaccine-Related Adverse Events."

The Centers for Disease Control and Prevention have resources available for Health Care Providers, including but not limited to:

- Vaccination Schedules - https://www.cdc.gov/vaccines/schedules/hcp/index.html

[1] "Ten Threats to Global Health in 2019" https://www.who.int/emergencies/ten-threats-to-global-health-in-2019. Accessed June 7, 2019

- Vaccine Administration Protocols - https://www.cdc.gov/vaccines/hcp/admin/admin-protocols.html
- Patient Education Resources - https://www.cdc.gov/vaccines/hcp/patient-ed/educating-patients.html

Additionally, the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) have a large number of free resources regarding immunizations on their respective websites. These can be accessed at:

- AAFP Immunization Center: https://www.aafp.org/patient-care/public-health/immunizations.html
- AAP Immunization Center: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunizations/Pages/Immunizations-home.aspx

California recently enacted Senate Bill 276, which will prevent fake medical exemptions and require oversight of the medical exemption process. https://sd06.senate.ca.gov/news/2019-09-09-governor-signs-sb-276-law. The bill will require physicians to submit information to California Department of Public Health (CDPH), including the physician's name and license number and the reason for the exemption, which CDPH will check to ensure they are consistent with the Center for Disease Control's guidelines or stand of care. The physician must also certify that they have examined the patient in person.

The College does not have a policy that specifically addresses the elimination of non-medical exclusions for vaccines. The AMA recently modified their policy," Nonmedical Exemptions from Immunizations." The AMA policy clearly states nonmedical exemptions endanger the health of unvaccinated individuals and the public at large and calls for advocacy and support for legislation that eliminates nonmedical exemptions. Additionally, the American Academy of Pediatrics 2016 Policy on Medical Versus Nonmedical Immunization Exemptions for Child Care and School Attendance also recommends that all states and the District of Columbia use their public health authority to eliminate nonmedical exemptions from immunization requirements.

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

January 2019, approved the policy statement, "Reporting of Vaccine-Related Adverse Events."

June 2015, approved the revised policy statement, Immunization of Adults and Children in the Emergency Department; revised and approved January 2008, replacing "Immunizations in the Emergency Department" approved in 2002, "Immunizations of Pediatric Patients approved in 2000, and "Immunization of Adult Patients" approved in 2000.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2019 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 54(19)

SUBMITTED BY: New York Chapter

SUBJECT: Vaccine Preventable Illnesses Toolkit

PURPOSE: Develop resources for physicians to help with early identification, diagnosis, and recommendations for limiting spread of illness previously rare because of vaccinations and issue a statement supporting vaccinations as a safe and effective method to prevent disease and improve population health in all individuals who can be vaccinated.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, There have been multiple outbreaks of vaccine preventable illnesses; and

WHEREAS, There is a low adult vaccination coverage rate and some parents delay or refuse vaccines for their children; and

WHEREAS, Vaccine success has resulted in fewer doctors and other providers have experienced the serious and potentially life-threatening consequences of vaccine preventable illnesses; therefore be it

RESOLVED, That ACEP develop resources for physicians to help with the early identification, diagnosis, and recommendations for limiting spread of illness previously rare due to vaccination; and be it further

RESOLVED, That ACEP make a statement supporting vaccinations as a safe and effective method to prevent disease and improve population health in all individuals who medically can be vaccinated.

Background

This resolution calls for the College to develop resources for physicians to help with the early identification, diagnosis, and recommendations for limiting spread of illness previously rare due to vaccination and issue a statement supporting vaccinations as a safe and effective method to prevent disease and improve population health in all individuals who medically can be vaccinated. This resolution is similar to Resolution 52(19) Supporting Vaccination for Preventable Diseases. Much of the background information is the same for both resolutions.

ACEP has long had policies recognizing that vaccines effectively and significantly reduce the spread of vaccine-preventable infectious diseases, including the 2015 policy statement "Immunization of Adults and Children in the Emergency Department" and the 2019 policy statement "Reporting of Vaccine-Related Adverse Events."

The Centers for Disease Control and Prevention have resources available for Health Care Providers, including but not limited to:

- Vaccination Schedules - https://www.cdc.gov/vaccines/schedules/hcp/index.html
- Vaccine Administration Protocols - https://www.cdc.gov/vaccines/hcp/admin/admin-protocols.html
- Patient Education Resources - https://www.cdc.gov/vaccines/hcp/patient-ed/educating-patients.html

Additionally, the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) have a large number of free resources regarding immunizations on their respective websites. These can be accessed at:

- AAFP Immunization Center: https://www.aafp.org/patient-care/public-health/immunizations.html

- AAP Immunization Center: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunizations/Pages/Immunizations-home.aspx

ACEP Strategic Plan Reference

Goal 1 Improve the Delivery System for Acute Care
Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

January 2019, approved the policy statement, "Reporting of Vaccine-Related Adverse Events."

June 2015, approved the revised policy statement, Immunization of Adults and Children in the Emergency Department; revised and approved January 2008, replacing "Immunizations in the Emergency Department" approved in 2002, "Immunizations of Pediatric Patients approved in 2000, and "Immunization of Adult Patients" approved in 2000.

Background Information Prepared by: Margaret Montgomery, RN, MSN
Practice Management Manager

Sam Shahid, MBBS, MPH
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Reviewed by: John McManus, MD, MBA, FACEP, Speaker
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