INTRODUCTION

2018 Annual Council Meeting
Friday Evening, September 28 through Sunday, September 30, 2018
Grand Manchester Hyatt Hotel

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 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 c-mail (the Council's e-list).* You may post a message to the Council elist, cmail@elist.acep.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 San Diego!

Your Council officers,

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

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

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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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Council Meeting Schedule of Events

Manchester Grand Hyatt
September 28-30, 2018
San Diego, CA

Friday, September 28

3:00 pm – 8:00 pm	Councillor Credentialing – *Grand Hall Foyer, Lobby Level*
4:30 pm – 6:00 pm	Candidate Forum Subcommittee – *Hillcrest A-C, Seaport Tower, 3rd Level*
6:00 pm – 7:00 pm	Steering Committee Meeting – *Grand Hall D, Lobby Level*
7:00 pm – 8:00 pm	Tellers, Credentials, & Elections Committee – *Hillcrest A-C, Seaport Tower, 3rd Level*
7:00 pm – 8:00 pm	Reference Committee Briefing – *Bankers Hill, Seaport Tower, 3rd Level*
8:00 pm – 9:00 pm	Councillor Orientation – *Grand Hall D, Lobby Level*

Saturday, September 29

7:30 am – 5:30 pm	Councillor Credentialing – *Grand Hall Foyer, Lobby Level*
7:30 am – 8:00 am	Council Continental Breakfast – *Grand Hall Foyer, Lobby Level*
8:00 am – 9:15 am	Council Meeting – *Grand Hall A-C, Lobby Level*
9:30 am – 12:30 pm	Reference Committee A – *Harbor Ballroom A-C, Harbor Tower, 2nd Level*
9:30 am – 12:30 pm	Reference Committee B – *Harbor Ballroom D-F, Harbor Tower, 2nd Level*
9:30 am – 12:30 pm	Reference Committee C – *Harbor Ballroom G-I, Harbor Tower, 2nd Level*
11:00 am – 12:30 pm	Reference Committee Boxed Luncheon – *Harbor Ballroom Foyer, Harbor Tower, 2nd Level*
12:30 pm – 2:30 pm	Reference Committee Executive Sessions A – *Harbor Ballroom A-C, Harbor Tower, 2nd Level* B – *Harbor Ballroom D-F, Harbor Tower, 2nd Level* C – *Harbor Ballroom G-I, Harbor Tower, 2nd Level*
12:45 pm – 1:45 pm	Town Hall Meeting – *Grand Hall A-C, Lobby Level*
2:00 pm – 2:30 pm	Candidate Forum for President-Elect Candidates – *Grand Hall A-C, Lobby Level*
2:45 pm – 4:30 pm	Candidate Forum for Board of Directors Candidates – *Harbor Ballroom A-C, D-F, G-I, Harbor Tower, 2nd Level*
4:45 pm – 6:00 pm	Council Reconvenes – *Grand Hall A-C, Lobby Level*
6:15 pm – 7:15 pm	Candidate Reception – *Seaview, Lobby Level*

Sunday, September 30

7:00 am – 8:30 am	Keypad Distribution – *Grand Hall Foyer, Lobby Level*
7:00 am – 5:30 pm	Councillor Credentialing – *Grand Hall Foyer, Lobby Level*
7:30 am – 8:00 am	Council Continental Breakfast – *Grand Hall Foyer, Lobby Level*
8:00 am – 12:00 pm	Council Meeting – *Grand Hall A-C, Lobby Level*
12:00 pm – 1:30 pm	Council Awards Luncheon – *Grand Hall D, Lobby Level*
1:45 pm – 5:45 pm	Council Reconvenes – *Grand Hall A-C, Lobby Level*
5:10 pm – 5:40 pm	Elections – *Grand Hall A-C, Lobby Level*

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2018 Council Meeting

September 28-30, 2018
Pre-Meeting Events Occur Friday Evening, September 28, 2018, Manchester Grand Hyatt
Grand Hall A-C, Lobby Level
San Diego, CA

TIMED AGENDA

Saturday, September 29, 2018

Continental Breakfast – Grand Hall Foyer, Lobby Level		***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 CA Chapter President	Dr. Moulin	8:12 am
4. Tellers, Credentials, & Election Committee A. Credentials Report B. Meeting Etiquette	Dr. Kessler	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 – October 27-28, 2017	Dr. McManus	8:25 am
10. Approval of Steering Committee Actions A. Steering Committee Meeting – February 6, 2018 B. Steering Committee Meeting – May 20, 2018	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. Ratification of President-Elect Election	Dr. McManus	8:30 am
14. Nominating Committee Report A. President-Elect 1. Slate of Candidates 2. Call for Floor Nominations B. Board of Directors 1. Slate of Candidates 2. Call for Floor Nominations	Dr. McManus	8:30 am

Saturday, September 29, 2018 (*Continued*)

15. Candidate Opening Statements	Dr. Katz	
A President-Elect Candidates (5 minutes each)		8:35 am
B. Board of Directors Candidates (2 minutes each)		8:45 am
16. Reference Committee Assignments	Dr. McManus	9:05 am
BREAK		***9:10 am – 9:30 am***
17. Reference Committee Hearings –		9:30 am – 12:30 pm
A – Governance & Membership – *Harbor A-C, Harbor Tower, 2nd Level*		
B – Advocacy & Public Policy – *Harbor D-F, Harbor Tower, 2nd Level*		
C – Emergency Medicine Practice – *Harbor G-I, Harbor Tower, 2nd Level*		
Lunch Available – Grand Hall Foyer		***11:00 am – 12:30 pm***
18. Reference Committee Executive Sessions		12:30 pm – 2:30 pm
A – *Harbor A-C, Harbor Tower, 2nd Level*		
B – *Harbor D-F, Harbor Tower, 2nd Level*		
C – *Harbor G-I, Harbor Tower, 2nd Level*		
BREAK – Return to main Council meeting room – Grand Hall A-C, Lobby Level.		***12:30 pm – 12:45 pm***
19. Town Hall Meeting – *Grand Hall A-C, Lobby Level*	Dr. Katz	12:45 pm – 1:45 pm
A. Single Payer: Has the Time Finally Arrived?		
20. Candidate Forum for the President-Elect Candidates – *Grand Hall A-C, Lobby Level*		2:00 pm – 2:30 pm
BREAK – Return to Reference Committee meeting rooms – Harbor A-I, Harbor Tower, 2nd Level.		***2:30 pm – 2:45 pm***
21. Candidate Forum for the Board of Directors Candidates – *Harbor A-I, Harbor Tower, 2nd Level*		2:45 pm – 4:30 pm
Candidates rotate through Reference Committee meeting rooms.		
BREAK – Return to main Council meeting room – Grand Hall A-C, Lobby Level.		***4:30 pm – 4:45 pm***
22. Speaker's Report	Dr. McManus	4:45 pm
A. Leadership Development Advisory Group		
B. Board Actions on 2017 Resolutions		
C. Introduction of Honored Guests		
D. Introduction of Council Steering Committee		
E. Introduction of Board of Directors		
23. 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.		
24. ABEM Report	Dr. Muelleman	5:10 pm
25. Secretary-Treasurer's Report	Dr. Anderson	5:15 pm
26. EMRA Report	Dr. Jarou	5:20 pm
27. EMF Report	Dr. Celeste	5:25 pm
28. NEMPAC Report	Dr. Jacoby	5:30 pm
29. President's Address	Dr. Kivela	5:35 pm

Candidate Reception ● 6:15 pm – 7:15 pm ● *Seaview, Lobby Level*

Sunday, September 30, 2018

Keypad Distribution – Grand Hall Foyer, Lobby Level		***7:00 am***
Continental Breakfast – Grand Hall Foyer, Lobby Level		***7:30 am***
1. Call to Order	Dr. McManus	8:00 am
2. Tellers, Credentials, & Elections Committee Report	Dr. Kessler	8:00 am
3. Electronic Voting A. Keypad Testing/Demographic Data Collection	Dr. Kessler	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 – *Grand Hall D, Lobby Level*		*12:00 pm*
A. Welcome	Dr. McManus	12:45 pm
1. Recognition of Past Speakers and Past Presidents 2. Recognition of Chapter Executives		
B. Award Announcements	Dr. Kivela	12:55 pm
1. Wiegenstein Leadership Award 2. Mills Outstanding Contribution to Emergency Medicine Award 3. Tintinalli Outstanding Contribution in Education Award 4. Outstanding Contribution in Research Award 5. Outstanding Contribution in EMS Award 6. Policy Pioneer Award 7. Rorrie Excellence in Health Policy Award 8. Rupke Legacy Award 9. Honorary Membership Award 10. Disaster Medical Sciences Award		
C. Reading and Presentation of Commendation Resolutions	Dr. McManus/Dr. Katz	
D. Council Award Presentations	Dr. McManus	
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 – Grand Hall A-C, Lobby Level.***		***1:30 pm***
9. Reference Committee Reports Continue C. Reference Committee ___		1:45 pm
10. President-Elect's Address	Dr. Friedman	4:45 pm
11. Installation of President	Dr. Kivela/Dr. Friedman	5:05 pm
12. Elections A. Board of Directors B. President-Elect	Dr. Kessler	5:10 pm
13. Announcements	Dr. McManus	5:40 pm
14. Adjourn	Dr. McManus	5:45 pm

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2018 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 9-20

J. David Barry, MD, FACEP (GS), Chair
Nida Degesys, MD (EMRA)
Andrea L. Green, MD, FACEP (TX)
Muhammad N. Husainy, DO, FACEP (AL)
James L. Shoemaker, Jr., MD, FACEP (IN)
Larisa M. Traill, MD, FACEP (MI)

Leslie Moore, JD
Maude Surprenant Hancock

Reference Committee B
Advocacy & Public Policy
Resolutions 21-35

Kristin B. McCabe-Kline, MD, FACEP (FL), Chair
Justin W. Fairless, DO, FACEP (TX)
Chadd K. Kraus, DO, DrPH, MPH, FACEP (PA)
Diana Nordlund, DO, JD, FACEP (MI)
Livia M. Santiago-Rosado, MD, FACEP (NY)
Liam T. Yore, MD, FACEP (WA)

Ryan McBride, MPP
Harry Monroe

Reference Committee C
Emergency Medicine Practice
Resolutions 36-48

Michael D. Smith, MD, MBA, CPE, FACEP (LA) Chair
Melissa W. Costello, MD, FACEP (AL)
Carrie de Moor, MD, FACEP (TX)
William D. Falco, MD, MS, FACEP (WI)
Daniel Freess MD, FACEP (CT)
Nicole A. Veitinger, DO, FACEP (OH)

Margaret Montgomery, RN, MSN
Travis Schulz, MLS, AHIP
Sam Shahid, MBBS, MPH

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2018 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Hans R. House, MD, FACEP *Iowa Chapter*	
2	Commendation for Jay A. Kaplan, MD, FACEP *Louisiana Chapter*	
3	Commendation for Les Kamens *Board of Directors*	
4	Commendation for Rebecca B. Parker, MD, FACEP Illinois *College of Emergency Physicians*	
5	Commendation for Eugene Richards *Board of Directors*	
6	Commendation for John J. Rogers, MD, CPE, FACEP *Board of Directors* *53 Chapters* *37 Sections* *Council of Emergency Medicine Residency Directors* *Emergency Medicine Residents' Association*	
7	In Memory of Lawrence Scott Linder, MD, FACEP *Maryland Chapter*	
8	In Memory of Kevin Rodgers, MD, FAAEM, FACEP *Indiana Chapter*	
9	American College of Osteopathic Emergency Physicians Councillor Allocation – Bylaws Amendment *Fredrick Blum, MD, FACEP* *Marco Coppola, DO, FACEP* *Alexander Rosenau, DO, FACEP* *Robert E. Suter, DO, FACEP* *Emergency Medicine Residents' Association*	A
10	Achieving Unity by Expanding Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council – College Manual Amendment *Juan Acosta, DO, FACEP* *Tim Cheslock, DO, FACEP* *Stephanie Davis, DO, FACEP* *Brandon Lewis, DO, FACEP* *Robert Suter, DO, FACEP*	A
11	Codifying the Leadership Development Advisory Group (LDAG) - Council Standing Rules Amendment *Leadership Diversity Task Force* *Council Steering Committee* *Board of Directors*	A

Resolution #	Subject/Submitted by	Reference Committee
12	Nominating Committee Revision to Promote Diversity – Council Standing Rules Amendment *Leadership Diversity Task Force* *Council Steering Committee* *Board of Directors*	A
13	Growth of the ACEP Council *Council Steering Committee*	A
14	Diversity of ACEP Councillors *Emergency Medicine Residents' Association* *Young Physicians Section*	A
15	Divestment from Fossil Fuel-Related Companies *Marc Futernick, MD, FACEP* *Jeremy Hess, MD, MPH, FACEP* *Jay Lemery, MD, FACEP* *Victoria Leytin, MD* *Luke Palmisano, MD, FACEP* *James Rayner, MD* *Renee Salas, MD, MPH, MS* *Ted C. Shieh, M.D., FACEP* *Jonathan Slutzman, MD* *Cecelia Sorensen, MD* *Larry Stock, MD, FACEP* *California Chapter*	A
16	No More Emergency Physician Suicides *Pennsylvania College of Emergency Physicians*	A
17	Physician Suicide is a Sentinel Event *Council of Emergency Medicine Residency Directors* *Emergency Medicine Residents' Association* *Wellness Section*	A
18	Reducing Physician Barriers to Mental Health Care *Council of Emergency Medicine Residency Directors* *Emergency Medicine Residents' Association* *Wellness Section*	A
19	Reduction of Scholarly Activity Requirements by the ACGME *Pennsylvania College of Emergency Physicians*	A
20	Verification of Training *New York Chapter*	A
21	Adequate Resources for Safe Discharge Requirements *Arjun Chanmugam,MD, FACEP* *Kyle Fischer, MD* *Michael Silverman, MD, FACEP* *Maryland Chapter*	A
22	Addressing Mental Health Treatment Barriers Created by the Medicaid IMD Exclusion Relationships *Wisconsin Chapter*	A

Resolution #	Subject/Submitted by	Reference Committee
23	Advocating for CMS Policy Restraint to Avoid Restricting Quality Emergency Care *Texas College of Emergency Physicians*	A
24	ED Copayments for Medicaid Beneficiaries *Dan Freess, MD, FACEP* *Lisa Maurer, MD, FACEP* *Michael McCrea, MD, FACEP* *James Mitchiner, MD, FACEP* *John Moorhead, MD, FACEP* *Jay Mullen, MD, FACEP* *Liam Yore, MD, FACEP* *California Chapter* *Louisiana Chapter* *Missouri College of Emergency Physicians* *Rhode Island Chapter* *Washington Chapter* *Wisconsin Chapter*	A
25	Funding for Buprenorphine-Naloxone Treatment Programs *Yemi Adebayo, MD* *Arjun Chanmugam, MD, FACEP* *Kyle Fischer, MD, FACEP* *Maryland Chapter*	B
26	Funding of Substance Use Intervention and Treatment Programs *Yemi Adebayo, MD* *Arjun Chanmugam, MD, FACEP* *Kyle Fischer, MD, FACEP* *Maryland Chapter*	B
27	Generic Injectable Drug Shortages *Rick Blum, MD, FACEP* *Mark DeBard, MD, FACEP* *Nicholas Jouriles, MD, FACEP* *West Virginia Chapter*	B
28	Inclusion of Methadone in State Drug and Prescription Databases *Daniel Freess, MD, FACEP* *Greg Shangold, MD, FACEP* *Connecticut College of Emergency Physicians*	B
29	Insurance Collection of Patient Financial Responsibility *Daniel Freess, MD, FACEP* *Greg Shangold, MD, FACEP* *Connecticut College of Emergency Physicians*	B
30	Naloxone Layperson Training *Pennsylvania College of Emergency Physicians*	B
31	Payment of Opioid Sparing Pain Treatment Alternatives *Yemi Adebayo, MD* *Stephen Schenkel, MD, FACEP* *Maryland Chapter*	B

Resolution #	Subject/Submitted by	Reference Committee
32	POLST Forms *Indiana Chapter* *Palliative Medicine Section*	B
33	Separation of Migrating Children from Their Caregivers *John Corker, MD, FACEP* *Hillary Fairbrother, MD, FACEP* *Young Physicians Section*	B
34	Violence is a Health Issue *Trauma & Injury Prevention Section*	B
35	ACEP Policy Related to Immigration *Massachusetts College of Emergency Physicians*	B
36	ACEP Policy Related to Medical Cannabis *Arizona College of Emergency Physicians* *Connecticut College of Emergency Physicians* *Massachusetts College of Emergency Physicians* *Missouri College of Emergency Physicians* *North Carolina College of Emergency Physicians* *South Carolina College of Emergency Physicians* *Utah Chapter* *West Virginia Chapter*	C
37	ACEP Policy Related to Recreational Cannabis *Arizona College of Emergency Physicians* *Connecticut College of Emergency Physicians* *Massachusetts College of Emergency Physicians* *North Carolina College of Emergency Physicians* *South Carolina College of Emergency Physicians* *Utah Chapter* *West Virginia Chapter*	C
38	Antimicrobial Stewardship *California Chapter* *Washington Chapter* *Wisconsin Chapter*	C
39	Care of the Boarded Behavioral Health Patient *Pennsylvania College of Emergency Physicians*	C
40	Care of Individuals with Autism Spectrum Disorder in the Emergency Department *Pennsylvania College of Emergency Physicians*	C
41	Emergency Department and Emergency Physician Role in the Completion of Death Certificates *New York Chapter*	C
42	Expert Witness Testimony *Kerry Forrestal, MD, FACEP* *Orlee Panitch, MD, FACEP* *Maryland Chapter*	C

Resolution #	Subject/Submitted by	Reference Committee
43	Fair Remuneration in Health Care *Arjun Chanmugam, MD, FACEP* *Orlee Panitch, MD, FACEP*	C
44	Firearm Safety and Injury Prevention Policy Statement *Social Emergency Medicine Section* *Trauma & Injury Prevention Section*	C
45	Support for Extreme Risk Protection Orders to Minimize Harm *California Chapter* *Social Emergency Medicine Section* *Trauma & Injury Prevention Section*	C
46	Law Enforcement Information Gathering in the ED Policy Statement *Pennsylvania College of Emergency Physicians*	C
47	Supporting Medication for Opioid Use Disorder *Pain Management & Addiction Medicine Section* *Social Emergency Medicine Section* *Washington Chapter*	C
48	Surreptitious Recording in the Emergency Department *Emergency Medicine Informatics Section*	C

Late Resolutions

49	In Memory of C. Christopher King *New York Chapter* *Pennsylvania College of Emergency Physicians*	

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).

RESOLUTION: 1(18)

SUBMITTED BY: Iowa Chapter

SUBJECT: Commendation for Hans R. House, MD, FACEP

WHEREAS, Hans R. House, MD, MPH, FACEP, has capably served the American College of Emergency Physicians with highest distinction since becoming a member in 1998; and

WHEREAS, Dr. House served in many leadership roles, including the national ACEP Board of Directors 2011-17 and as Board Liaison to a variety of committees, task forces, and sections during that time; and

WHEREAS, During his time on the ACEP Board of Directors, Dr. House was passionate about the Residency Visit Program and worked tirelessly to improve and expand residency visits; and

WHEREAS, Dr. House served on the Board of Trustees of the Emergency Medicine Foundation 2015-18 and as its chair in 2017 and continues to support his commitment to emergency medicine research through his contributions and participation in the Wiegenstein Legacy Society; and

WHEREAS, Dr. House has extensive service in leadership roles in the Iowa Chapter, serving on the Board of Directors 2003-10 and as President 2006-08; and

WHEREAS, Dr. House served the ACEP Council as a councillor 2006-10; and

WHEREAS, Dr. House has helped train and mentor numerous emergency medicine residents, and currently serves as Professor of Emergency Medicine and as Vice Chair for Education for the Department of Emergency Medicine at the University of Iowa; and

WHEREAS, Dr. House has enjoyed a distinguished career serving his patients by continually striving for excellence as a compassionate and capable emergency physician; and

WHEREAS, Despite the challenges of his tenure on the national ACEP Board of Directors, as well as his numerous other activities, Dr. House remained a devoted husband and father; and

WHEREAS, Dr. House 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 Hans R. House, MD, FACEP, for his service as an emergency physician, clinical investigator, educator, and leader in a life-long quest dedicated to the advancement of the specialty of emergency medicine.

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).

RESOLUTION: 2(18)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Commendation for Jay A. Kaplan, MD, FACEP

WHEREAS, Jay A. Kaplan, MD, FACEP, has been an extraordinary leader for the American College of Emergency Physicians with complete dedication, having served on the Board of Directors 2009-2017, including President-Elect 2014-15, President 2015-16, and Immediate Past President 2016-17; and

WHEREAS, Dr. Kaplan brought the depth and breadth of his experience with his tireless efforts and expertise on various committees, task forces, sections, the Council, and Board of Directors; and

WHEREAS, During his tenure on the Board of Directors, Dr. Kaplan made it a top priority to maintain close relationships with ACEP chapters, increase visits to residency programs, and foster greater dialogue with other national medical specialty societies; and

WHEREAS, Dr. Kaplan is a passionate advocate for emergency physician wellness and resiliency; and

WHEREAS, Dr. Kaplan instituted the first Wellness Week in January 2016 and hosted the inaugural Physician Wellness and Resiliency Summit in February 2017 that included representation from every emergency medicine organization; and

WHEREAS, Dr. Kaplan has devoted his career to finding better ways to care for patients and was instrumental in the development of ACEP's Hospital Flow Conference and enhancing ACEP's relationship with the American Hospital Association; and

WHEREAS, Dr. Kaplan is a nationally known and respected educator, has served as faculty for many of ACEP's conferences over the years, and received the Outstanding Speaker of the Year Award multiple times; and

WHEREAS, Dr. Kaplan has been an articulate spokesperson for ACEP's advocacy agenda and a champion for the National Emergency Medicine Political Action Committee, having served on its Board of Trustees and working to advance critical issues for ACEP members; and

WHEREAS, Dr. Kaplan served on the Board of Trustees of the Emergency Medicine Foundation and as its chair in 2012, and continues to support his commitment to emergency medicine research through his contributions and participation in the Wiegenstein Legacy Society; and

WHEREAS, In all his meetings and travels, Dr. Kaplan has represented the College with diplomacy, integrity and honor, and is a role model of commitment and productivity; and

WHEREAS, Dr. Kaplan is known to prefer to "happen to things" instead of things happening to him; and

WHEREAS, Despite the challenges of his tenure on the national ACEP Board of Directors, as well as his numerous other activities, Dr. Kaplan remained a devoted husband and father; and

WHEREAS, Dr. Kaplan 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 Jay A. Kaplan, MD, FACEP, for his outstanding service, leadership, and commitment to the specialty of emergency medicine and to the College.

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).

RESOLUTION: 3(18)

SUBMITTED BY: Board of Directors

SUBJECT: Commendation for Les Kamens

WHEREAS, For 20 years, Les Kamens has been the official photographer for ACEP's *Scientific Assembly*; and

WHEREAS, Armed with his camera and photographic skills, Les has chronicled some of the most remarkable years of growth and change in ACEP, its members, and its leaders; and

WHEREAS, Les has been a reassuring, low-profile presence, photographing innumerable moments of leadership change, organizational transformation, and untold instances of personal reflection and connectivity; and

WHEREAS, Les is a consummate professional, always smiling and engaging, while still "getting the shot" to give permanence to the key moments in the life of the organization; and

WHEREAS, Les is ever-present to photograph the events of each annual meeting and to record them for posterity; and

WHEREAS, Les' contribution to ACEP and emergency medicine has been unique, and his contribution is a reminder that not only are history and legacy critical aspects of the life of every organization, but that pictures are truly worth a thousand words; and

WHEREAS, Les was first contracted to photograph ACEP's 30th anniversary in 1998 in San Diego, and he will celebrate 20 years as ACEP's official photographer at the 50th anniversary in 2018 in San Diego; therefore, be it

RESOLVED, That the American College of Emergency Physicians bestows with gratitude this commendation to Les Kamens for his dedicated support and service.

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).

RESOLUTION: 4(18)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Commendation for Rebecca B. Parker, MD, FACEP

WHEREAS, Rebecca B. Parker, MD, FACEP, has served the American College of Emergency Physicians with complete dedication in numerous leadership roles since her election to the Board of Directors in 2009, including Chair of the Board 2014-15, President-Elect 2015-16, President 2016-17, and Immediate Past President 2017-18, and brought the depth and breadth of her experience to her role on the Board of Directors; and

WHEREAS, Dr. Parker, as Chair of the Board, demonstrated extraordinary leadership by keeping participation balanced and meetings focused; and

WHEREAS, Dr. Parker, during her tenure on the ACEP Board of Directors, participated in multiple visionary efforts; and

WHEREAS, Dr. Parker identified diversity and inclusion as a priority for the College and convened the ACEP Diversity Summit on April 14, 2016; and

WHEREAS, During her term as President, Dr. Parker, appointed a Diversity & Inclusion Task Force to: 1) engage the specialty of emergency medicine on diversity and inclusion; 2) identify obstacles to advancing within the specialty of emergency medicine related to diversity and inclusion and ways to overcome these obstacles; and 3) highlight the effects of diversity and inclusion on patient outcomes and identify ways to improve these outcomes; and

WHEREAS, Dr. Parker appointed a Leadership Diversity Task Force to identify ways to increase leadership diversity within ACEP; and

WHEREAS, Dr. Parker has shown exemplary leadership and outstanding service with her tireless efforts and expertise on various committees, task forces, sections, the Council, and Board of Directors, and is a staunch advocate for preserving reimbursement for emergency physicians; and

WHEREAS, Dr. Parker provided leadership to assemble a coalition of national medical specialty societies to develop a reasonable solution to ensure fair out-of-network reimbursement for physicians, was instrumental in obtaining passage of the resolution by the American Medical Association embracing this solution, and has advocated in the media and with policy makers for its adoption into law; and

WHEREAS, Dr. Parker has demonstrated leadership development through chapter involvement, having served on the Board of Directors of the Illinois College of Emergency Physicians and maintaining an active presence in the chapter during her tenure on the national ACEP Board of Directors; and

WHEREAS, Dr. Parker is a passionate advocate of advancing the specialty, an articulate spokesperson for ACEP's advocacy agenda, and a champion for the National Emergency Medicine Political Action Committee having served on its Board of Trustees and working to advance critical issues for ACEP members; and

WHEREAS, Dr. Parker has been a leader in helping ACEP, its leaders, and staff embrace social media and become more effective in using the latest forms of communication; and

WHEREAS, Despite the challenges of her tenure on the national ACEP Board of Directors, as well as her numerous other activities, Dr. Parker remained a devoted wife and mother; and

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

RESOLVED, That the American College of Emergency Physicians commends Rebecca B. Parker, MD, FACEP, for her outstanding service, leadership, and commitment to the specialty of emergency medicine and to the College.

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).

RESOLUTION: 5(18)

SUBMITTED BY: Board of Directors

SUBJECT: Commendation for Eugene Richards

WHEREAS, Eugene Richards is an award-winning photographer whose interest in emergency medicine began in the 1980s; and

WHEREAS, Mr. Richards, while in Denver, CO, spent 18 months learning about emergency medicine and documenting emergency physicians; and

WHEREAS, Mr. Richards' photographs were published in 1989 in the book *The Knife & Gun Club: Scenes from an Emergency Room,* and remains an iconic rendering of the specialty of emergency medicine*;* and

WHEREAS, Mr. Richards' latest book, *Bring 'Em All*, celebrates the depth and diversity of emergency medicine through a collection of 50 photographs and essays in commemoration of ACEP's 50th anniversary; and

WHEREAS, *Bring 'Em All* will be treasured forever by emergency physicians and the general public; therefore, be it

RESOLVED, That the American College of Emergency Physicians bestows with gratitude this commendation to Eugene Richards for capturing the breathtaking moments that comprise the lives and careers of emergency physicians across the United States.

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).

RESOLUTION: 6(18)

SUBMITTED BY: Board of Directors
Alabama Chapter
Alaska Chapter
AZ College of Emergency Physicians
Arkansas Chapter
California Chapter
Colorado Chapter
Connecticut Chapter
Delaware Chapter
District of Columbia Chapter
FL College of Emergency Physicians
GA College of Emergency Physicians
Government Services Chapter
Hawaii Chapter
Idaho Chapter
IL College of Emergency Physicians
Indiana Chapter
Iowa Chapter
Kansas Chapter
Kentucky Chapter
Louisiana Chapter
Maine Chapter
Maryland Chapter
MA College of Emergency Physicians
MI College of Emergency Physicians
Minnesota Chapter
Mississippi Chapter
MO College of Emergency Physicians
Montana Chapter
Nebraska Chapter
Nevada Chapter
New Hampshire Chapter
New Jersey Chapter
New Mexico Chapter
New York Chapter
NC College of Emergency Physicians
North Dakota Chapter
Ohio Chapter
OK College of Emergency Physicians
Oregon Chapter
PA College of Emergency Physicians
Puerto Rico Chapter
Rhode Island Chapter
SC College of Emergency Physicians
South Dakota Chapter
Tennessee College of Emergency Physicians
TX College of Emergency Physicians
Utah Chapter
Vermont Chapter
VA College of Emergency Physicians
Washington Chapter
West Virginia Chapter
Wisconsin Chapter
Wyoming Chapter

Council of Emergency Medicine Residency Directors
Emergency Medicine Residents' Association

Air Medical Transport Section
AAWEP Section
Careers in EM Section
Critical Care Medicine Section
Cruise Ship Medicine Section
Democratic Group Practice Section
Disaster Medicine Section
Diversity, Inclusion, & Health Equity Section
Dual Training Section
EM Informatics Section
EM Prac Mgmt & Health Pol Section
EM Research Section
EM Medicine Workforce Section
Emergency Telemedicine Section
Emergency Ultrasound Section
EMS-Prehospital Care Section
Event Medicine Section
Forensic Medicine Section
Freestanding Emergency Centers Section
Geriatric Emergency Medicine Section
International Emergency Medicine Section
Medical Directors Section
Medical Humanities Section
Observation Medicine Section
Pain Mgmt & Addiction Medicine Section
Palliative Medicine Section
Pediatric Emergency Medicine Section
Quality Improvement & Patient Safety Section
Rural Emergency Medicine Section
Social Emergency Medicine Section
Sports Medicine Section

Tactical EM Section
Toxicology Section
Trauma & Injury Prevention Section
Undersea & Hyperbaric Med Section
Wellness Section
Wilderness Medicine Section
Young Physicians Section

SUBJECT: Commendation for John J. Rogers, MD, CPE, FACEP

WHEREAS, John J. Rogers, MD, CPE, FACEP, joined the American College of Emergency Physicians (ACEP) in 1999, and since that time has been a tireless advocate for the mission and values of ACEP in an exemplary manner with complete focus and dedication, as both a clinician and in voluntary service to the specialty of emergency medicine at the local, state, and national levels; and

WHEREAS, Dr. Rogers has provided, with distinction, direct patient care since 1978, and has promoted excellence in clinical care for emergency patients as a consultant, an emergency physician, an ED Director, and as President of his hospital medical staff in a rural community hospital; and

WHEREAS, Dr. Rogers has worked tirelessly as a leader and visionary in Georgia to improve rural emergency medicine delivery and training through the auspices of the Georgia College of Emergency Physicians and the Medical Association of Georgia; and

WHEREAS, Dr. Rogers has a depth and breadth of superlative work on behalf of his peers and patients as a member of ACEP through serving on expert panels, task forces, and initiating, leading and/or growing the Sections on Emergency Medicine Workforce, Rural Emergency Medicine, and Emergency Telemedicine; and

WHEREAS, Dr. Rogers has served with inestimable grace and honor in numerous leadership positions within ACEP; and

WHEREAS, Dr. Rogers has served the Council as a councillor and as a member of several Council committees, including the Council Steering Committee, Nominating Committee, and Reference Committtees; and

WHEREAS, Dr. Rogers served on the Board of Trustees of the Emergency Medicine Foundation and as its chair in 2014; and

WHEREAS, Dr. Rogers has demonstrated leadership development through chapter involvement, having served on the Board of Directors of the Georgia College of Emergency Physicians and as its President 2013-14 and maintaining an active presence in the chapter during his tenure on the national ACEP Board of Directors; and

WHEREAS, Dr. Rogers was elected to the national ACEP Board of Directors in 2011, was re-elected in 2014, was elected by his peers on the Board of Directors to serve as Secretary-Treasurer 2014-15, Vice President 2015-16, Chair of the Board 2016-17, and was duly elected by the Council in 2017 to serve as ACEP's President-Elect; and

WHEREAS, Dr. Rogers has been a peerless, eloquent, and outstanding spokesman in the support of critical issues such as patient access to emergency services, fair payment coverage, and diversity in membership and leadership; and

WHEREAS, Dr. Rogers has been a consistent and strong supporter of emergency medicine residency and fellowship training and board certification in the specialty of emergency medicine; and

WHEREAS, Dr. Rogers has served as an incredibly effective advocate and mentor for young (and the not-so-young) emergency physicians interested in professional growth, maturation, and leadership, including current and past leaders in the College; and

WHEREAS, Dr. Rogers has further demonstrated his true passions for excellence in emergency medicine by being a charter member of the Wiegenstein Legacy Society; and

WHEREAS, Dr. Rogers has consistently demonstrated a peerless level of ethical concern and morality, putting the interests of the College and its members above any personal goals or desires; and

WHEREAS, The College has already bestowed previous honors on Dr. Rogers, such as the Council Teamwork Award and the ACEP Section Award for Promoting Membership; therefore, be it

RESOLVED, that the American College of Emergency Physicians recognizes and commends John J. Rogers, MD, CPE, FACEP, for his lifetime of outstanding and selfless service, leadership, and commitment to the College, the specialty of emergency medicine, and the patients in the communities which we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2017 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 7(18)

SUBMITTED BY: Maryland Chapter

SUBJECT: In Memory of Lawrence Scott Linder, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a staunch advocate, extraordinary leader, mentor, and trailblazer in Lawrence Scott Linder, MD, FACEP, who passed away suddenly on May 1, 2018, at the age of 56; and

WHEREAS, Dr. Linder was born in Philadelphia, PA, graduated from Franklin and Marshall College in 1984, and earned his medical degree from the University of Pennsylvania in 1988; and

WHEREAS, Dr. Linder completed his emergency medicine residency at Christiana Care Health System in 1991; and

WHEREAS, Dr. Linder joined the medical staff in 1991 at the University of Maryland Baltimore Washington Medical Center, where he practiced until his retirement in 2017; and

WHEREAS, Dr. Linder assumed a variety of leadership positions, including Chair of the Department of Emergency Medicine, Chief Medical Officer, Senior Vice President, and President of the University of Maryland Community Medical Group; and

WHEREAS, Dr. Linder was well known for his tireless efforts to solve specialty on-call challenges and his fairness in dealings with all members of the hospital community; and

WHEREAS, Dr. Linder served as President of the Maryland Chapter from 1998-2002, and as councillor for many years; and

WHEREAS, Dr. Linder was widely recognized for bringing fun to learning health law through his eagerly anticipated “Legal Jeopardy” game; and

WHEREAS, Dr. Linder led Maryland’s effort in 1993 to become the first state to establish the prudent layperson definition of an emergency in state law and subsequently in federal law for federal programs; and

WHEREAS, Dr. Linder was recognized as an ACEP “Hero of Emergency Medicine” in 2008; and

WHEREAS, Dr. Linder was mentor to many, as evidenced by the steady stream of emergency medicine leaders who followed in the wake of his pioneering career; and

WHEREAS, Dr. Linder was well known for his zest for adventure with his frequent high-altitude treks to some of the most beautiful, but treacherous areas of the world, including the Khumbu Valley in Nepal, Mount Kilimanjaro in Africa, and white water rafting trips through the Grand Canyon; and

WHEREAS, Dr. Linder was a devoted husband and father, and is survived by his wife, Jeanette Linder, MD, and daughter, Kaylie; therefore, be it

RESOLVED, That the American College of Emergency Physicians and the Maryland Chapter hereby acknowledge the many contributions that Lawrence Scott Linder, MD, FACEP, made as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife, Jeanette Linder, MD, his daughter, Kaylie, our condolences and gratitude for Dr. Linder's trailblazing leadership and service to the specialty of emergency medicine and to the patients and physicians of Maryland and the United States.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2017 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 8(18)

SUBMITTED BY: Indiana Chapter

SUBJECT: In Memory of Kevin Rodgers, MD, FACEP, FAAEM

WHEREAS, Emergency medicine lost a tireless advocate, a dedicated educator, a national leader, and mentor to many in emergency medicine with the tragic passing of Kevin Rodgers, MD, FACEP, FAAEM, on November 20, 2017.

WHEREAS, Dr. Rodgers was a graduate of the University of Virginia undergraduate and Emory Physician Associate program, receiving his medical degree from the Medical College of Virginia and completing his residency training at Brooke Army Medical Center; and

WHEREAS, Dr. Rodgers served in multiple educational leadership roles including Prehospital Care Director, Assistant Program and Research Director, Associate Program Director, and Residency Program Director while at Brooke Army Medical Center between 1990-1998; as Associate Program Director from 1998-2002; and subsequently served as Program Director and Program Director Emeritus at Indiana University until his passing; and

WHEREAS, Dr. Rodgers served in multiple national leadership roles advocating for the specialty of emergency medicine, including extensive involvement in the American Academy of Emergency Medicine (AAEM) where he served on the Board of Directors for 12 years, and most recently served as president; and

WHEREAS, Dr. Rodgers received many awards as a result of his countless contributions to our specialty, including but not limited to: The Teacher of the Year Award at Brooke Army Medical Center (twice); the AAEM Written Board Top Speaker Award; the Joe Lex Educator of the Year award; the AAEM/RSA Program Director of the Year Award; the Indiana University EM Inspirational Educator of the Year Award; the AAEM Service Award for Excellence in Education (five times); and the Hal Jayne Excellence in Education Award; and

WHEREAS, Dr. Rodgers was a well-recognized leader through his contributions to medicine and the community regionally, and as such was awarded the Sagamore of the Wabash, the highest award given for civilian contributions to the State of Indiana; and

WHEREAS, Dr. Rodgers sought to help all in need and fervently served patients internationally, helping maintain and staff a clinic in Haiti for approximately 20 years, in the process introducing budding physicians to the importance of serving the underserved beyond their national borders; and

WHEREAS, Dr. Rodgers touched countless lives through service as an educator, a physician, a lacrosse coach, a world-class chef, and an incredibly dedicated husband and father; and

WHEREAS, Dr. Rodgers helped shape emergency medicine to where it is as a specialty today and continues his influence through the actions of the countless emergency medicine residency graduates that he taught their craft; therefore, be it

RESOLVED, That the American College of Emergency Physicians extends to the family of Kevin Rodgers, MD, FACEP, FAAEM, his friends, and his colleagues our condolences and our immense gratitude for his tireless service to his residents, his students, and the countless patients globally who will continue to benefit from his incredible life spent in service to others.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 9-20

J. David Barry, MD, FACEP (GS), Chair
Nida Degesys, MD (EMRA)
Andrea L. Green, MD, FACEP (TX)
Muhammad N. Husainy, DO, FACEP (AL)
James L. Shoemaker, Jr., MD, FACEP (IN)
Larisa M. Traill, MD, FACEP (MI)

Leslie Moore, JD
Maude Surprenant Hancock

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).

Bylaws Amendment

RESOLUTION: 9(18)

SUBMITTED BY: Frederick Blum, MD, FACEP
Marco Coppola, DO, FACEP
Alex Rosenau, DO, FACEP
Robert Suter, DO, FACEP
Emergency Medicine Residents' Association

SUBJECT: American College of Osteopathic Emergency Physicians (ACOEP) Councillor Allocation

PURPOSE: Establishes that ACOEP will be allocated one councillor.

FISCAL IMPACT: Cost for additional councillors is included in the annual Council budget. Budgeted staff resources for updating the Bylaws and comparing the ACOEP membership to ACEP membership.

WHEREAS, The Council is the representative deliberative body of the American College of Emergency Physicians(ACEP) for the specialty of Emergency Medicine where the diversity within the specialty is respected, including by the inclusion of other emergency medicine organizations; and

WHEREAS, The ACEP Council aspires to consider all views on the issues pertinent to the specialty by the inclusion of all representative voices; and

WHEREAS, ACOEP is an independent 501(c)(3) association established in 1975 to represent the interests of osteopathic emergency physicians and advance emergency medicine education within the American Osteopathic Association (AOA) and to the American Osteopathic Board of Emergency Medicine (AOBEM); and

WHEREAS, ACOEP continues to have a special status to be at the forefront of representing issues unique to osteopathic emergency physicians to the AOA and the AOBEM; and

WHEREAS, ACOEP continues to have an important position and role in supporting the DO students in the large number of osteopathic medical schools that do not have departments of emergency medicine; and

WHEREAS, ACOEP and ACEP have enjoyed a long history of mutual respect and cooperation in advancing the specialty of emergency medicine; and

WHERAS, ACOEP has repeatedly and consistently worked closely with ACEP and supported important ACEP-lead initiatives including the Emergency Medicine Action Fund; therefore, be it

RESOLVED, That the ACEP Bylaws Article VIII – Council be amended to read:

The Council is an assembly of members representing ACEP's chartered chapters, sections, the Emergency Medicine Residents' Association (EMRA), the **American College of Osteopathic Emergency Physicians (ACOEP),** Association of Academic Chairs in Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors (CORD), and the Society for Academic Emergency Medicine (SAEM). These component bodies, also known as sponsoring bodies, shall elect or appoint councillors to terms not to exceed three years. Any limitations on consecutive terms are the prerogative of the sponsoring body.

Section 1 — Composition of the Council

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. However, a member holding memberships simultaneously in multiple chapters may be counted for purposes of councillor allotment in only one chapter. Councillors shall be elected or appointed from regular and candidate physician members in accordance with the governance documents or policies of their respective sponsoring bodies.

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.

EMRA shall be entitled to eight councillors, each of whom shall be a candidate or regular member of the College, as representative of all of the members of EMRA.

ACOEP shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of ACOEP.

AACEM shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of AACEM.

CORD shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of CORD.

SAEM shall be entitled to one councillor, who shall be a regular member of the College, as representative of all of the members of SAEM.

Each chartered section shall be entitled to one councillor as representative of all of the members of such chartered section if the number of section dues-paying and complimentary candidate members meets the minimum number established by the Board of Directors for the charter of that section based on the membership rolls of the College on December 31 of the preceding year.

A councillor representing one component body may not simultaneously represent another component body as a councillor or alternate councillor.

Each component body shall also elect or appoint alternate councillors who will be empowered to assume the rights and obligations of the sponsoring body's councillor at Council meetings at which such councillor is not available to participate. An alternate councillor representing one component body may not simultaneously represent another component body as a councillor or alternate councillor.

Councillors shall be certified by their sponsoring body to the Council secretary on a date no less than 60 days before the annual meeting.

Background

This resolution establishes that the American College of Osteopathic Emergency Physicians (ACOEP) will be allocated one councillor. ACOEP was established in 1975 and promotes the interests of osteopathic emergency physicians.

ACOEP desires to strengthen its relationship and collaboration with ACEP through representation in the ACEP Council. Members of ACOEP identify with their own organization and would like to have direct representation in the Council in a manner similar to the Emergency Medicine Residents' Association (EMRA), the Association for Academic Chairs in Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors

(CORD), and the Society for Academic Emergency Physicians (SAEM), which can only be accomplished by amending the ACEP Bylaws.

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.

The College Manual, also a governing document for ACEP, states:

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, 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.

It is unknown at this time whether a majority of ACOEP's members are also members of ACEP. Staff were not successful in obtaining the current ACOEP membership data for a comparison with ACEP membership data before the 2018 Council meeting.

In October 2014, ACEP and ACOEP shared their membership data. At that time there were 4,431 ACOEP members and 1,990 were current ACEP members (44.9%). ACEP also found that 1,721 of ACOEP members had previously been members of ACEP and, therefore, were still eligible for ACEP membership.

The members of ACOEP that are currently members of ACEP are counted as chapter members for the purposes of chapter councillor allocation. These members would, essentially, also be represented by the ACOEP councillor if this resolution is adopted. The same scenario applies to EMRA, AACEM, CORD, and SAEM members. All members of ACEP sections are represented by a section councillor as well as having chapter councillor representation.

ACEP Strategic Plan Reference

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

Fiscal Impact

The cost for additional councillors is included in the annual Council budget. Budgeted staff resources for updating the Bylaws and comparing the ACOEP membership to ACEP membership.

Prior Council Action

None specific to establishing a councillor seat for ACOEP.

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.

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 as stated 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 Council.

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 7(10) CORD Councillor Allocation adopted.

Resolution 8(09) AACEM Councillor Allocation adopted.

Resolution 2(92) EMRA Councillor Allotment adopted.

Resolution 1(88) EMRA Councillor Allotment adopted.

Resolution 2(76) adopted.

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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

College Manual Amendment

RESOLUTION: 10(18)

SUBMITTED BY: Juan Acosta DO, FACEP
Tim Cheslock, DO, FACEP
Stephanie Davis, DO FACEP
Brandon Lewis, DO, FACEP
Robert Suter, DO, FACEP

SUBJECT: Achieving Unity by Expanding Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council

PURPOSE: Amends the College Manual for organizations seeking representation in the Council to meet at least eight criteria and adds a ninth criterion that "The organization supports major ACEP initiatives, such as the Emergency Medicine Action Fund."

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The ACEP Council is the representative deliberative body for the specialty of Emergency Medicine where the diversity within the specialty is respected; and

WHEREAS, The ACEP Council aspires to maximally consider all views on the issues confronting the specialty by the inclusion of all representative voices; and

WHEREAS, The representation of other physician majority organizations filling unique roles in emergency medicine on the Council has been a uniformly positive experience; and

WHEREAS, The inclusion of organizations that include non-ACEP members provides an important mechanism for norming the discussions on the Council and better preparing it to best and most effectively represent the specialty; and

WHEREAS, The current requirement that an organization's membership be composed of a "majority of ACEP members" creates a difficult bureaucratic challenge at both the onset and ongoing basis that creates a barrier to inclusion; and

WHEREAS, The Council expects chapters to represent ACEP members, and sections and other organizations to represent diverse and unique voices; and

WHEREAS, The criterion setting a minimum percentage of members for organizations that otherwise meet all other criteria for representation could deny the Council an otherwise appropriate diverse and unique voice; and

WHEREAS, A criterion that measured organizational support of ACEP would be an excellent alternative for organizations that might not meet the current membership criteria; and

WHEREAS, The Council has the wisdom to make appropriate determinations of which organizations should have representation without a minimum percentage requirement; therefore, be it

RESOLVED, That the ACEP College Manual, VI. Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council be amended to read:

Organizations that seek representation as a component body in the Council of the American College of Emergency Physicians (ACEP) must meet, and continue to meet, **at least eight (8) of** 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. **The organization supports major ACEP initiatives, such as the Emergency Medicine Action Fund.**
~~F.~~**G.** Established, stable, and in existence for at least 5 years prior to requesting representation in the ACEP Council.
~~G.~~**H.** 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.~~**I.** 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

The resolution seeks to amends the College Manual for organizations seeking representation in the Council to meet at least eight criteria and adds a ninth criterion.

Allowing organizations to meet only eight of the criteria could be problematic and result in unintended consequences. For example:

- for profit emergency medicine organizations could be allowed to petition for representation in the Council
- organizations could have Bylaws requirements and policies that are in conflict with ACEP
- physicians would not be required to comprise a majority of the voting membership of the organization
- organizations would no longer be required to have a majority of members as ACEP members even though the ACEP Council is an important part of the governance and policy-setting for ACEP

Adding the criterion "The organization supports major ACEP initiatives, such as the Emergency Medicine Action Fund" (EMAF) could also be challenging. EMAF is the only example provided of major ACEP initiatives. If EMAF ceased to exist, a housekeeping College Manual amendment would be required to remove the reference. Without a reference, "supports major ACEP initiatives" is vague and could be open to interpretation.

In 2012, the Council adopted a resolution directing 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 Council. At that time, the Association of Academic Chairs in Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors (CORD), the Emergency Medicine Residents' Association (EMRA), and the Society for Academic Emergency Medicine (SAEM) had already been approved for representation in the ACEP Council through Bylaws amendments. These organizations have a long-standing collaborative relationship with ACEP and the majority of AACEM, CORD and SAEM members were also members of ACEP. The EMRA bylaws require that EMRA members also be members of ACEP. It was noted that there are many other emergency medicine organizations that may wish to petition for a seat in the ACEP Council, but there were no criteria established for the Council to consider such requests.

In 2013, the Council and the Board amended the College Manual to include the criteria for organizations seeking representation as a component body in the Council.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources.

Prior Council Action

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 as stated 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 Council.

Prior Board Action

Resolution 13(13) Criteria for Eligibility & Approval of Organizations Seeking Representation in the Council – College Manual Amendment 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.

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

Reviewed by: John McManus, MD, FACEP, Speaker
Gary Katz, MD, 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).

Council Standing Rules Amendment

RESOLUTION: 11(18)

SUBMITTED BY: Leadership Diversity Task Force
Council Steering Committee
Board of Directors

SUBJECT: Codifying the Leadership Development Advisory Group (LDAG)

PURPOSE: Seeks to amend the Council Standing Rules to codify the existence and charge of the LDAG.

FISCAL IMPACT: Budgeted staff resources to update the Council Standing Rules.

WHEREAS, The Leadership Development Group (LDAG) was created to identify and mentor potential leaders within ACEP; and

WHEREAS, The LDAG contacts College members meeting the criteria for nomination for elected positions and encourages them to have their names formally placed for consideration by the Nominating Committee; and

WHEREAS, The Council Standing Rules charge the Nominating Committee with development of a slate of candidates for all offices elected by the Council; and

WHEREAS, The LDAG is not codified in the Council Standing Rules; therefore, be it

RESOLVED, That the Council Standing Rules be amended to include a new section titled "Leadership Development Advisory Group" to read:

"**The Leadership Development Advisory Group (LDAG) shall be charged with identifying and mentoring diverse College members to serve in College leadership roles. The LDAG will offer to interested members guidance in opportunities for College leadership and, when applicable, in how to obtain and submit materials necessary for consideration by the Nominating Committee."**

Background

This resolution proposes amending the Council Standing Rules to codify the existence and charge of the Leadership Development Advisory Group (LDAG).

The LDAG was established by the speaker and vice speaker in 2011 and strives to identify ACEP members with leadership potential and mentor and guide them through their maturation in the College. The immediate past speaker serves as the chair and other members include the current speaker and vice speaker, several past presidents, several past speakers, and several past Board members who did not serve as president. The LDAG does not provide nominations or recommendations to the Nominating Committee for consideration.

Prior to the LDAG's formation, ACEP's Nominating Committee had the onerous task of contacting individuals to determine their interest in seeking nomination for the Board of Directors or as a Council officer. Many believed this practice was inherently wrong because the Nominating Committee should not influence future leaders and it could be misconstrued that the Nominating Committee was selecting the individuals it determined should seek nomination. The formation of the LDAG allowed the Nominating Committee to refine its role and use its judgment in selecting the final slate of candidates. The work of the LDAG has been successful in that each year there are an ever-increasing

number of nominations submitted by individuals and component bodies to the Nominating Committee for consideration.

The 2016 Council adopted Amended Resolution 7(16) Diversity in Emergency Medicine Leadership:

> RESOLVED, That the ACEP Board of Directors 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 Leadership Diversity Task Force (LDTF) was appointed in response to the resolution, in addition to other initiatives, to address the resolution. The LDTF objectives are:

1. Review the national ACEP Board of Directors nominating process(es), both formal and informal, and recommend best practices.
2. Survey current pipeline programs within council component bodies (i.e. chapters, sections, outside organizations) to identify successful initiatives and make recommendations to replicate best practices to improve diversity within ACEP leadership.
3. Identify barriers to becoming a councillor, council leader, and member of the national Board of Directors and suggest ways to eliminate these barriers. Include considerations such as age, gender, race, religion, LGBTQ, and practice type.

Through their work, the LDTF determined that most members were unaware of the LDAG and its intent and that the work of the LDAG was not codified in any of the College's governing documents.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted resources to update the Council Standing Rules.

Prior Council Action

None specific to the Leadership Development Advisory Group.

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

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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Council Standing Rules Amendment

RESOLUTION: 12(18)

SUBMITTED BY: Leadership Diversity Task Force
Council Steering Committee
Board of Directors

SUBJECT: Nominating Committee Revision to Promote Diversity

PURPOSE: Seeks to amend the Council Standing Rules to strengthen the Nominating Committee charge by providing further guidance regarding candidate qualifications to increase leadership diversity.

FISCAL IMPACT: Budgeted staff resources to update the Council Standing Rules.

WHEREAS, The ACEP Bylaws, Article VIII – Council, Section 7 – Nominating Committee, and the Council Standing Rules charge the Nominating Committee with development of a slate of candidates for all offices elected by the Council; and

WHEREAS, The Council Standing Rules direct the Nominating Committee to consider activity with the College, Council, and component bodies in the development of the slate of candidates; and

WHEREAS, Evidence suggests that companies with diverse representation at board and top management levels perform better than those without and that more diverse boards increase productivity and profitability[1,2,3]; and

WHEREAS, Amended Resolution 7(16) Diversity in Emergency Medicine charged 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;" therefore, be it

RESOLVED, That the "Nominating Committee" section of the Council Standing Rules be amended to read:

"The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committee shall consider activity and involvement in the College, the Council, and component bodies, **leadership experience in other organizations or practice institution, candidate diversity, and specific experiential needs of the organization** when considering the slate of candidates."

References

1. Women Matter: gender diversity, a corporate performance driver, McKinsey & Company, 2007.
2. Joy L, Carter NM, Wagener HM, Narayanan S. The Bottom Line: Corporate Performance and Women's Representation on Boards. *Catalyst*, 2007.
3. Herring C. Does diversity pay?: race, gender, and the business case for diversity. *Am Sociol Rev. 2009;74(2):208-224.*

Background

This resolution seeks to amend the Council Standing Rules to strengthen the Nominating Committee's charge by providing further guidance regarding candidate qualifications to increase leadership diversity.

The 2016 Council adopted Amended Resolution 7(16) Diversity in Emergency Medicine Leadership:

RESOLVED, That the ACEP Board of Directors 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 Leadership Diversity Task Force (LDTF) was appointed in response to the resolution, in addition to other initiatives, to address the resolution. The LDTF objectives are:

1. Review the national ACEP Board of Directors nominating process(es), both formal and informal, and recommend best practices.
2. Survey current pipeline programs within council component bodies (i.e. chapters, sections, outside organizations) to identify successful initiatives and make recommendations to replicate best practices to improve diversity within ACEP leadership.
3. Identify barriers to becoming a councillor, Council leader, and member of the national Board of Directors and suggest ways to eliminate these barriers. Include considerations such as age, gender, race, religion, LGBTQ, and practice type.

Through their work, the LDTF determined that the language in the Council Standing Rules for the Nominating Committee should be expanded to provide additional guidance to the Nominating Committee

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted resources to update the Council Standing Rules.

Prior Council Action

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

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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 13(18)

SUBMITTED BY: Council Steering Committee

SUBJECT: Growth of the ACEP Council

PURPOSE: Directs the Council officers to appoint a task force to study the growth of the Council and determine whether to submit a Bylaws amendment to the 2019 Council limiting the size of the Council and the relative allocation of councillors.

FISCAL IMPACT: Budgeted Council and staff resources to conduct the study.

WHEREAS, Since 1999, the Council has grown an average of 2.81% per year, which is an average of nine additional councillors per year (Attachment A); and

WHEREAS, Each component body receives one additional councillor for every 100 members; and

WHEREAS, The number of sections continues to grow each year and there are currently 37 sections; and

WHEREAS, At some time in the not too distant future, the size of the Council will exceed the available space and logistical support that is currently available at the hotel facilities, potentially forcing the Council meeting and ancillary events into a convention center facility that may not be convenient or conducive to the Council activities; and

WHEREAS, The human, technical, and financial resources needed to implement the Council meeting increases as the size of the Council grows; and

WHEREAS, The Steering Committee has discussed whether there should be a limit placed on the maximum number of councillors allocated to each component body without reaching any conclusion; and

WHEREAS, The Council has not previously discussed whether limits on the maximum number of councillors should be implemented; therefore, be it

RESOLVED, That the Council direct the Council officers to appoint a task force of councillors to study the growth of the Council and determine whether a Bylaws amendment should be submitted to the 2019 Council limiting the size of the Council and the relative allocation of councillors.

Background

This resolution directs the Council officers to appoint a task force to study the growth of the Council and determine whether to submit a Bylaws amendment to the 2019 Council limiting the size of the Council and the relative allocation of councillors.

The size of the Council continues to expand each year as the membership grows and the number of sections increase. At their May 2018 meeting, the Council Steering Committee reviewed the growth of the Council over the past 20 years (Attachment A). It was determined that the Council has averaged 2.81% growth, which is an average of 9 additional councillors per year.

The Steering Committee discussed various options that could be considered for limiting the number of councillors, such as a maximum number per component body and changing the number of additional members required before an additional councillor is allocated. There was consensus that the Council should discuss the growth of the Council and determine whether such action should be studied and/or pursued.

The amount of square footage needed for the Council meeting and Reference Committees has become more difficult to obtain as ACEP's requirements often fill the capacity of some hotel ballrooms. There are often complaints about the (lack of) space in the main Council meeting room and in the Reference Committees. At times, ACEP has had to use the convention center ballroom for the Council meeting and this will become increasingly necessary as the Council grows. Additionally, the annual costs for Council activities continues to increase. The FY 2018-19 budget for Council activities is $519,942. The costs and staffing requirements will continue to rise each year as the Council grows and the technical and audio/visual requirements are enhanced.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Membership Engagement

Fiscal Impact

Budgeted Council and staff resources to conduct the study.

Prior Council Action

None specific to studying the growth of the Council or limiting the size of the Council.

Prior Board Action

None.

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

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

Councillor Allocation 1999-2018

	# councillors	# increase from prior year	% growth from prior year
2018	421	11	2.7%
2017	410	14	3.5%
2016	396	21	5.6%
2015	375	8	2.2%
2014	367	10	2.8%
2013	357	7	2.0%
2012	350	12	3.6%
2011	338	8	2.4%
2010	330	12	3.8%
2009	318	11	3.6%
2008	307	10	3.4%
2007	297	13	4.6%
2006	284	8	2.9%
2005	276	7	2.6%
2004	269	8	3.1%
2003	261	6	2.4%
2002	255	0	no change
2001	255	4	1.6%
2000	251	8	3.3%
1999	243		

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).

RESOLUTION: 14(18)

SUBMITTED BY: Emergency Medicine Residents' Association
Young Physicians Section

SUBJECT: Diversity of ACEP Councillors

PURPOSE: Encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including candidate physician and young physician members.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, As of July 2018, ACEP had 8,674 candidate physician members who comprised 23% of ACEP's total membership; and

WHEREAS, At the 2017 ACEP Council meeting, only 14 councillors and 20 alternate councillors out of the 547 total credentialed councillors and alternate councillors were ACEP candidate members, representing only 11 chapters; and

WHEREAS, ACEP is committed to increasing diversity and inclusion, including multigenerational diversity within our organization; and

WHEREAS, The current composition of the ACEP Council does not reflect the diversity of ACEP's membership; and

WHEREAS, Early engagement of ACEP candidate and young physician members is more likely to keep them engaged in the ACEP throughout their careers; and

WHEREAS, Investing in future leaders and giving them representation and a voice is critical for increasing member retention, value, and participation; therefore, be it

RESOLVED, That ACEP strongly encourage its chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including candidate physician and young physician members.

Background

This resolution calls for ACEP to strongly encourage chapters to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including candidate physician and young physician members.

ACEP is committed to increasing the diversity of members in leadership positions in the Council, the national Board of Directors, committees, section leadership, and in chapter leadership positions. 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. Increasing diversity in leadership at the chapter and section levels will automatically increase the diversity in leadership within the Council.

In 2017, a similar resolution, Resolution 11(17) Diversity of ACEP Councillors – Bylaws Amendment, was 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. Testimony in the Reference Committee was almost evenly split in favor and opposed. There was unanimous support for the intent of the resolution – to increase diversity within the Council – however, a slight majority of those testifying believed that the language was not appropriate for the ACEP Bylaws. Opposition testimony on behalf of chapters emphasized the importance of chapter independence and that this would create roadblocks for small chapters because of the limited number of councillors allotted to them and it would force them to substitute a more knowledgeable councillor for those with less experience. Those in favor of the resolution testified that, as the future of emergency medicine, residents should have a voice within the Council. It was further emphasized that ACEP has no power to mandate this action, but rather the resolution is designed to encourage chapters to appoint these councillors. Appointment is at the discretion of the chapter leadership.

The 2016 Council adopted Amended Resolution 7(16) Diversity in Emergency Medicine Leadership:

> RESOLVED, That the ACEP Board of Directors 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 Amended Resolution 7(16). The Diversity & Inclusion Task Force was assigned the following objectives:

1. Engage the specialty of emergency medicine on diversity and inclusion.
2. Identify obstacles to advancement within the profession of emergency medicine related to diversity and inclusion, and ways to overcome these obstacles.
3. Highlight the effects of diversity and inclusion on patient outcomes and to identify ways to improve these outcomes.

The 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. Diversity and inclusion focus groups will also be conducted during *ACEP18*

The Leadership Diversity Task Force (LDTF) was assigned the following objectives:

1. Review the national ACEP Board of Directors nominating process(es), both formal and informal, and recommend best practices.
2. Survey current pipeline programs within council component bodies (i.e. chapters, sections, outside organizations) to identify successful initiatives and make recommendations to replicate best practices to improve diversity within ACEP leadership.
3. Identify barriers to becoming a councillor, Council leader, and member of the national Board of Directors and suggest ways to eliminate these barriers. Include considerations such as age, gender, race, religion, LGBTQ, and practice type.

In June 2018, the Board of Directors approved the LDTF'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 F – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

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

June 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.

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, FACEP, Speaker
Gary Katz, MD, 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).

RESOLUTION: 15(18)

SUBMITTED BY: Marc Futernick, MD, FACEP
Jeremy Hess, MD, MPH, FACEP
Jay Lemery, MD, FACEP
Victoria Leytin, MD
Luke Palmisano, MD, FACEP
James Rayner, MD
Renee Salas, MD, MPH, MS
Ted C. Shieh, M.D., FACEP
Jonathan Slutzman, MD
Cecelia Sorensen, MD
Larry Stock, MD, FACEP
California Chapter

SUBJECT: Divestment from Fossil Fuel-Related Companies

PURPOSE: Directs ACEP to: 1) end all financial investments or relationships with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; 2) choose for its commercial relationships entities that demonstrate environmentally sustainable practices; 3) support emergency physicians, chapters, EMF, and other medical societies in making similar divestments, while educating the public and policymakers about the health consequences of burning fossil fuels.

FISCAL IMPACT: Unknown impact on investment income from divesting energy-related holdings in ACEP's investment portfolio and from the potential termination of sponsor or vendor relationship with companies that do not meet this standard. Unbudgeted staff resources to research and determine the financial investments and commercial relationships that meet these criteria and to educate the public and policymakers on the health consequences of burning fossil fuels.

WHEREAS, The Intergovernmental Panel on Climate Change has concluded that the burning of fossil fuels by humans to generate energy is the principal driver of climate change and is already causing accelerated warming of the Earth's surface, which is a direct threat to both environmental and human health; and

WHEREAS, The burning of fossil fuels, such as coal, petroleum derivatives, and natural gas, has been found by numerous studies to be detrimental to human health and to contribute significantly to global climate change; and

WHEREAS, An MIT study in 2013 estimated that the air pollution resulting from the burning of fossil fuels causes 200,000 premature deaths annually in the United States; and

WHEREAS, Emergency Physicians are typically the first to care for patients harmed by natural disasters related to climate change, such as wildfires, more powerful winter and summer storms, tornados, and floods; and

WHEREAS, Emergency Physicians care for patients every day with ailments related to the consequences of burning fossil fuels, such as asthma, chronic obstructive pulmonary disease, and cardiovascular disease; and

WHEREAS, The American Medical Association (AMA) House of Delegates has recently resolved to initiate the process of divesting from all fossil fuel-related companies; and

WHEREAS, In recent years, divestment of fossil fuel companies by healthcare organizations has been initiated by Gundersen Health, a well-known health system based in Wisconsin; by HESTA Australia, a health care industry retirement fund worth $26 billion; and full divestment has been initiated already by the World Medical Association, Canadian Medical Association, and British Medical Association; and

WHEREAS, As physicians who have committed to the principle of "First do no harm," we share an ethical obligation to minimizing fossil fuel consumption in our daily activities and to strive to influence the health care institutions within which we practice and our professional societies to divest from fossil fuels;

WHEREAS, The AMA Board of Trustees' report on fossil fuels divestment (B of T Report 34-A-18) acknowledges that fossil fuels divestment over the last 20 years would have improved the AMA's portfolio results; therefore, be it

RESOLVED, That ACEP, and any affiliated corporations, shall work in a timely and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and be it further

RESOLVED, That ACEP shall, when fiscally responsible, choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and be it further

RESOLVED, That ACEP shall support efforts of emergency physicians, state chapters, the Emergency Medicine Foundation, and other health professional associations to proceed with divestment, including to support continuing medical education, and to inform our patients, the public, legislators, and government policy makers about the health consequences of burning fossil fuels.

Background

This resolution calls for the College to work in a timely and fiscally responsible manner, to the extent allowed by legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; to, when fiscally responsible, choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and to support efforts of emergency physicians, state chapters, the Emergency Medicine Foundation, and other health professional associations to proceed with divestment, including to support continuing medical education, and to inform our patients, the public, legislators, and government policy makers about the health consequences of burning fossil fuels.

ACEP's Investment Policy/Guidelines, which are included in the "Compendium of Financial Policies & Operational Guidelines," states:

> "No funds will be invested directly in any source that produces goods or services contrary to ACEP's policies, as published in its annual Policy Summaries. This includes but is not limited to investments in securities of companies whose primary business lines include alcohol, tobacco, and firearms. No funds will be directly invested in any source that may imply a conflict of interest for ACEP, such would include organizations that contribute to ACEP projects or conduct joint ventures with ACEP. This includes but is not limited to investments in securities of companies whose primary business lines include managed-care organizations, group medical management companies, for profit hospitals and medical billing companies.
>
> However, this does not preclude ACEP's direct investment in mutual funds or other mixed portfolios which may include as a minor part of such portfolios securities in the prohibited (or limited) categories. Issues

> that subsequently are determined to imply conflict of interest are to be eliminated on a timely basis at the discretion of the investment manager."

In the current investment portfolio, about 10% of the individual bonds are in energy-related companies. Most of the portfolio is in passive investments (ETFs and indexes). About 2% of ACEP's portfolio is invested in energy pipeline companies through the Clearbridge Energy MLP fund, which currently pays a 9.5% dividend. From a financial standpoint, ACEP's Financial Advisor does not advise selling any of these securities.

ACEP also has a policy detailing internal guidelines and processes to be followed regarding all arrangements for financial or other support from for-profit and non-profit entities. The "Guiding Principles for Interaction with External Entities" addresses advertising, endorsement, sponsorship, and other support that outside organizations may provide to ACEP. The policy includes stringent review and approval processes for certain types of arrangements and entities, such as pharmaceutical companies and medical device manufacturers, but there is no mention of energy-related companies or the environmentally sustainable practices of any sponsoring entities.

In June 2018, the AMA House of Delegates approved a policy to "Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies" (H-135.921). The policy reads:

> "1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption.
> 2. Our AMA will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers."

An accompanying AMA directive of the same name (D-135.969) reads:

> "Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels."

ACEP Strategic Plan Reference

None

Fiscal Impact

Unknown impact on investment income from divesting energy-related holdings in ACEP's investment portfolio and from the potential termination of sponsor or vendor relationship with companies that do not meet this standard. Unbudgeted staff resources to research and determine the financial investments and commercial relationships that meet these criteria and to educate the public and policymakers on the health consequences of burning fossil fuels.

Prior Council Action

None

Prior Board Action

October 2017, approved the revised "Guiding Principles for Interaction with External Entities."

January 2017, approved the revised "Compendium of Financial Policies & Operational Guidelines," which includes the Investment Policy/Guidelines.

Background Information Prepared by: Layla Powers
Chief Financial Officer

Reviewed by: John McManus, MD, FACEP, Speaker
Gary Katz, MD, 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).

RESOLUTION: 16(18)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: No More Emergency Physician Suicides

PURPOSE: 1) Study the unique, specialty-specific contributory factors leading to depression and suicide in emergency physicians; 2) formulate an action plan to address the contributory factors leading to depression and suicide among emergency physicians; 3) provide a report to the 2019 Council.

FISCAL IMPACT: Budgeted committee/task force and staff resources.

WHEREAS, Physicians commit suicide at a rate about twice that of the general population[1]; and

WHEREAS, Emergency physicians, in dealing with crisis daily, are particularly at risk for depression, burnout, and suicide and often refrain from addressing their own needs as they care for others; and

WHEREAS, Root causes for physician depression and suicide have been suggested but not comprehensively studied; and

WHEREAS, There may be specific contributory factors unique to emergency medicine; and

WHEREAS, Current ACEP wellness and resiliency resources do not address directly the issue of depression and suicide in emergency physicians; therefore, be it

RESOLVED, That ACEP study the unique, specialty-specific factors leading to depression and suicide in emergency physicians; and be it further

RESOLVED, That ACEP formulate an action plan to address contributory factors leading to depression and suicide unique to our specialty and provide a report of these findings to the 2019 Council.

Background

This resolution calls for the College to study the unique, specialty-specific contributory factors leading to depression and suicide in emergency physicians; formulate an action plan to address the contributory factors leading to depression and suicide among emergency physicians; and provide a report of these findings to the 2019 Council.

ACEP's efforts addressing the factors that contribute to physician depression and suicide have focused on physician well-being. Since 1990, ACEP's Well-Being Committee has been tasked to carry out member-driven personal and professional wellness-related objectives. The Well-Being Committee's 2018-19 objectives that focus on physician well-being are:

- Continue to enhance and implement the Wellness Week program for emergency physicians and providers to encourage personal and professional wellness strategies. Explore wellness training tactics for residents and young physicians.
- Continue collaborating with ACEP's Education Committee to complete development of interactive online CME tutorials on resiliency strategies as part of Wellness Week activities.

- Compile and disseminate information on the "joys" (professional and personal satisfaction) of practicing emergency medicine. Incorporate ideas of well-being and wellness into a sustainable platform beyond wellness week. Refine campaigns for a culture change for emergency physicians to focus on the positive accomplishments in the ED.
- Analyze emergency departments with higher and lower physician and nurse turnover and examine characteristics of the department and individuals that may have a positive or negative effect on wellness.
- Develop a series of articles for submission to *ACEP Now*, including how to improve being well in emergency medicine and bringing "joy" to practice.
- Discover exemplary practices that contribute to wellness in emergency medicine and disseminate the information to all EDs in the U.S.
- Continue collaboration with EMRA and ACEP's Academic Affairs Committee to identify and/or develop resources for residents and medical students to address resiliency and coping mechanisms.

CME opportunities that address physician burnout and resilience are available through VirtualACEP. These presentations, recorded at ACEP's 2015, 2016, and 2017 annual meetings, are Physician, Heal Thyself: The Importance of Creating Resilience, Combating Burnout in the ED, and ACEP Connect: Burnout Prevention, Diagnosis, and Treatment Today!.

Non-credit educational opportunities that address wellness, well-being, resiliency, and burnout are available to members through the ACEP eCME portal. The resource guide "Being Well in Emergency Medicine: ACEP's Guide to Investing in Yourself" provides readers with the information to take a reflective, multidimensional look at their personal wellness and professional satisfaction. Two ACEP Frontline podcasts featuring Rita Manfredi, MD and Jay Kaplan, MD are available through the ACEP eCME portal address emergency physician wellness and burnout.

The ACEP Academic Affairs Department initiated a project in February 2018 to identify and address the management of patients with suicidal ideation in the emergency department. The deliverables of this project will be an online tool, scheduled to be available in September 2018, followed by a peer-reviewed paper.

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. In 2017, ACEP began working with partner organizations, such as CORD and AAEM to develop a campaign to raise awareness about physician suicide. Another campaign is planned to occur during National Suicide Prevention Week, September 10-16, 2018. ACEP also plans to participate in CORD's *Vision Zero* campaign on September 17, 2018, to raise awareness of physician suicide. The campaign goals are to shed light on physician suicide and contribute to a culture of change. In addition, the Wellness Section intends to screen the documentary, DO NO HARM, during their meeting at *ACEP18* to continue to engage in dialogue about this issue.

References

1. Anderson, Pauline. Physicians Experience Highest Suicide Rate of Any Profession. Available at: www.medscape.com/viewarticle/896257#vp_1. Accessed August 1, 2018.

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.
Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.
Objective F - Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

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

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

None

Prior Board Action

None

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 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: 17(18)

SUBMITTED BY: Council of Emergency Medicine Residency Directors
Emergency Medicine Residents' Association
Wellness Section

SUBJECT: Physician Suicide is a Sentinel Event

PURPOSE: 1) acknowledge the unique role that workplace factors, as well as departmental and institutional culture play in physician suicides; 2) treat physician suicides as sentinel events; 3) partner with medical organizations to advocate for the adoption of policies that consider physician suicides as sentinel events.

FISCAL IMPACT: Budgeted committee/task force and staff resources.

WHEREAS, Physicians in the United States have the highest suicide rate of any profession[1]; and

WHEREAS, The physician suicide rate is approximately 28 to 40 per 100,000, more than double that of the general population; and

WHEREAS, Physician suicide is a public health crisis, with one million Americans losing their doctors to suicide each year; and

WHEREAS, The suicide rate of male physicians is 40% higher than men in general, and the rate among female physicians is 130% higher than that among women in general[2,3]; and

WHEREAS, Data from the Center for Disease Control's National Violent Death Reporting System shows that compared to the general population, physicians are three-times more likely to have job problems identified as a factor contributing to suicide, including tensions with a co-worker, poor performance reviews, increased pressure at work, or fear of being laid off[4]; and

WHEREAS, Suicide is a leading cause of death amongst physicians-in-training[5]; and

WHEREAS, Sentinel events have been defined as unexpected occurrences involving death or serious physical or psychological injury that signal the need for immediate investigation and response; and

WHEREAS, Sentinel events currently include issues related to patient suicide and staff safety[6]; and

WHEREAS, The goals of responding to sentinel events include understanding factors that contributed to the event, and changing a hospital's culture, systems, and processes to reduce the probability of such an event in the future; and

WHEREAS, Investigation of physician suicides as sentinel events could be done in a confidential manner to respect the memory of the deceased, without tarnishing the reputation of hospitals, practice groups, or other employers who commit themselves to improvement by reporting and investigating these events; therefore, be it

RESOLVED, That ACEP acknowledges the unique role that workplace factors, as well as departmental and institutional culture play in physician suicides, and that ACEP believes that physician suicides should be treated as sentinel events that should be investigated through internal and confidential review to better understand workplace systems, processes, and culture that can be changed to reduce the probability of future events; and be it further

RESOLVED, That ACEP work with partner organizations, including the American Medical Association, the American Hospital Association, and the National Academy of Medicine to advocate for the adoption of policies that consider physician suicides as sentinel events.

Background

This resolution calls ACEP to acknowledge the unique role that workplace factors, as well as departmental and institutional culture play in physician suicides; treat physician suicides as sentinel events; and partner with medical organizations to advocate for the adoption of policies that consider physician suicides as sentinel events.

ACEP's efforts addressing the factors that contribute to physician depression and suicide have focused on physician well-being. Since 1990, ACEP's Well-Being Committee has been tasked to carry out member-driven personal and professional wellness related objectives. The Well-Being Committee has an objective for the 2018-19 committee year to "Analyze emergency departments with higher and lower physician and nurse turnover and examine characteristics of the department and individuals that may have a positive or negative effect on wellness."

The Joint Commission accreditation and certification is a voluntary effort undertaken by healthcare organizations to enhance quality of care and patient safety.[7] Accredited healthcare organizations demonstrate compliance with The Joint Commission Standards, National Patient Safety Goals, and Accreditation Participation Requirements that focus on functions essential to providing safe, high quality care.[7]

A "sentinel event" is a term used by The Joint Commission to describe a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) resulting in death, permanent harm, or severe temporary harm.[8] The Joint Commission's Sentinel Event Policy explains how The Joint Commission partners with accredited healthcare organizations that have experienced a serious patient safety event to protect the patient, improve systems, and prevent further harm.[9] Joint Commission Standard LD.04.04.05, EP 7, requires each accredited healthcare organization to define a 'sentinel event' for its own purposes in establishing procedures to identify, report and manage these events.[9,10]

When an accredited organization experiences a sentinel event subject to the Sentinel Event Policy, the organization is expected to report the event to The Joint Commission.[11] The organization is then expected to conduct a root cause analysis and develop an action plan to reduce future risk of the event.[11]

Reporting a sentinel event is encouraged, but not mandatory.[11] However, reporting information on an event contributes to the evidence base for developing and maintaining the Joint Commission's National Patient Safety Goals and informing prevention advice to hospitals through the *Sentinel Event Alert* and other media.[11]

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. In 2017, ACEP began working with partner organizations, such as CORD and AAEM to develop a campaign to raise awareness about physician suicide. Another campaign is planned to occur during National Suicide Prevention Week, September 10-16, 2018. ACEP also plans to participate in CORD's *Vision Zero* campaign on September 17, 2018, to raise awareness of physician suicide. The campaign goals are to shed light on physician suicide and contribute to a culture of change. In addition, the Wellness Section intends to screen the documentary, DO NO HARM, during their meeting at *ACEP18* to continue to engage in dialogue about this issue.

References

1. Anderson, Pauline. Physicians Experience Highest Suicide Rate of Any Profession. Available at: www.medscape.com/viewarticle/896257#vp_1. Accessed May 7, 2018.
2. Schernhammer E. Taking Their Own Lives — The High Rate of Physician Suicide. *NEJM*. 2015;352(24):2473-2476.
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8. The Joint Commission. Sentinel Events (SE). Available at: https://www.jointcommission.org/assets/1/6/CAMH_24_SE_all_CURRENT.pdf. Accessed August 1, 2018.

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10. The Joint Commission. *2018 Hospital Accreditation Standards*. Oak Brook, IL: Joint Commission Resources; 2018.
11. The Joint Commission. Facts about the Sentinel Event Policy. Available at: https://www.jointcommission.org/assets/1/18/Sentinel%20Event%20Policy.pdf. Accessed August 1, 2018.

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.
Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.
Objective F - Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Goal 2 – Enhance Membership Value and Member Engagement
Objective A – Improve member well-being and resiliency.
Objective E – Provide and promote leadership development among emergency medicine organizations and strengthen liaison relationships.

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

None

Prior Board Action

None

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

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RESOLUTION: 18(18)

SUBMITTED BY: Council of Emergency Medicine Residency Directors
Emergency Medicine Residents' Association
Wellness Section

SUBJECT: Reducing Physician Barriers to Mental Health Care

PURPOSE: Work with stakeholders to advocate for changes in state medical board licensing application questions about a physician's mental health to more appropriately address impairment vs illness.

FISCAL IMPACT: Budgeted staff, committee, and section resources.

WHEREAS, More than 400 physicians die by suicide each year, a rate more than double that of the general population[1]; and

WHEREAS, Untreated or inadequately treated depression has been shown to be a major cause of suicide[2]; and

WHEREAS, The majority of physicians who commit suicide are not in psychiatric treatment at the time of their death[2]; and

WHEREAS, Physicians-in-training are at high risk for depression, affecting approximately one-quarter to half of all trainees[3,4]; and

WHEREAS, Suicide is a leading cause of death amongst physicians-in-training[5]; and

WHEREAS, Despite high rates of depression, few interns appear to seek mental health treatment because of time constraints, preference to manage problems on their own, lack of convenient access, and concerns about confidentiality[4]; and

WHEREAS, The Emergency Medicine Residents' Association advocates for access to mental health care and/or services by physician self-referral through efforts such as encouraging support, reducing stigma, increasing availability, and ensuring confidentiality[6]; and

WHEREAS, Two-thirds of state medical boards require reporting of all past or current mental health conditions[7]; and

WHEREAS, Only half limited all questions to mental health conditions causing current impairment, and just 14% limited their questions to ongoing mental health conditions[8] regardless of whether there is current impairment[7]; and

WHEREAS, Many state medical boards have indicated that the diagnosis of mental illness was by itself sufficient for sanctioning physicians regardless of impairment[9]; and

WHEREAS, Experts believe that decisions about professional licensing and credentials should be based on professional performance, not psychiatric diagnosis or treatment[10]; and

WHEREAS, Many physicians report that they are reluctant to seek care for mental health conditions because

of concerns about repercussions to their medical licensure[7]; and

WHEREAS, State medical boards may ask physicians who report they are in psychiatric treatment to provide the name of their treating psychiatrist who is then asked to provide private, personal records, which may cause harm if not protected carefully[9]; therefore, be it

RESOLVED, That ACEP work with partner organizations to promote a culture where physician mental health issues can be addressed proactively, confidentially, and supportively, without fear of retribution; and be it further

RESOLVED, That ACEP work with the American Medical Association, Federation of State Medical Boards, and the American Psychiatric Association to petition state medical boards to end the practice of requesting a broad report of mental health information on licensure application forms unless there is a current diagnosis that causes physician impairment or poses a potential risk of harm to patients; and be it further

RESOLVED, That ACEP work with ACEP chapters to encourage state medical boards to amend their questions about both the physical and mental health of applicants to use the language recommended by the American Psychiatric Association: "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?"

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4. Guille G *et al.* Utilization and Barriers to Mental Health Services Among Depressed Medical Interns: A Prospective Multisite Study. *J Grad Med Educ.* 2010; 2(2): 210-214. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2941380/
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AMA Policy

- Access to Confidential Health Services for Medical Students and Physicians H-295.858 https://policysearch.ama-assn.org/policyfinder/detail/physician%20suicide?uri=%2FAMADoc%2FHOD-295.858.xml
- Self-Incriminating Questions on Applications for Licensure and Specialty Boards H-275.945: https://policysearch.ama-assn.org/policyfinder/detail/state%20license%2C%20mental%20health?uri=%2FAMADoc%2FHOD.xml-0-1923.xml

Background

This resolution directs ACEP to work with stakeholders to advocate for changes in state medical board licensing application questions about a physician's mental health to more appropriately address impairment vs illness

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 to comply with the ADA when asking about a physician's mental health. In much of case law, state boards run into challenges with this in defining the line between an applicant's right to privacy with their duty to protect the public.

Currently, state board licensing application questions about physician mental health vary from broad-based to what has been called "consistent." Some states ask generally if the physician has "ever been treated for a mental health condition" while others follow the recommendations of the American Medical Association (AMA), Federation of State Medical Boards (FSMB), and the APA with a more targeted question intended to address impairment. The AMA, FSMB and APA have all 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 relicensure 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."

A recent analysis of medical licensure application questions found that only 16 of 48 applications appropriately addressed this issue by either limiting their questions to "current impairment from a mental health condition," or refrained from the question altogether. It has been noted that in states with broad questions about mental health care, physician are less likely to seek care. ACEP plans to meet with the FSMB in the fall of 2018 to further discuss this issue.

In 2010, the Well-Being Committee contributed to a health resource document for emergency physicians. The document listed resources for physicians, such as local Federation of State Physician Health Programs (FSPHP). The FSPHP evolved from an initiative of the AMA and state-based physician health programs. 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 are able to provide and typically focus on substance use disorders. Several studies have noted that suicide is a leading cause of death among people who misuse alcohol and drugs and that this misuse contributes to significant increases in the risk of suicide.

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. In 2017, ACEP began working with partner organizations, such as CORD and AAEM to develop a campaign to raise awareness about physician suicide. Another campaign is planned to occur during National Suicide Prevention Week, September 10-16, 2018. ACEP also plans to participate in CORD's *Vision Zero* campaign on September 17, 2018, to raise awareness of physician suicide. The campaign goals are to shed light on physician suicide and contribute to a culture of change. In addition, the Wellness Section intends to screen the documentary, DO NO HARM, during their meeting at *ACEP18* to continue to engage in dialogue about this issue.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement; Objective A – Improve member well-being and improve resiliency.

Fiscal Impact

Budgeted staff, committee, and section resources.

Prior Council Action

None

Prior Board Action

None

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

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American College of Emergency Physicians
ADVANCING EMERGENCY CARE

RESOLUTION: 19(18)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Reduction of Scholarly Activity Requirements by the ACGME

PURPOSE: Address changes in scholarly activity requirements by the ACGME to include: advocacy, model policy language, exploration of alternative ways to provide financial support to residency and training programs, collaboration with CORD and SAEM, and a statement to the ACGME on explicit requirements for scholarship.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Scholarship is one of the cornerstones of emergency medicine and the foundation upon which progress in safe, effective, evidence-based patient care is made; and

WHEREAS, The Accreditation Council for Graduate Medical Education (ACGME) has promulgated Institutional and Common Program Requirements for scholarly activity; the current requirements have been successful in promoting quality and quantity of scholarship; and

WHEREAS, Proposed changes to scholarly activity requirements by the ACGME will result in a decline in quality and quantity of scholarly work in emergency medicine; and

WHEREAS, Removing scholarship mandates for institutions and programs increases the risk of reduced resources, including financial support, allocated for faculty and the training program, and removes the responsibility of the sponsoring institution to ensure adequate resources for scholarly activity among its faculty and trainees; and

WHEREAS, Reducing scholarly requirements will disproportionately harm smaller, non-university-based emergency medicine training programs where the current requirements protect what little funding is available; and

WHEREAS, Removal of scholarly requirements will significantly impact emergency medicine trainees' ability to develop the necessary skill to appraise the literature critically and make evidence-based patient care decisions based on this appraisal; and

WHEREAS, Knowledge and skills derived from participating in scholarship is critical to the ACGME's six core-competencies, particularly that of practice-based learning and improvement; and

WHEREAS, Decreasing faculty requirements for scholarship will limit their ability to mentor trainees in scholarly pursuits; therefore, be it

RESOLVED, That ACEP reaffirms its position on the importance of scholarship and will advocate aggressively with the Accreditation Council for Graduate Medical Education to preserve core faculty teaching and academic time, including support of scientifically rigorous research and education that improves the patient care in emergency medicine; and be it further

RESOLVED, That ACEP develop model policy language on the importance of scholarship and the need for core faculty teaching and academic time, which training programs can access and present to hospital systems as evidence for the need for financial support for scholarly activity; and be it further

RESOLVED, That ACEP explore additional ways to provide financial support to residency and training

programs in carrying out scholarly activities; and be it further

RESOLVED, That ACEP work with the Council of Emergency Medicine Residency Directors and the Society for Academic Emergency Medicine to establish initiatives and processes to ensure all areas of scholarship are supported; and be it further

RESOLVED, That ACEP provide a statement to the Accreditation Council for Graduate Medical Education to request that accreditation requirements for scholarship be explicit to ensure institutional and program funding support is directed toward these activities.

Background

This resolution directs ACEP to address changes in scholarly activity requirements by the ACGME to include: advocacy, model policy language, exploration of alternative ways to provide financial support to residency and training programs, collaboration with CORD and SAEM, and a statement to the ACGME on explicit requirements for scholarship

In February 2018, the ACGME distributed a memo notifying the public that the Phase 2 Common Program Requirements Task Force completed its preliminary work in reviewing and revising the Common Program Requirements. The Task Force developed two sets of Common Program Requirements – one for resident programs and the other for fellowships. The ACGME noted that the revisions are intended to provide programs with increased flexibility. The changes included: removal of the requirement that sponsoring organizations adequately allocate resources for resident *and* faculty involvement in scholarly activity; and, changes to the mandate on protected time.

ACEP staff notified the Academic Affairs Committees as well as sections and committees with relevant fellowships, such as pediatrics and EMS, requesting review and comments. Among the concerns raised by ACEP members around changes to scholarly activity requirements were that individual faculty were no longer required to produce scholarly activity, but rather it was now required in aggregate at the program level. There were also concerns about the lack of protected time and fear that without it the faculty would not have any time dedicated to academics or scholarly activity because of their clinical schedule. Members believed these changes could lead to decreased core faculty participation, especially for junior and mid-career faculty, without external funding. Comments were reviewed, compiled, and sent to the ACGME in March 2018. In addition to the comments, ACEP requested and opportunity to provide input to individual Review Committees (EM) to influence the final version.

Last year, the Emergency Medicine Research Section submitted Resolution 19(17) Advocacy and Support for "Scholarly Activity" Requirements for Emergency Medicine Residents calling for a uniform, consistent approach for the definition of scholarly activity. The majority of testimony was in strong opposition to the resolution. Several residency and program directors testified that this approach limits flexibility and stifles creativity in programs. Others stated that the resolution could limit the definition of "scholarly activity" to only allow for research activities and that regulations on program requirements are already too restrictive. Those in favor of the resolution testified that this would further scientific requirements in emergency medicine and that it would allow programs to become more robust. The Council did not adopt the resolution.

The Academic Affairs Committee was assigned an objective for the 2017-18 year to develop an information paper on transparency in how emergency medicine programs are funded and outline alternative methodologies for funding. This paper is currently in development.

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 and staff resources.

Prior Council Action

Resolution 19(17) Advocacy and Support for "Scholarly Activity" Requirements for Emergency Medicine Residents. not adopted. The resolution called for working with stakeholders to develop a uniform, consistent approach towards the scholarly activity for residents using a consensus approach.

Prior Board Action

June 2018, approved the revised policy statement "Financing of Graduate Medical Education in Emergency Medicine;" revised October 2012; reaffirmed September 2005; originally approved September 1999.

June 2014, approved dissemination of the "Pipeline Survey on Research" results on resident scholarly activity and resident research curriculum and supported implementation of proposed strategies.

June 2013, reaffirmed the policy statement "Scholarly Sabbatical Leave for Emergency Medicine Faculty;" reaffirmed October 2007; originally approved April 2001.

June 2017, approved the revised policy statement "Academic Departments of Emergency Medicine in Medical Schools;" reaffirmed April 2011 and September 2005; approved March 1999; originally approved November 1974.

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

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RESOLUTION: 20(18)

SUBMITTED BY: New York Chapter

SUBJECT: Verification of Training

PURPOSE: Work with various stakeholders to support the development of standardized forms and applications to create a streamlined process for hospital credentialing.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Hospitals and their medical staff services' offices have developed unique forms to verify resident training for credentialing as required for hospital accreditation; and

WHEREAS, Most facilities seek verification of resident training within the past five years from the primary source, the residency program; and

WHEREAS, Most facilities seek additional peer references with unique forms for credentialing as required for hospital accreditation; and

WHEREAS, The Accreditation Council for Graduate Medical Education, American Hospital Association, National Association of Medical Staff Services, and Organization of Program Directors Associations has collaborated to create a standardized "Verification of Graduate Medical Education Training"; and

WHEREAS, Each potential applicant must endure scores of unique application forms for each employment position; therefore be it

RESOLVED, That ACEP work with stakeholders including the Federation of American Hospitals (FAH), American Hospital Association (AHA), and others as appropriate, to develop a standardized and streamlined application process for hospital credentialing; and be it further

RESOLVED, That ACEP support the development of a standardized verification of training form for hospital credentialing and be it further

RESOLVED, That ACEP support the development of a standardized peer reference form for hospital credentialing; and be it further

RESOLVED, That ACEP support the development of a standardized verification of employment form for hospital credentialing; and be it further

RESOLVED, That ACEP support the development of a standardized employment application for board eligible or board certified emergency physicians for hospital credentialing.

Background

This resolution directs ACEP to work with various stakeholders to support the development of standardized forms and applications to create a streamlined process for hospital credentialing.

ACEP's policy statement, "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" and the corresponding Policy Resource and Education Paper (PREP) "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine are resources for members. The PREP includes a list of considerations for emergency medicine credentialing appointment or reappointment as well as a sample request for emergency medicine privileges.

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 and staff resources.

Prior Council Action

Amended Resolution 15(03) Granting Clinical Privileges adopted. The resolution directed ACEP to revise the policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" to reflect that the emergency physician medical director or chief of emergency medicine, acting in a manner consistent with the hospital credentialing process, should be responsible for assessing and making recommendations to the hospital's credentialing body related to the qualifications of the ED's physicians with respect to the clinical privileges granted to that physician.
"

Resolution 53(95) Managed Care – Application and Certification adopted. This resolution states ACEP believes there should be a standardized application to be used by all managed care companies, with a single completed application centrally stored and distributed to managed care companies as required, with annual updated only if pertinent changes occur and that ACEP should work with other physician organizations to promulgate this policy.

Prior Board Action

June 2018, reaffirmed the policy statement "Emergency Medicine Training, Competency and Professional Practice Principles;" reaffirmed April 2012; revised and approved January 2006; originally approved November 2001.

August 2017, reviewed the revised PREP "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" originally published June 2006.

April 2017, approved the revised policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" revised and approved October 2014, June 2006, June 2004; reaffirmed October 1999; revised and approved September 1995, June 1991; originally approved April 1985 titled "Guidelines for Delineation of Clinical Privileges in Emergency Medicine."

Amended Resolution 15(03) Granting Clinical Privileges adopted.

Resolution 53(95) Managed Care – Application and Certification 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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 Council Meeting
Reference Committee Members

Reference Committee B
Advocacy & Public Policy
Resolutions 21-35

Kristin B. McCabe-Kline, MD, FACEP (FL), Chair
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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).

RESOLUTION: 21(18)

SUBMITTED BY: Arjun Chanmugam,MD, FACEP
Kyle Fischer, MD
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Maryland Chapter

SUBJECT: Adequate Resources for Safe Discharge Requirements

PURPOSE: Support advocacy to assure that adequate financial, community resources, and patient supports are included in proposed local, state, or federal policies dictating criteria for safe patient discharge from the ED.

FISCAL IMPACT: Staff and consultant resources to convey ACEP's position and encourage federal, state, and local lawmakers and regulators.

WHEREAS, Emergency departments act as safety nets for patients with complex medical and social needs; and

WHEREAS, Emergency departments have a well-established history of providing food, shelter, and other resources to both homeless individuals and those with significant disability or mental illness; and

WHEREAS, Recent high-profile events have highlighted the difficulties and limitations of providing this social safety net; and

WHEREAS, Policymakers have enacted mandates specifying "Safe Discharge Criteria" for emergency department patients; and

WHEREAS, Many elements of proposed mandates are not feasible for emergency departments to provide after discharge in the absence of additional community supports and resources; and

WHEREAS, Post-discharge support and resources require a diverse group of community stakeholders to ensure patients have 24-hour access to shelter, food, transportation, and other basic needs; therefore, be it

RESOLVED, That ACEP support advocacy to assure that adequate financial, community resources, and patient supports are included in proposed local, state, or federal policies dictating criteria for safe patient discharge from the emergency department.

Background

This resolution directs ACEP to advocate at the local, state, and federal levels to help ensure adequate financial, community resources, and patient supports are included in proposed policies dictating criteria for safe patient discharge from the emergency department.

While there are federal requirements for hospitals around discharges in the form of Medicare and Medicaid conditions of participation, no such federal standards or requirements exist for emergency departments specifically. There is also limited information about whether individual states and local governments have created separate discharge standards for emergency departments. Some states have included guidance about emergency department discharges in their overall hospital discharge guidelines.

In 2015, the Agency for Healthcare Research and Quality (AHRQ), in conjunction with the Johns Hopkins University Armstrong Institute for Patient Safety and Quality, issued a report[1] examining the state of the emergency department discharge process and ways to improve it. AHRQ and Johns Hopkins conducted an extensive literature review and also asked members of ACEP for input. Based on their findings, AHRQ and Johns Hopkins defines a safe emergency department discharge as including the following three main characteristics:

1. It informs and educates patients on their diagnosis, prognosis, treatment plan, and expected course of illness. This includes informing patients of the details of their visit (treatments, tests, procedures).
2. It supports patients in receiving post-ED discharge care. This might include medications, home care of injuries, use of medical devices/equipment, further diagnostic testing, and further health care provider evaluation.
3. It coordinates ED care within the context of the health care system (other health care providers, social services, etc.)

The report goes on to define a discharge failure as well as some social and medical characteristics that could lead to a failure. Social problems that put patients at risk for emergency department discharge failure include lack of insurance or inadequate insurance, homelessness, low income, lack of a primary care provider (PCP), poor comprehension or health literacy, and race/ethnicity.

Finally, the report outlines some potential strategies from the literature that could improve the discharge process, including: discharge instructions/education, telephone follow-up, ED-made appointment, prescription assistance, transportation assistance, care coordination, care bundles, drop-in group appointments, and housing assistance.

With respect to transportation and housing assistance, AHRQ and Johns Hopkins only found a few studies that directly analyzed the impact of these social supports on the emergency department discharge process and follow-up care.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Fiscal Impact

Staff and consultant resources to convey ACEP's position and encourage federal, state, and local lawmakers and regulators.

Prior Council Action

Substitute Resolution 34(07) Patient Support Services Addressing the Gaps adopted. Directed that ACEP supports that hospitals develop resources to improve ED patients' access to outpatient community health and support services.

Prior Board Action

Substitute Resolution 34(07) Patient Support Services Addressing the Gaps adopted.

Background Information Prepared by: Jeffrey Davis
Regulatory Affairs Director

Reviewed by: John McManus, MD, MBA, FACEP, Speaker
Gary Katz, MD, MBA, FACEP, Vice Speaker

[1] The AHRQ and Johns Hopkins Report can be found here:
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/edenvironmentalscan/edenvironmentalscan.pdf

Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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RESOLUTION: 22(18)

SUBMITTED BY: Wisconsin Chapter

SUBJECT: Addressing Mental Health Treatment Barriers Created by the Medicaid IMD Exclusion

PURPOSE: Directs ACEP to: 1) issue a statement to inform members about the Medicaid IMD Exclusion and its impact on ED psychiatric patients; 2) work through legislation or regulation to repeal the Medicaid IMD Exclusion; and 3) support Medicaid waiver demonstration applications that seek to receive federal financial participation for IMD services provided to Medicaid beneficiaries.

FISCAL IMPACT: Unbudgeted staff and consultant time and resources to issue a statement and convey ACEP's position to federal lawmakers and regulators.

WHEREAS, ACEP has dedicated significant resources to decreasing emergency department (ED) boarding for psychiatric patients; and

WHEREAS, ACEP's 2017 revised clinical policy on psychiatric boarding affirms that "the number of mental health-related visits to emergency departments has increased steadily, [while] the number of inpatient psychiatric beds has decreased"; and

WHEREAS, ACEP's 2017 revised clinical policy on psychiatric boarding calls for "new systems and resources…to be made available to better serve mental health patients"; and

WHEREAS, The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in non-inpatient mental health treatment facilities larger than 16 beds; and

WHEREAS, Securing Medicaid funding for non-hospital inpatient psychiatric care facilities would free up hospital inpatient beds for those psychiatric patients who have been detained emergently, are medically complex, or are suffering from severe, acute, mental health crises; and

WHEREAS, Psychiatrists are largely informed about the negative impact that the Medicaid IMD Exclusion has on ED psychiatric boarding, while emergency physicians are generally uninformed about the issue; therefore, be it

RESOLVED, That ACEP issue a statement to inform members about the Medicaid Institutions for Mental Diseases Exclusion and its impact on ED psychiatric patients; and be it further

RESOLVED, That ACEP work through legislation or regulation to repeal the Medicaid Institutions for Mental Diseases Exclusion; and be it further

RESOLVED, That ACEP support Medicaid waiver demonstration applications that seek to receive federal financial participation for Institutions for Mental Diseases services provided to Medicaid beneficiaries.

General References for the Resolution

1. Barlas, Stephen. "Medicaid demonstration aims to reduce psychiatric boarding." *Psychiatric Times* 28.11 (2011): 57-57.
2. Davoli, Joanmarie Illaria. "No room at the inn: how the federal Medicaid program created inequities in psychiatric hospital access for the indigent mentally ill." *Am. JL & Med.* 29 (2003): 159.

3. Geller, Jeffrey L. "Excluding institutions for mental diseases from federal reimbursement for services: strategy or tragedy?" *Psychiatric Services* 51.11 (2000): 1397-1403.
4. Knopf, Alison. "Medicaid projects set to evaluate IMD-exclusion alternatives: although it's an outdated policy, change will be a long time in coming." *Behavioral healthcare* 34.5 (2014): 32-34.
5. Rosenbaum, Sara J., Joel B. Teitelbaum, and D. Richard Mauery. "An analysis of the Medicaid IMD exclusion." (2002).

Background

This resolution directs ACEP to:

- Issue a statement to inform members about the Medicaid IMD Exclusion and its impact on ED psychiatric patients;
- Work through legislation or regulation to repeal the Medicaid IMD Exclusion; and
- Support Medicaid waiver demonstration applications that seek to receive federal financial participation for IMD services provided to Medicaid beneficiaries.

The Medicaid IMD exclusion prohibits the use of federal Medicaid financing for care provided to most patients in non-hospital inpatient mental health treatment facilities larger than 16 beds. The exclusion is one of the very few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21 and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services.

The IMD exclusion is found in Section 1905(a)(B) of the Social Security Act, which prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases" except for "inpatient psychiatric hospital services for individuals under age 21." The law goes on to define "institutions for mental diseases" as any "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." The IMD exclusion was intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services. The IMD exclusion has been part of the Medicaid program since Medicaid's enactment in 1965.

In the State Medicaid Manual, the federal Department of Health and Human Services (HHS) interprets the IMD exclusion to include any institution that, by its *overall character* is a facility established and maintained primarily for the care and treatment of individuals with mental diseases. The guidelines used to evaluate if the overall character of a facility is that of an IMD are based on whether the facility:

- Is licensed or accredited as a psychiatric facility;
- Is under the jurisdiction of the state's mental health authority;
- Specializes in providing psychiatric/psychological care and treatment, which may be ascertained if indicated by a review of patients' records, if an unusually large proportion of the staff has specialized psychiatric/psychological training, or if a facility is established and/or maintained primarily for the care and treatment of individuals with mental diseases; or
- Has more than 50 percent of all its patients admitted based on a current need for institutionalization as a result of mental diseases.

If any of these criteria is met, a thorough IMD assessment will be made. Therefore, a facility is determined to be an IMD based on the character of the institution, including its governance, staffing, and patient population.

Despite the general prohibition in federal law, there are three main ways that states can receive federal Medicaid funds for IMD services for nonelderly adults: Section 1115 demonstration waivers, Medicaid managed care "in lieu of" authority, and disproportionate share hospital (DSH) payments.

More and more states are using Section 1115 waivers to request authority to use federal Medicaid funds for services provided in IMDs – especially as a means to tackle the opioid epidemic and to improve access to substance use disorder (SUD) services. According to the Kaiser Health Foundation, twelve states have approved IMD SUD waivers, and thirteen IMD SUD requests (including 12 new states, and one seeking to expand existing authority) are pending with CMS as of June 2018.[1]

It is important to note that the waivers distinguish between payments for SUD services and mental health services. All 12 states with approved IMD waivers to date have authority to use federal Medicaid funds to pay for IMD SUD services. One state (Vermont) also has waiver authority for IMD mental health services, although those payments must be phased out between 2021 and 2025. Vermont had sought expanded waiver authority for IMD mental health services along with new SUD authority, but CMS approved only the SUD authority in June 2018. Similarly, Illinois requested authority for both IMD mental health and SUD services, but CMS approved Illinois' waiver for SUD services only in May 2018. In both cases, CMS stated that the agency would not allow Medicaid payments for individuals who receive only mental health treatment in IMDs.

Twenty-six states use Medicaid managed care "in lieu of" authority to cover IMD SUD. This authority is included in the federal Medicaid managed care regulation[2], which permit states to use federal Medicaid funds for capitation payments to managed care plans that cover IMD inpatient or crisis residential services for non-elderly adults "in lieu of" other services covered under the state plan. Under this regulation, federal payments for IMD services are limited to 15 days per month. This regulation took effect in July 2016.

With respect to disproportionate share hospital (DSH) payments, federal law allows states to spend some of their DSH funds on IMD services.

Congress has also introduced legislation recently to modify the IMD payment exclusion. In May 2018, the House Energy and Commerce Committee approved a bill for consideration by the full House that would alter the IMD payment exclusion. Specifically, the IMD CARE Act would create a five-year state plan option, from January 2019 through December 2023, to allow states to receive federal Medicaid payments for IMD services only for adults ages 21 to 64 with opioid use disorder. The bill limits IMD payments to any 30 days in a 12-month period. The IMD Care Act was incorporated into H.R. 6, the SUPPORT for Patients and Communities Act, which was passed by the House of Representatives on June 22, 2018.

The Senate Finance Committee held a markup on S. 3120, Helping to End Addiction and Lessen Substance Use Disorders Act on June 12, 2018. Provisions related to Medicaid IMD services in this bill include authorizing payment for other Medicaid services provided to pregnant women receiving SUD treatment in IMDs and codifying the 2016 Medicaid managed care regulation that allows capitation payments to include up to 15 days of IMD services in a month. The Committee discussed an amendment to the bill that would remove the IMD payment exclusion for SUD services for adults ages 21 through 64 for five years, from January 2019 through December 2023, provided that states maintain their current level of spending on inpatient services.

The Congressional bills limit IMD services to specific populations and to specific diagnoses. In other words, they do not fully repeal the Medicaid IMD exclusion. ACEP has long advocated for the full repeal of the IMD exclusion and continues to work with Congress on this priority.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective B – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

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[1] The Kaiser Family Foundation Report available at https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-payment-for-services-in-institutions-for-mental-disease/.
[2] The Medicaid Managed Care Final Rule is available at https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

Fiscal Impact

Unbudgeted staff and consultant time and resources to issue a statement and convey ACEP's position to federal lawmakers and regulators.

Prior Council Action

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted. The resolution directed ACEP to support legislative efforts that grant the emergency physician authority to involuntarily hold and/or transfer psychiatric patients to an appropriate facility when medically indicated.

Prior Board Action

January 2017, approved the "Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department."

Substitute Resolution 49(05) Emergency Psychiatric Transfers adopted.

Background Information Prepared by: 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

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RESOLUTION: 23(18)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: Advocating for CMS Policy Restraint to Avoid Restricting Quality Emergency Care

PURPOSE: Request that any CMS policies effectively restricting the administration of rapid sequence intubation drugs by RNs or EMS providers be revised or revoked as soon as possible and advocate for CMS to not promulgate policies, rules, or regulations that dictate or restrict emergency physicians, nurses, or EMS providers from providing quality emergency care to our patients.

FISCAL IMPACT: Unbudgeted committee and staff resources to develop educational materials to ACEP members and hospitals. Budgeted staff resources to convey ACEP's position to CMS. Costs are dependent on type of educational materials developed.

WHEREAS, ACEP exists to promote quality emergency care by qualified emergency physicians and is in the best position to determine what is appropriate for emergency practice; and

WHEREAS, The Centers for Medicare and Medicaid Services (CMS) recently published A-1001 – Standard: Organization & Staffing, §482.52(a) Standard: Organization and Staffing, establishes a list of professionals who are allowed to "administer anesthesia" that does not include Registered Nurses (RN); and

WHEREAS, The practice of most emergency departments involves the administration of agents considered anesthesia or deep sedation as part of Rapid Sequence Intubation (RSI) by RNs; and

WHEREAS, Some hospitals have dictated that emergency physicians may not use appropriate RSI drugs as a result of the CMS A-1001 standard; and

WHEREAS, These provisions have also been interpreted to include EMS providers and resulted in EMS practice restrictions; and

WHEREAS, This policy impacts negatively on the quality of care provided to our patients; therefore, be it

RESOLVED, That ACEP request that any CMS policies effectively restricting the administration of rapid sequence intubation drugs by RNs or EMS providers be revised or revoked as soon as possible; and be it further

RESOLVED, That ACEP advocate for CMS to not promulgate policies, rules, or regulations that dictate or restrict emergency physicians, nurses, or EMS providers from providing quality emergency care to our patients.

Background

This resolution directs ACEP to urge CMS to revise or rescind any policies or regulations that restrict the administration of rapid sequence intubation drugs by registered nurses (RNs) or Emergency Medical Service (EMS) providers, and that ACEP urge CMS to not promulgate any policies or regulations that "dictate or restrict emergency physicians, nurses, or EMS providers from providing quality emergency care to our patients."

The genesis of this resolution comes from current CMS regulations that pertain to anesthesia or deep sedation policies in hospitals. In May 2010, CMS established interpretive guidelines for "A-1001-- Standard: Organization & Staffing,

§482.52(a) Standard: Organization and Staffing, which include the following list of professionals who can provide Anesthesia:

The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by --

(1) A qualified anesthesiologist;
(2) A doctor of medicine or osteopathy (other than an anesthesiologist);
(3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
(4) A certified registered nurse anesthetist (CRNA), as defined in §410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or
(5) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.

§482.52(c) Standard: State Exemption

(1) A hospital may be exempted from the requirement for MD/DO supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from MD/DO supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current MD/DO supervision requirement, and that the opt-out is consistent with State law.

(2) The request for exemption and recognition of State laws, and the withdrawal of the request may be submitted at any time, and are effective upon submission.

The list above does not include RNs, meaning that RNs cannot perform anesthesia. Another issue raised by the resolution is that hospitals have interpreted these guidelines to mean that RNs cannot administer Rapid Sequence Intubation (RSI) drugs.

The way hospitals have interpreted these CMS guidelines raises a broader issue. In 2011, CMS issued clarifying guidance to State Survey Agency Directors on hospital anesthesia/sedation services.[1] In this guidance, CMS states that one physician must oversee anesthesia/sedation services in the hospital. However, as long as one physician is overseeing the program, the hospital can use multiple policies and guidelines. The 2011 guidelines clearly state that hospitals may follow the guidelines of specialty organizations (specifically citing ACEP's clinical policies) and that emergency physicians are 'uniquely qualified' to administer all levels of sedation 'from moderate to deep to general'. The guidance does not dictate which guidelines hospitals must use. Later in 2011, ACEP distributed a membership communication highlighting this guidance and included the policy statement "Procedural Sedation in the Emergency Department," which states: "The Emergency Nurses Association (ENA) and the American College of Emergency Physicians (ACEP) support the delivery of medications used for procedural sedation and analgesia by credentialed emergency nurses working under the direct supervision of an emergency physician. These agents include but are not limited to etomidate, propofol, ketamine, fentanyl, and midazolam."

Despite this CMS guidance, which states that hospitals can use guidelines for anesthesia and sedation that pertain to the emergency department, hospitals in many cases have chosen to establish policies that are extremely restrictive in terms of who can administer anesthesia and sedation. Since one physician needs to be in charge of anesthesia/sedation services in the hospital, hospitals usually choose an anesthesiologist. The anesthesiologist in charge then establishes the same protocols and requirements for every department in the hospital, including the emergency department. ACEP is currently working on resources for emergency physicians to use to help them educate their hospitals about the CMS

[1] This guidance is available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter11_10.pdf.

guidelines and advocate for policies that allow emergency physicians to deliver anesthesia and sedation. As part of this effort, ACEP is developing comprehensive clinical practice guidelines specific to unscheduled procedural sedation. This consensus guideline is expected to be reviewed by the Board in September 2018.

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

Unbudgeted committee and staff resources to develop educational materials to ACEP members and hospitals. Budgeted staff resources to convey ACEP's position to CMS. Costs are dependent on type of educational materials developed.

Prior Council Action

Amended Resolution 37(15) IV Ketamine for Pain Management in the ED adopted. Directed ACEP to work with ENA, AAENP, SEMPA, and other emergency care providers to develop a joint position statement endorsing the use of sub-dissociative ketamine under the same procedures and policies as other analgesic agents administered by nursing staff in the emergency department setting and that the policy statement be distributed to all state nursing boards.

Amended Resolution 29(06) Procedural Sedation adopted. Directed ACEP to modify the clinical policy "Procedural Sedation and Analgesia in the ED" to state that emergency nurses are trained qualified personnel to administer all agents for procedural sedation under the direct supervision of emergency physicians and that ACEP opposes efforts by other professional organizations or nursing boards to restrict the supervised administration of sedating agents by emergency nurses.

Amended Substitute Resolution 42(04) Procedural Sedation in the ED adopted. The resolution directed ACEP to work with ENA to develop a position statement regarding the administration of agents for procedural sedation/analgesia by emergency nurses to assist state chapters and hospitals in dealing with State Boards of Nursing.

Resolution 21(92) Amended Substitute Resolution adopted. The resolution directed ACEP to develop a policy statement outlining standards for procedural sedation and analgesia to include patient preparation and monitoring, medical personnel to be involved, equipment to be readily available, and discharge criteria.

Prior Board Action

February 2018, reaffirmed the policy statement "Rapid-Sequence Intubation;" reaffirmed April 2012, October 2006, October 2000, originally approved September 1996.

June 2017, approved the revised policy statement "Procedural Sedation in the Emergency Department;" revised and approved January 2011 titled "Sedation in the Emergency Department," replacing two rescinded policy statements "Procedural Sedation in the Emergency Department" (approved in October 2004) and "The Use of Pediatric Sedation and Analgesia" (revised in April 2008, reaffirmed in October 2001, revised January in 1997, and originally approved in March 1992).

October 2017, approved the policy statement "Sub-dissociative Dose Ketamine for Analgesia."

Amended Resolution 37(15) IV Ketamine for Pain Management in the ED adopted.

Amended Substitute Resolution 42(04) Procedural Sedation in the ED adopted.

Background Information Prepared by: 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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 24(18)

SUBMITTED BY: Dan Freess, MD, FACEP
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Michael McCrea, MD, FACEP
James Mitchiner, MD, FACEP
John Moorhead, MD, FACEP
Jay Mullen, MD, FACEP
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California Chapter
Louisiana Chapter
Missouri College of Emergency Physicians
Rhode Island Chapter
Washington Chapter
Wisconsin Chapter

SUBJECT: ED Copayments for Medicaid Beneficiaries

PURPOSE: Oppose copays for Medicaid beneficiaries seeking ED care and submit a resolution to the AMA House of Delegates opposing copays for Medicaid beneficiaries seeking care in the ED.

FISCAL IMPACT: Budgeted resources for the Section Council on Emergency Medicine and staff resources for advocacy initiatives.

WHEREAS, Copayments (copays) for Emergency Department (ED) services have been shown to create a significant barrier to necessary emergency care for Medicaid enrollees[1;] and

WHEREAS, Many Medicaid programs utilize the current federally-allowed copay up to $8 for ED services determined to be non-emergent[2;] and

WHEREAS, For the purposes of determining non-emergency, and therefore imposition of copay for Medicaid enrollees, many states use Emergency Severity Index (ESI) triage levels or final diagnoses rather than the Prudent Layperson Standard[3] as directed in the CMS guidance for implementation of such copays[4]; and

WHEREAS, States are using Section 1115 Medicaid waiver demonstrations to implement ED copays of increasing amounts and to apply such ED copays even for emergent services; and

WHEREAS, Medicaid programs that have copays for non-emergent use of the ED do not decrease such non-emergent use[5] and do not decrease overall Medicaid costs[6]; and

WHEREAS, The calculated effect of Indiana's increased Medicaid ED copay ($25), allowed by a 2015 CMS Medicaid waiver demonstration, used a retrospective definition of "emergency," disregarding the federal Prudent Layperson Standard; and

WHEREAS, Copays requested at the time of registration in the ED could intimidate patients from receiving a mandated medical screening exam, thus placing the hospital at risk for an EMTALA violation[7]; therefore, be it

RESOLVED, That ACEP opposes imposition of copays for Medicaid beneficiaries seeking care in the ED; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association House of Delegates to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED.

References

1. Artiga S, Ubri P, Zur J. The effects of premiums and cost sharing on low-income populations: updated review of research findings. Kaiser Family Foundation. June 1, 2017. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/
2. Medicaid: Cost Sharing Out of Pocket Costs. https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html
3. Prudent Layperson Standard - 42 U.S.C.1395w-22(d)(3)(B) & 1396u-2(b)(2)(C)
4. Medicaid Cost-sharing. https://www.medicaid.gov/medicaid/cost-sharing/index.html based on 42 CFR 447.5
5. Mortensen, K. Copayments did not reduce Medicaid enrollees' nonemergency use of emergency departments. *Health Affairs*. 2010: 29(9), abstract http://content.healthaffairs.org/content/29/9/1643.abstract
6. MACPAC. July 2014. Revisiting Emergency Department Use in Medicaid. https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts- EDuse_2014-07.pdf
7. Emergency Medical Treatment and Labor Act - 42 United States Code (U.S.C.) 1395dd

Background

The resolution calls for ACEP to oppose the imposition of copays for Medicaid beneficiaries seeking ED care and submit a resolution to the AMA House of Delegates opposing copays for Medicaid beneficiaries seeking care in the ED.

The first Prudent Layperson (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, 2017, 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.

Numerous states make use of copays at the $8 limit imposed by CMS for non-emergent visits to the ED by Medicaid patients. As described below, many states have requested to be allowed to impose copays in excess of that amount. Indiana was the first state to seek approval of its Medicaid waiver application, which allows for a $25 copay if a claimant makes a second or subsequent non-emergent visit to the emergency department within one year. An $8 copay is applied to an initial non-emergent visit.

Kentucky is in the process of seeking to implement a waiver demonstration project that reduces funds available in a "My Rewards Account" if an emergency department visit is deemed nonemergent. These accounts are used by Medicaid expansion claimants to access benefits for services such as dental or vision.

A request by Arizona to be allowed to apply a $200 emergency department co-pay was not approved by CMS. Maine and Wisconsin waiver applications currently remain pending. Maine would require a $10 copay for nonemergent visits. Wisconsin would apply an $8 copay on all visits, including those deemed emergent.

In 2018, members of the State Legislative/Regulatory Committee and the ACEP/EDPMA Joint Task Force prepared a paper articulating that such policies are ineffective at driving appropriate patient use of the emergency department. A synopsis of the paper was distributed to ACEP chapters for use in advocating in opposition to emergency department co-pays.

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 resources for the AMA Section Council on Emergency and staff resources for advocacy initiatives.

Prior Council Action

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to work with third party payers to ensure access to and subsequent reimbursement for emergency medical care as defined by the prudent layperson definition of an emergency regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care.

Referred Amended Resolution 17(16) Insurance Collection of Beneficiary Deductibles to the Board of Directors. The resolution requested that ACEP add to its legislative agenda as a priority to advocate for health care insurance companies to be required to collect patients' deductibles for EMTALA-related care after the insurance company pays the physician; and that ACEP submit a resolution to the American Medical Association House of Delegates that advocates for a national law requiring health care insurance companies to collect patient's deductibles after the insurance company pays the physician for EMTALA related 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 Physician Services adopted. Directed ACEP to collaborate with other organizations to to lobby the federal government to fund EMTALA-mandated services not covered by current funding mechanisms

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted. Directed that ACEP solicit member input to formulate and submit recommendations to CMS EMTALA advisory process and other appropriate bodies, including recommendations for clarifying medical staff on call responsibilities, obtaining greater consistency of EMTALA enforcement among CMS regional offices, protection of peer review confidentiality, and utilizing consultative peer review for issues involving medical decision making.

Amended Substitute Resolution 15(00) EMTALA adopted. This resolution called for the College to work with appropriate organizations and agencies to improve EMTALA for emergency departments; and that the Board of Directors report back to the membership regarding progress on these endeavors at the 2001 Leadership/Legislative Issues Conference.

Amended Substitute Resolution 24(98) HMO Practices referred to the Board. The resolution 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. The resolution called for the College 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. This resolution called on the College to continue its 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.

Prior Board Action

July 2018, reviewed the information paper "Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine," developed by the State Legislative/Regulatory Committee.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to: 1) continue to uphold federal prudent layperson laws; 2) advocate for patients to prevent negative clinical or financial impact caused by lack of reimbursement; 3) partner with affected states and the AMA; and 4) work with Anthem and other third party payers to ensure access to and subsequent reimbursement for emergency medical care as defined by the prudent layperson definition of an emergency regardless of the initial presenting complaint, final diagnosis, or access to lower levels of care.

October 2017, approved the Federal Government Affairs Committee recommendation to not add insurance collection of beneficiary deductibles to the legislative and regulatory priorities given the scope of work on initiatives related to the repeal and/or replacement of the Affordable Care Act.

January 2017, revised and approved the "Code of Ethics for Emergency Physicians," which has been periodically reviewed and approved since 1991. "Insurers, including managed care organizations, must support insured patients' access to emergency medical care for what a prudent layperson would reasonably perceive as an emergency medical condition. Society, through its political process, must adequately fund emergency care for all who need it."

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.

Assigned Referred Amended Resolution 17(16) Insurance Collection of Beneficiary Deductibles to the Federal Government Affairs Committee to review and provide a recommendation to the Board regarding further action on the resolution.

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.

April 2015, revised and approved The Patient-Centered Medical Home Model, originally approved August 2008. "Of utmost importance is that all patients have access to emergency medical care according to the "prudent layperson" standard when they believe they have an emergency and they should not be penalized if subsequent evaluation determines there was no serious medical diagnosis."

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.

Resolution 31(01) Possible Violation of the Constitutional Rights of Emergency Physicians not adopted. Called for ACEP to obtain a legal opinion on whether EMTALA violates the constitutional rights of emergency physicians.
Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Amended Substitute Resolution 15(00) EMTALA adopted.

Substitute Resolution 21(98) EMTALA: Mandatory Reporting of Suspected Violations adopted.

Resolution 43(97) Prudent Layperson Legislation adopted.

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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 25(18)

SUBMITTED BY: Yemi Adebayo, MD,
Arjun Chanmugam, MD, FACEP
Kyle Fischer, MD, FACEP
Maryland Chapter

SUBJECT: Funding for Buprenorphine-Naloxone Treatment Programs

PURPOSE: Seek federal and state appropriation funding and/or grants for purposes of initiating buprenorphine-naloxone treatment programs in EDs with provided funding for start-up, training, and appropriate patient follow up

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Opioid addiction has been declared a national emergency; and

WHEREAS, Emergency departments have been called on to intervene by way of identifying patients with opioid associated substance use disorder, assessing them for willingness to treat their addiction, and transitioning them to care; and

WHEREAS, Buprenorphine-naloxone medication programs offer a safe and effective method of treating opioid addiction; therefore, be it

RESOLVED, That ACEP seek federal and state appropriation funding and/or grants for purposes of initiating buprenorphine-naloxone treatment programs in emergency departments with provided funding for start-up, training, and appropriate patient follow up.

Background

This resolution calls for ACEP to seek federal and state appropriation funding and/or grants for purposes of initiating buprenorphine-naloxone treatment programs in emergency departments with provided funding for start-up, training, and appropriate patient follow up.

The scope of this resolution is similar to Resolution 26(18) and Resolution 47(18); therefore, the content of the background information is similar for all three 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. 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, emergency 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. The opioid crisis is the worst addiction epidemic in American history. Drug overdoses kill more than 64,000 people per year, and the nation's life expectancy has fallen for two years in a row. According to a recent CDC Vital Signs analysis of near real-time data, emergency department (ED) visits due to suspected opioid overdoses increased nearly 30% from the third quarter of 2016 to the third quarter of 2017. In the battle against this debilitating epidemic, EDs are a critical entry point to addiction treatment and for the prevention of overdose. Across the country, emergency departments are taking additional steps to address the crisis, including overdose prevention education, naloxone distribution, engaging in motivational interventions with patients, initiating treatment for opioid use disorder, and improving surveillance efforts in collaboration with health departments.

An article was published on the results of a four-year Yale study of ED patients presenting with opioid addiction. A group of these patients was provided a screening and brief intervention for their addiction, then treatment was initiated with buprenorphine in the ED, and the patients were referred for follow-up care with a primary care physician. Of the 346 patients eligible for the study, 114 patients were assigned to the group that received buprenorphine in the ED. Seventy-eight percent of these patients were receiving treatment at 30 days.

Numerous ACEP chapters have worked to address the opioid prescribing issue in their states. For example, the Washington and Oregon chapters, working with other organizations within their states, have developed statewide ED opioid prescribing guidelines. The Florida College of Emergency Physicians has developed guidelines about chronic non-malignant pain management in the ED that have been adopted at numerous hospitals in Florida. The Ohio Chapter provided input into the Opioids and Other Controlled Substances Prescribing Guidelines for Ohio and endorsed the guidelines. The Kentucky Chapter developed an informational guidance document on narcotics and sedatives usage in the ED for use in Kentucky.

ACEP has been awarded two federal grants to help support the efforts in response to the opioid crisis. These are the Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response (STR) Technical Assistance (TA) Grant and the Providers Clinical Support System (PCSS) grant. Through the SAMSHA-STR grant ACEP has conducted an Emergency Medicine Practice Research Network survey on Buprenorphine practice, awareness around the 3-day rule and MAT Waiver training and will be providing educational training sessions at various ACEP Chapter meetings around the waiver training and 3-day rule. Also, through this grant and the STR-TA Consortium, ACEP is identifying local resources and members to serve as subject matter experts and provide education on various opioid related topics, including podcasts and webinars. As part of the PCSS grant, ACEP is working to identify local resources for education and awareness and moving forward ACEP will be hosting MAT Waiver training sessions. The first session will occur Sunday, September 20, 2018, in San Diego, CA.

ACEP also recently launched the ACEP E-QUAL Network Opioid Initiative, The Opioid Management Learning Collaborative, with the aim to collaborate on opioid-focused interventions, develop a best-practice toolkit, collect data on quality, assess the state of ED and hospital care, study the effectiveness of engaging EDs in quality improvement and help EDs implement alternatives to opioids (ALTO), improve opioid prescribing, and adopt harm reduction strategies such as naloxone prescribing and medication assisted therapies. Also, in June 2018, ACEP issued a press release: Emergency Departments Help Close Gaps in Opioid Abuse and Addiction Treatment.

Under the Drug Addiction Treatment Act of 2000 (DATA 2000), physicians are required to complete eight hours of training to qualify for a waiver to prescribe and dispense the medication. DATA 2000 allows qualified physicians to obtain a waiver to treat opioid dependency with Schedule III, IV and V medications or combinations of medications.

In 2015-16, the Clinical Policies Committee prepared an abstract for the WHO Guidelines for community management of opioid overdose for *ACEP Now* and made it available on the ACEP Website. They also identified the opioid policy for review/update, including addition of opioid and benzodiazepine withdrawal and of the need to develop a practice resource. In the same year, the Emergency Medicine Practice Committee and the Quality & Patient Safety Committees prepared comments to the CMS draft measure specifications for the Safe Use of Opioids-Concurrent Prescribing Measure. The Federal Government Affairs Committee completed 106 meetings with Members of Congress, attended 96 fundraisers and provided comments and recommendation to every member of Congress regarding opioid/pain management policies. The State Legislative/Regulatory Committee prepared a summary

document addressing Prescription Drug Monitoring Program mandates, limits on opioid prescription and access to Naloxone.

Amended Resolution 39(14) Naloxone Prescriptions by Emergency Physicians was adopted by the Council and the Board of Directors. It directed the College to develop a clinical policy on the clinical conditions for which it is appropriate for emergency physicians to prescribe naloxone. The Clinical Policies Committee was assigned to address the resolution. After review of the literature, the committee determined that there was not quality evidence for a clinical policy on this topic and that, at most, the review would result in a consensus recommendation. The committee developed the policy statement, "Naloxone Prescriptions by Emergency Physicians."

In 2013, two Council resolutions were considered regarding Naloxone. There was testimony in the Reference Committee that portions of Resolution 39(13) Naloxone Prescriptions in the ED were too prescriptive and could result in potential medical-legal consequences. As a result, Resolution 39(13) was not adopted. Resolution 38(13) Naloxone as an Over the Counter (OTC) Drug was also not adopted. Those speaking in opposition to Resolution 38(13) expressed concern about side effects from the drug, and that it could result in patients having a false sense of security and therefore not come to the ED. The Reference Committee opined that Naloxone should be incorporated into the larger discussion of drug dependence and overdose. Amended Resolution 44(13) Prescription Drug Overdose Deaths was adopted, which directed the College to review solutions to decrease the death rate from prescription drug overdoses and create a document offering best practice solutions.

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.
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 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 39(14) Naloxone Prescriptions by Emergency Physicians adopted. Directed ACEP to develop a clinical policy on the clinical conditions for which it is appropriate for emergency physicians to prescribe Naloxone.

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.

Resolution 39(13) Naloxone Prescriptions in the ED not adopted. The resolution called for supporting and advising emergency physicians to dispense and/or prescribe Naloxone for victims of opioid overdose treated in the ED and

promote the ability of emergency physicians to prescribe Naloxone lawfully and explicitly for potential future opiate overdose through legislative or regulatory advocacy.

Resolution 38(13) Naloxone as an Over the Counter Drug not adopted. The resolution called for adoption of a policy in support of Naloxone becoming available as an OTC drug and promote education and safeguards for its use.

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

February 2018, revised and approved the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012.

April 2017, revised and approved the 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."

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, revised and approved the 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 39(14) Naloxone Prescriptions by Emergency Physicians 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 *Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department*.

Background Information Prepared by: 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: 26(18)

SUBMITTED BY: Yemi Adebayo, MD
Arjun Chanmugam, MD, FACEP
Kyle Fischer, MD, FACEP
Maryland Chapter

SUBJECT: Funding of Substance Use Intervention and Treatment Programs

PURPOSE: Advocate for federal and state funding for substance abuse intervention programs that will be fully accessible and utilizable to their fully potential by all patients regardless of insurance status or ability to self-pay and that a pre-determined share of cost be covered by insurers to offset the cost to the government.

FISCAL IMPACT: Budgeted staff resources

WHEREAS, Opioid addiction has been declared a national emergency; and

WHEREAS, Emergency departments have been called on to intervene by way of identifying patients with opioid associated substance use disorder, assessing them for willingness to treat their addiction, and transitioning them to care; and

WHEREAS, Much of this work is either unreimbursed or grant supported; therefore, be it

RESOLVED, ACEP advocate for federal and state appropriations and/or federal and state grants for use in fully funding substance abuse intervention programs that are accessible seven days a week and 24 hours each day and will be initiated in emergency departments; and be it further

RESOLVED, That ACEP advocate for federal and state funding for substance abuse intervention programs that will be fully accessible and utilizable to their fully potential by all patients regardless of insurance status or ability to self-pay and that a pre-determined share of cost be covered by insurers to offset the cost to the government.

Background

This resolution calls for ACEP to dvocate for federal and state funding for substance abuse intervention programs that will be fully accessible and utilizable to their fully potential by all patients regardless of insurance status or ability to self-pay and that a pre-determined share of cost be covered by insurers to offset the cost to the government

The scope of this resolution is similar to Resolution 25(18) and Resolution 47(18); therefore, the content of the background information is similar for all three 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. 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 actively been 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. The opioid crisis is the worst addiction epidemic in American history. Drug overdoses kill more than 64,000 people per year, and the nation's life expectancy has fallen for two years in a row. According to a recent CDC Vital Signs analysis of near real-time data, emergency department (ED) visits due to suspected opioid overdoses increased nearly 30% from the third quarter of 2016 to the third quarter of 2017. In the battle against this debilitating epidemic, EDs are a critical entry point to addiction treatment and for the prevention of overdose. Emergency physicians are improving their own opioid prescribing habits and treating acute opioid overdose, but they can take a further step - treatment. They can save lives through overdose prevention education and naloxone distribution, engaging in motivational interventions with patients, initiating treatment for opioid use disorder, and improving surveillance efforts in collaboration with health departments.

An article was published on the results of a four-year Yale study of ED patients presenting with opioid addiction. A group of these patients was provided a screening and brief intervention for their addiction, then treatment was initiated with buprenorphine in the ED, and the patients were referred for follow-up care with a primary care physician. Of the 346 patients eligible for the study, 114 patients were assigned to the group that received buprenorphine in the ED. Seventy-eight percent of these patients were receiving treatment at 30 days.

Numerous ACEP chapters have worked to address the opioid prescribing issue in their states. For example, the Washington and Oregon chapters, working with other organizations within their states, have developed statewide ED opioid prescribing guidelines. The Florida College of Emergency Physicians has developed guidelines about chronic non-malignant pain management in the ED that have been adopted at numerous hospitals in Florida. The Ohio Chapter provided input into the Opioids and Other Controlled Substances Prescribing Guidelines for Ohio and endorsed the guidelines. The Kentucky Chapter developed an informational guidance document on narcotics and sedatives usage in the ED for use in Kentucky.

ACEP has been awarded two federal grants to help support the efforts in response to the opioid crisis. These are the Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response (STR) Technical Assistance (TA) Grant and the Providers Clinical Support System (PCSS) grant. Through the SAMSHA-STR grant ACEP has conducted an Emergency Medicine Practice Research Network survey on Buprenorphine practice, awareness around the 3-day rule and MAT Waiver training and will be providing educational training sessions at various ACEP Chapter meetings around the waiver training and 3-day rule. Also, through this grant and the STR-TA Consortium, ACEP is identifying local resources and members to serve as subject matter experts and provide education on various opioid related topics, including podcasts and webinars. As part of the PCSS grant, ACEP is working to identify local resources for education and awareness and moving forward ACEP will be hosting MAT Waiver training sessions. The first session will occur Sunday, September 20, 2018, in San Diego, CA.

ACEP also recently launched the ACEP E-QUAL Network Opioid Initiative, The Opioid Management Learning Collaborative, with the aim to collaborate on opioid-focused interventions, develop a best-practice toolkit, collect data on quality, assess the state of ED and hospital care, study the effectiveness of engaging EDs in quality improvement and help EDs implement alternatives to opioids (ALTO), improve opioid prescribing, and adopt harm reduction strategies such as naloxone prescribing and medication assisted therapies. Also, in June 2018, ACEP issued a press release: Emergency Departments Help Close Gaps in Opioid Abuse and Addiction Treatment.

Under the Drug Addiction Treatment Act of 2000 (DATA 2000), physicians are required to complete eight hours of training to qualify for a waiver to prescribe and dispense the medication. DATA 2000 allows qualified physicians to obtain a waiver to treat opioid dependency with Schedule III, IV and V medications or combinations of medications.

In 2015-16, the Clinical Policies Committee prepared an abstract for the WHO Guidelines for community management of opioid overdose for *ACEP Now* and made it available on the ACEP Website. They also identified the

opioid policy for review/update, including addition of opioid and benzodiazepine withdrawal and of the need to develop a practice resource. In the same year, the Emergency Medicine Practice Committee and the Quality & Patient Safety Committees prepared comments to the CMS draft measure specifications for the Safe Use of Opioids-Concurrent Prescribing Measure. The Federal Government Affairs Committee completed 106 meetings with Members of Congress, attended 96 fundraisers and provided comments and recommendation to every member of Congress regarding opioid/pain management policies. The State Legislative/Regulatory Committee prepared a summary document addressing Prescription Drug Monitoring Program mandates, limits on opioid prescription and access to Naloxone.

Amended Resolution 39(14) Naloxone Prescriptions by Emergency Physicians was adopted by the Council and the Board of Directors. It directed the College to develop a clinical policy on the clinical conditions for which it is appropriate for emergency physicians to prescribe naloxone. The Clinical Policies Committee was assigned to address the resolution. After review of the literature, the committee determined that there was not quality evidence for a clinical policy on this topic and that, at most, the review would result in a consensus recommendation. The committee developed the policy statement, "Naloxone Prescriptions by Emergency Physicians."

In 2013, two Council resolutions were considered regarding Naloxone. There was testimony in the Reference Committee that portions of Resolution 39(13) Naloxone Prescriptions in the ED were too prescriptive and could result in potential medical-legal consequences. As a result, Resolution 39(13) was not adopted. Resolution 38(13) Naloxone as an Over the Counter (OTC) Drug was also not adopted. Those speaking in opposition to Resolution 38(13) expressed concern about side effects from the drug, and that it could result in patients having a false sense of security and therefore not come to the ED. The Reference Committee opined that Naloxone should be incorporated into the larger discussion of drug dependence and overdose. Amended Resolution 44(13) Prescription Drug Overdose Deaths was adopted, which directed the College to review solutions to decrease the death rate from prescription drug overdoses and create a document offering best practice solutions.

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.
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 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 39(14) Naloxone Prescriptions by Emergency Physicians adopted. Directed ACEP to develop a clinical policy on the clinical conditions for which it is appropriate for emergency physicians to prescribe Naloxone.

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.

Resolution 39(13) Naloxone Prescriptions in the ED not adopted. The resolution called for supporting and advising emergency physicians to dispense and/or prescribe Naloxone for victims of opioid overdose treated in the ED and promote the ability of emergency physicians to prescribe Naloxone lawfully and explicitly for potential future opiate overdose through legislative or regulatory advocacy.

Resolution 38(13) Naloxone as an Over the Counter Drug not adopted. The resolution called for adoption of a policy in support of Naloxone becoming available as an OTC drug and promote education and safeguards for its use.

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

February 2018, revised and approved the policy statement"Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012.

April 2017, revised and approved the 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."

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, revised and approved the 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 39(14) Naloxone Prescriptions by Emergency Physicians 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 *Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.*

Background Information Prepared by: 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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American College of Emergency Physicians
ADVANCING EMERGENCY CARE

RESOLUTION: 27(18)

SUBMITTED BY: Rick Blum, MD, FACEP
Mark DeBard, MD, FACEP
Nicholas Jouriles, MD, FACEP
West Virginia Chapter

SUBJECT: Generic Injectable Drug Shortages

PURPOSE: Issue a press release calling for the repeal of the group purchasing organization (GPO) safe harbor.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The U.S. healthcare system in general and emergency medicine/EMS systems in particular, as well as the millions of patients we serve, continue to suffer from a severe, ongoing shortage of numerous vital generic injectable drugs; and

WHEREAS, The American Society of Healthcare Pharmacists (ASHP) currently lists more than 130 drugs in active shortage, including such critical drugs as normal saline, epinephrine, sodium bicarbonate, nitroglycerin, succinylcholine, vancomycin, and many more; and

WHEREAS, The drug supply chain, and the group purchasing organizations (GPOs) that dominate that chain, have been unwilling, unmotivated, or unable to solve this long-running, pernicious, and deadly issue; and

WHEREAS, The very existence of these persistent shortages violates the most basic free-market law of supply-and-demand and indicates that something significant has perverted the free-market system that would otherwise serve to correct such shortages; and

WHEREAS, Hospital GPOs were originally created in 1910 as cooperatives to reduce the cost of hospital goods, including drugs, medical devices, supplies, capital equipment and other items, by obtaining volume discounts, a model that worked well for more than 80 years; and

WHEREAS, In 1987, at the behest of GPO and hospital lobbyists, Congress enacted the Medicare Anti-Kickback Safe Harbor provision as an amendment to the Social Security Act, which exempted GPOs from criminal penalties for taking kickbacks from suppliers, and in 1991 the Office of the Inspector General of the Department of Health and Human Services issued the safe harbor rules; and

WHEREAS, GPOs constitute a virtual buyer's monopoly for the vast majority of all supplies purchased by the nation's 5,000 acute care hospitals and these same 5,000 hospitals (along with EMS and Oncology centers) constitute nearly the entire market for generic injectable drugs; and

WHEREAS, Only four of these giant GPOs account for over 90% of the total annual GPO contract volume of $300 billion dollars per year; and

WHEREAS, Since receiving that safe harbor protection, the GPO industry has developed a complex and opaque scheme of literally selling market share in exclusionary, sole-source, long-term contracts to the highest bidder and being paid for that by having a significant portion of the artificially inflated price of such drugs kicked back to them in the form of GPO fees, thereby subverting normal free market economic forces; and

WHEREAS, These GPO fees (aka "legalized" kickbacks), under the safe harbor model, are based on a percentage of sales revenue; GPOs have little or no incentive to negotiate better prices for hospitals, or choose lower priced generic drugs over higher priced non-generic alternatives, since lower prices actually result in lower revenues for GPOs; and the result is that GPOs actually inflate the cost of health supplies by as much as 39%, according to government studies and independent research; and

WHEREAS, The only way for generic injectable drug producers to find relief from these low margin, long-term contracts, is to quit making the drug altogether; and

WHEREAS, The GPO industry has concealed this root cause of the shortages in a well-financed public relations and lobbying campaign that promulgates the fiction that these shortages are "complex and multifactorial;" all of the multiple causative factors offered by the GPOs have been easily debunked; and in February 2014, a Government Accountability Office (GAO) study on this issue concluded that the anti-kickback safe harbor for GPOs was likely the key underlying factor in these drug shortages; and

WHEREAS, The Council adopted Amended Resolution 34(17) Generic Injectable Drug Shortages, which in the second resolved called for ACEP to work with other medical specialties and patient advocacy groups to seek Congressional repeal of the GPO safe harbor protection, and ACEP has not yet taken any action on that resolved; and

WHEREAS, The current administration, through the Secretary of HHS and FDA Commissioner, has announced a willingness to re-examine the role of the PBM/GPO safe-harbor protections in drug pricing/drug shortages respectively; therefore, be it

RESOLVED, That ACEP prepare a press release calling for repeal of the group purchasing organization (GPO) safe harbor.

Background

This resolution calls for ACEP to prepare a press release calling for a repeal of the federal group purchasing organization (GPO) safe harbor.

Shortages of commonly-used but essential medications remain an acute problem throughout the health care system, but these shortages tend to disproportionately affect emergency medicine (both hospital and pre-hospital) due to its reliance upon generic medications for rapid sequence intubation, seizures, antidotes, resuscitation, as well as analgesics, antiemetics, and anticoagulants. Examples of such drugs currently listed in shortage (as of September 2018) by the FDA include sterile injectables such as saline, epinephrine, and dextrose-filled syringes.

Reasons for drug shortages cited by those such as the non-partisan federal Government Accountability Office (GAO), the Food and Drug Administration (FDA), and the Pew Agency for Charitable Trusts, among others, include greater scrutiny and regulatory oversight on the manufacturing process and quality controls, as well as additional factors such as consolidation of manufacturers (especially for generic injectables), low profit margins, shortages of raw materials, absences of redundancy in the supply chain, increased demand, and discontinuations. A 2017 Pew Report on drug shortages for example found that while quality factors are one of the most significant driving factors, it is not the only issue leading to shortages, and that other key factors are market withdrawals, supply chain design, purchaser-manufacturer incentives, limited market insights into future demands, and managing regulatory expectations.

The resolution asserts that the primary root cause of generic injectable drug shortages is due to GPOs and the safe harbor provision provided to them under the federal Anti-Kickback Statute (AKS), and further, that claims that drug shortages are "complex and multifactorial" are "fiction." The resolution adds that, "all of the multiple causative factors offered by the GPOs have been easily debunked," though the resolution does not provide any information on which factors are being referred to nor how and by whom they have been correspondingly debunked. Reviews of available literature, including the 2017 Pew Report cited earlier, as well as several independent analyses conducted by

the non-partisan federal Government Accountability Office (GAO), indicate that the root causes of drug shortages are, in fact, multifactorial in nature. This perspective is echoed more recently by current FDA Commissioner Scott Gottlieb, who stated in May 2018 that:

> "While the causes of drug shortages vary, most shortages are due to disruptions in supply chain availability of actively marketed products. Among these interruptions, manufacturing and quality issues are the leading causes of drug shortages. This includes outdated equipment in need of repair or replacement, unexpected issues with a product's composition, and a manufacturer's inability to maintain facility and product quality. The availability of raw materials can affect production for many drug makers who all depend on that one source of raw material. Companies that supply raw materials can also be subject to quality problems, leading to shortages.[1]"

In the same statement, Gottlieb also notes that "only 2 percent of shortages are a result of product discontinuation."

The resolution also asserts that a February 2014 GAO report "concluded that the anti-kickback safe harbor for GPOs was likely the key underlying factor in these drug shortages." That is not accurate. The report, "Drug Shortages: Public Health Threat Continues, Despite Efforts to Help Ensure Product Availability," identified, based on an extensive literature review, twelve key immediate causes of drug shortages, including quality problems, permanent product discontinuations, "just-in-time" inventory practices, and others. GPOs were not among these twelve key immediate causes identified in the report; instead, the role of GPOs is cited as one of three additional *potential* underlying causes, along with competition focused primarily on price, and a change in Medicare Part B reimbursement policy. This is further underscored by a flowchart in the report (Figure 7; p. 39).

In examining the three additional potential underlying causes of drug shortages, the GAO reviewed twenty studies, half of which suggested that the immediate causes of drug shortages are driven by additional underlying factors stemming from the economics of the generic sterile injectable market. Of these, four studies suggested that the role of GPOs results in "fewer manufacturers producing generic drugs…" However, the five drug manufacturers contacted by the GAO were not all in agreement on this point – three commented that "GPOs may contribute to shortages by exerting downward price pressure," while another disagreed that GPOs were a cause, and another stating that GPOs had no greater a role than any other member of the supply chain. Yet another noted that "failing to obtain a GPO contract does not cause them to exit the market for a given drug." The report ultimately makes no conclusions about the overall magnitude about any of the potential underlying causes, including the role of GPOs. The GAO reiterated this point in testimony before a House Committee on Energy and Commerce hearing, "Examining Drug Shortages and Recent Efforts to Address Them," in February 2014.

Another GAO report published in 2016 titled "Drug Shortages: Certain Factors Are Strongly Associated with This Persistent Public Health Challenge," also found that two factors were strongly associated with shortages of sterile injectable anti-infective and cardiovascular drugs – a decline in the number of suppliers, and failure of at least one establishment making a drug to comply with manufacturing standards resulting in an FDA warning letter. According to the GAO, this suggests that "…shortages may be triggered by supply disruptions." The GAO report also indicates that a third factor (drugs with sales of a generic version) is associated with shortages, in that low profit margins for generic drugs mean that "…manufacturers are less likely to increase production, making the market vulnerable to shortages."

The last whereas statement reads: "WHEREAS, The current administration, through the Secretary of HHS and FDA Commissioner, has announced a willingness to re-examine the role of the PBM/GPO safe-harbor protections in drug pricing/drug shortages respectively…" The Administration has only indicated through the President's Drug Pricing Blueprint, "American Patients First," that they intend to examine the safe harbor protections for *pharmacy benefit managers (PBMs)*.The Blueprint specifically states that this reexamination is for the purposes of mitigating high prescription drug pricing – *not* also drug shortages, as the resolution states. Beyond that Blueprint, discussions around addressing safe harbor provisions shared by the Administration to date have specifically referenced PBMs without referencing GPOs. It should, however, be noted that since safe harbor protections were extended to PBMs in 1993 by

[1] https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm609453.htm

HHS via the already existing GPO safe harbor statute, it is theoretically possible that changes made by the Administration could in the end affect both GPOs *and* PBMs alike; but because the PBM exclusion was added later, the Administration could also opt to address only that PBM exclusion.

Without further details from the Administration it is not yet possible to determine what path they intend to take, but the title of a draft proposed rule that was submitted to the Office of Management and Budget for its review on July 18 may provide new clues. The rule is titled "Removal of Safe Harbor Protection for Rebates to Plans or PBMs Involving Prescription Pharmaceuticals and Creation of a New Safe Harbor Protection (Proposed Rule)." While the text of the proposed rule has not yet been publicly released for public notice and comment, it would appear from the title that the focus remains on the PBM market as opposed to GPOs.

This resolution also suggests that "ACEP has not yet taken any action on that resolved" regarding last year's Resolution 34(17) Generic Injectable Drug Shortages. Resolution 34(17) contains two resolved clauses, the first of which states:

> RESOLVED, That ACEP work with other medical specialties and patient advocacy groups to achieve consensus on the root cause of the shortage of generic injectable drugs and educate our members, the general medical community, and the public on this critical issue and how to solve it; and be it further

To this end, ACEP staff developed and led a successful effort to urge the FDA to convene a Drug Shortages Task Force to identify the root causes of drug shortages. ACEP drafted a bipartisan congressional sign-on letter, and secured lead Congressional sponsors for it of Reps. Brett Guthrie (R-KY) and Mike Doyle (D-PA) in the House, and Sens. Bill Cassidy (R-LA) and Chris Murphy (D-CT), that garnered 107 and 31 signatories, respectively. ACEP then arranged to have members advocate for the letter as part of the 2018 Legislative & Advocacy Conference and through the 911 Network; these efforts were supplemented both by ACEP staff as well as several other physician specialties affected by drug shortages that ACEP contacted to strengthen its efforts. The letter was successful in that just several weeks later, FDA Commissioner Gottlieb announced the creation of a new Drug Shortages Task Force to identify and address the root causes of drug shortages. His statement used verbatim language from the ACEP-led Congressional letter in describing the task force and its charge. ACEP staff have also been in direct contact with the FDA's lead staff of this task force to ensure that ACEP will have representation in this effort.

The second resolved of Resolution 34(17) reads:

> RESOLVED, That ACEP work with other medical specialties and patient advocacy groups to seek Congressional legislative repeal of the Group Purchasing Organizations' safe-harbor protection.

ACEP has met and consulted with other medical specialties on this specific topic and discussed potential strategy. Additionally, ACEP has broached the topic of the potential role of GPOs with some congressional staff, though congressional staff and members of Congress are reticent to make any specific assertions or take action without clear, compelling, and evidence-based research to support any legislative efforts. Early in 2018, ACEP also became aware of the fact that a member of Congress was looking into possible legislation to repeal the safe harbor repeal but ultimately declined to do so. ACEP also worked with congressional appropriators in an attempt to secure language in H.R. 6470, the FY2019 Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, to insert the following language into the committee's report:

> "Shortages of critical drugs continue to impact the delivery of health care in the U.S. The committee requests that GAO build upon its existing examinations of the causes of drug shortages and specifically examine the role of group purchasing organizations (GPO) and their related safe harbor in shortages."

This language was shared with House Appropriations Committee Chairman Tom Cole (R-OK). Unfortunately, this language was not included in the committee report accompanying the legislative text.

The role of Group Purchasing Organizations (GPOs) in the drug pricing and shortage debate has received scrutiny over the past several years. In 2014, the Government Accountability Office (GAO) issued a report, "Group Purchasing Organizations: Funding Structure Has Potential Implications for Medicare Costs.". It did note an inherent conflict of interest created by the GPO safe harbor protections and how as a result of it hospitals could be underreporting administrative fee revenue. The report also noted that repealing the safe harbor could eliminate the effects of the GPO funding structure on Medicare payment rates, but also recognized that doing so could create disruption within the health care supply chain in at least the near term. But the report did not address drug shortages. A footnote in the report (Footnote #6 on Page 3) states that the congressional requesters of the report had asked about the potential role of GPO contracting practices as the primary cause of generic injectable drug shortages, to which the GAO responded by referring the requesters to their 2014 report and congressional testimony that found drug shortages to be multifactorial in nature and did not determine GPOs to be a key immediate cause of drug shortages, only that they may be one of several potential underlying causes.

Other federal actions have been taken to help alleviate or mitigate drug shortages. In the Prescription Drug User Fee Act (PDUFA) of 2012, known as the Food and Drug Administration Safety and Innovation Act (FDASIA), ACEP helped secure language related to emergency drug shortages. The law eliminated the requirement that a company be the sole manufacturer of a drug to be subject to the drug shortage requirements. Additionally, FDASIA explicitly made drugs used in emergency medical care or during surgery subject to the drug shortage notice requirements. FDASIA established an annual report to Congress by the FDA on drug shortage statistics, communication within FDA on addressing shortages and actions taken by FDA to prevent or mitigate shortages. This legislation called for regular Government Accountability Office (GAO) reports to Congress on the cause of drug shortages and on recommendations on how to prevent or alleviate shortages. The most recent report was published in July 2016. PDUFA was reauthorized in August 2017, though few substantial changes were made to specifically address drug shortages.

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 staff resources.

Prior Council Action

Amended Resolution 34(17) Generic Injectable Drug Shortages adopted. Directed ACEP to work with other medical specialties and patient advocacy groups to achieve consensus on the root cause of ongoing shortages of generic injectable drugs; educate members, other stakeholders, and the public about the issue and how to solve it; seek a legislative repeal of the safe-harbor protections for Group Purchasing Organizations.

Amended Resolution 32(17) Essential Medications adopted. Directed ACEP to collaborate with other medical organizations to speak with a unified voice to government agencies and elected officials as to the urgent need for resolution of the on-going crisis of lack of access to emergency drugs; and that the ACEP Board of Directors make developing and promoting federal legislation to ensure adequate drug supply of critical medications a priority for ACEP's legislative agenda.

Amended Resolution 13(15) ACEP and the Pharmaceutical Industry adopted. Directed ACEP to work with pharmaceutical companies to ameliorate drug shortages affecting emergency medicine, identify ways to disseminate data regarding alternative uses of drugs used in emergency medicine, and

Amended Resolution 33(11) Medication Shortages adopted. Directed ACEP to work with appropriate entities to devise and support a solution to the medication shortage problem and the resulting patient safety issues.

Prior Board Action

Amended Resolution 34(17) Generic Injectable Drug Shortages adopted.

Amended Resolution 32(17) Essential Medications adopted.

Amended Resolution (13)15 ACEP and the Pharmaceutical Industry adopted.

Amended Resolution (33)11 Medication Shortages adopted.

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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 28(18)

SUBMITTED BY: Daniel Freess, MD, FACEP
Greg Shangold, MD, FACEP
Connecticut College of Emergency Physicians

SUBJECT: Inclusion of Methadone in State Drug and Prescription Databases

PURPOSE: Advocate for an end to the prohibition and instead advocate for the inclusion of Methadone in state and federal prescription databases.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency physicians and the medical community are taking active steps to curtail the use and abuse of opiates; and

WHEREAS, State and national drug/prescription databases provide a point of care reference for patient prescriptions and opiate use; and

WHEREAS, Most. if not all, databases are prohibited from including Methadone; and

WHEREAS, The use of Methadone and/or the presence of an active Methadone prescription can play a crucial role in emergency physician decision making regarding the use and prescriptions of opiates/controlled substances; therefore, be it

RESOLVED, That ACEP add to its legislative agenda to advocate for an end to the prohibition and corresponding inclusion of Methadone in state and federal prescription databases.

Background

The resolution calls for the College to advocate for an end to the prohibition and instead advocate for the inclusion of Methadone in state and federal prescription databases.

There has been a long-standing debate over whether outpatient treatment clinics should be required to report to state prescription drug monitoring programs. In 2016, the attorney generals for 33 states wrote a joint letter to the Secretary of the U.S. Department of Health and Human Services urging the amendment of relevant regulations to provide for such reporting, arguing that doing so was necessary to ensure that persons with substance abuse disorders receive appropriate treatment and that diversion, misuse, and abuse of controlled substances are reduced. Some addiction patient advocates oppose such reporting, arguing that the loss of confidentiality will disincentivize persons from receiving care.

The ACEP policy statement "Electronic Prescription Drug Monitoring Programs" supports the use of electronic prescription drug monitoring programs (PDMP) that facilitate seamless data flow from the PDMP into the electronic health record, minimize burdensome requirements, and provide liability protection for the provider.

The ACEP 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.

Numerous ACEP chapters have worked to address the opioid prescribing issue in their states. For example, the Washington and Oregon chapters, working with other organizations within their states, have developed statewide ED opioid prescribing guidelines. The Florida College of Emergency Physicians has developed guidelines about chronic nonmalignant pain management in the ED that have been adopted at numerous hospitals in Florida. The Ohio chapter provided input into the *Opioids and Other Controlled Substances Prescribing Guidelines* for Ohio and endorsed the guidelines. The Kentucky Chapter developed an informational guidance document on narcotics and sedatives usage in the ED for use in Kentucky.

The 2012 ACEP *Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department* addresses four critical questions: (1) the utility of state prescription drug monitoring programs in identifying patients at high risk for opioid abuse; (2) use of opioids for acute low back pain; (3) effectiveness of short-acting schedule II versus short-acting schedule III opioids for treatment of new-onset acute pain; and (4) the benefits and harms of prescribing opioids on discharge from the ED for acute exacerbation of noncancer chronic pain. This guideline acknowledges the increase in opioid deaths, recognizes the difficulties emergency physicians face in treating pain appropriately while avoiding adverse events, identifies the literature (and lack of literature) related to the four critical questions, and offers some guidance on prescribing opioids at ED discharge for acute pain and acute exacerbation of noncancer chronic pain. At the same time, it recognizes the importance of the individual physician's judgment, and provides information for individuals and groups such as state chapters to work within their states and institutions to develop opioid guidelines appropriate for their locations. This clinical policy was funded by the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury.

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, Tactic 3 – Monitor implementation and funding of federal and state legislation that seeks to reduce/eliminate prescription drug abuse and facilitates appropriate treatment for those addicted to prescription opioids or illicit substances.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None specific to advocating to include methadone in state and federal prescription databases.

Resolution 49(17) Participation in ED Information Exchange & Prescription Drug Monitoring Programs adopted. The resolution directs ACEP to collaborate with the Department of Veterans Affairs, the Department of Defense, the Indian Health Services, and potentially legislatures to encourage and facilitate participation in state Prescription Drug Monitoring Programs (PDMPs) and, as consistent with federal law, real-time electronic exchange of patient information.

Amended Resolution 29(13) Support of Health Information Exchanges adopted. Directed ACEP to investigate and support health information exchanges, work with stakeholders to promote the development, implementation, and utilization of a national HIE, and develop an information paper exploring a national HIE.

Amended Resolution 18(13) Creation and Federal Funding of a National Prescription Monitoring Program adopted. Directed ACEP to work with the federal government and stakeholders to create a best practice, federally funded, nationally accessible Prescription Drug Monitoring Program.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. This 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.

Amended Resolution 29(10) Prescription Electronic Monitoring adopted. Directed ACEP to create a policy supporting the use of web-based prescription monitoring programs in every state and support the authorization of federal funding for NASPER and intra-state linkages of databases.

Prior Board Action

Resolution 49(17) Participation in ED Information Exchange & Prescription Drug Monitoring Programs adopted.

April 2017, revised and approved "Optimizing the Treatment of Acute Pain in the Emergency Department" policy statement originally approved June 2009.

January 2017, revised and approved "Electronic Prescription Drug Monitoring Programs" policy statement originally approved October 2011.

June 2015, revised and approved "Health Information Technology" policy statement; originally approved October 1998 with approved revisions February 2003 and August 2008.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 39(14) Naloxone Prescriptions by Emergency Physicians adopted.

Amended Resolution 29(13) Support of Health Information Exchanges adopted.

Amended Resolution 18(13) Creation and Federal Funding of a National Prescription Monitoring Program adopted.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted.

June 2012, approved *Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.*

Amended Resolution 29(10) Prescription Electronic Monitoring adopted.

Background Information Prepared by: Harry J. Monroe, Jr.
Chapter & State 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: 29(18)

SUBMITTED BY: Daniel Freess, MD, FACEP
Greg Shangold, MD, FACEP
Connecticut College of Emergency Physicians

SUBJECT: Insurance Collection of Patient Financial Responsibility

PURPOSE: Advocate for federal laws to require insurance companies to pay the reported professional fees directly to the provider, collect deductibles or co-payments from its covered beneficiary, and develop an information paper or legislative toolkit to assist members in advocating for applicable changes to state insurance laws.

FISCAL IMPACT: Unbudgeted staff and consultant resources to convey ACEP's position to federal and state lawmakers and regulators in favor of insurance company mandate to collect deductibles directly from patients.

WHEREAS, Health insurance is a contract between a health insurance company and a patient, to which physicians are not a party; and

WHEREAS, Health insurance companies and employers have created insurance products with increased deductibles to lower premium costs and transfer health care risk and cost to patients and physicians; and

WHEREAS, High deductible health care plans have increased dramatically over the past 5-10 years; and

WHEREAS, Physicians collect less revenue from patient responsibility charges as compared to plans that pay the professional bill directly to the provider; therefore, be it

RESOLVED, That ACEP add to its legislative and regulatory agenda to advocate for bills and policy changes that would require healthcare insurance companies to pay the professional fee directly to the provider and subsequently collect whatever patient responsibility remains according to the specific healthcare plan directly from the patient; and be it further

RESOLVED, That ACEP create an information paper and/or legislative toolkit to assist members in advocating for applicable changes to state insurance laws; and be it further

RESOLVED, That ACEP advocate for a federal law requiring healthcare insurance companies to pay the professional fee directly to the provider and subsequently the insurance company may collect whatever remaining patient responsibility is required according to the specific healthcare plan directly from the patient.

Background

This resolution calls for ACEP to advocate for federal laws to require insurance companies to pay the reported professional fees directly to the provider, collect deductibles or co-payments from its covered beneficiary, and develop an information paper or legislative toolkit to assist members in advocating for applicable changes to state insurance laws.

Studies have shown that consumers exercise greater caution in spending when health plans require them to share more of the costs.[1] These findings, in conjunction with the enactment of the "Patient Protection and Affordable Care Act" in

2010, have accelerated the use and expansion of high-deductible health plans and additional beneficiary cost-sharing requirements.

In addition to any required premium contributions, most covered workers face cost-sharing for the medical services they use. Cost-sharing for medical services can take a variety of forms, including co-payments (fixed dollar amounts), deductibles (an amount that must be paid before most services are covered by the plan), and/or co-insurance (a percentage of the charge for services). The type and level of cost-sharing often vary by the type of plan in which a beneficiary is enrolled. Cost sharing may also vary by the type of service, such as office visits, hospitalizations or prescription drugs.

Deductibles are the most visible element of an insurance plan to patients, which may help explain why consumers are showing concern about their out-of-pocket costs for care. Although health insurance coverage continues to pay a large share of the cost of covered benefits, patients are generally paying a greater share of their medical expenses out-of-pocket. And, while health care spending has been growing at fairly modest rates in recent years, the growth in out-of-pocket costs comes at a time when wages have been largely stagnant.

The relatively high growth in payments toward deductibles is evident in the changes over time in the distribution of cost-sharing payments: deductibles accounted for 24% of cost-sharing payments in 2004, rising to 47% in 2014. Conversely, co-payments that accounted for nearly half of cost-sharing payments in 2004 fell to 20% in 2014.[2]

In addition to plans expanding the use of deductibles, they are also increasing the threshold amount of those deductibles. The percentage of covered workers with a general annual deductible of $1,000 or more for single coverage grew from 27% to 46% between 2010 and 2015 and 19% of these plans have an annual deductible of $2,000 or more.[3]

As patients bear more and more of the responsibility for covering out-of-pocket expenses, health care providers will be increasingly challenged to collect reimbursement for their services.

This is a bold concept to combat moves by insurance companies to place an ever-increasing share of the cost of health care on the patient and place the provider in the position of trying to collect an ever-larger amount of the billed charges directly from the patient. This concept was considered in the model legislation that was developed by ACEP committees and the ACEP/EDPMA Joint Task Force on Reimbursement Issues (JTF). Although it does not appear in the final model legislation, it does appear in the accompanying Guiding Principles and Annotations documents as an alternative to language in Section III dealing with Minimum Benefit Standards.

> From **Guiding Principles and Annotations Document for Out of Network (OON**
> **Annotation to lll: (Alternative language to lll.)** Insurance Carriers shall reimburse the Guarantor's Cost Sharing amount directly to the Clinician and the Insurance Carriers may subsequently bill the Guarantor for the applicable Guarantor Cost-Sharing amount.

Requiring the Insurance Carriers to reimburse the Patient's cost sharing directly to Clinicians was adopted and promoted by ACEP's Florida and Washington chapters.

The final model legislation and accompanying guidance and annotations were approved by the Board of Directors of ACEP, the Emergency Department Practice Management Association (EDPMA), and Physicians for Fair Coverage (PFC) in June 2017.

The ACEP Reimbursement Committee and State Legislative/Regulatory Committee have developed tool kits and other resources for members and chapters to aid in advocating for favorable out-of-network/balance billing legislation at the state level. These resources are available on the ACEP website. Additional resources continue to be developed as needed.

The Council referred Amended Resolution 17(16) Insurance Collection of Beneficiary Deductibles to the Board of Directors. Testimony in the Reference Committee strongly supported the resolution in pointing out that the insurance industry should not place physicians in the middle of their contractual relationships with their enrollees. The Board assigned the resolution to the Federal Government Affairs Committee to review and provide a recommendation to the Board regarding further action on the resolution. The Federal Government Affairs Committee did not support adding the issue to ACEP's legislative agenda based on several factors. First, and foremost, ACEP was actively engaged in Congress' efforts to repeal and replace the Patient Protection and Affordable Care Act (ACA), working with lawmakers to ensure no deterioration of the federal mandate to include emergency services as an essential health benefit or the number of insured Americans. Second, given the limited advocacy resources available, it was determined that the efforts by Congress to repeal the ACA should take precedent and that elevating this request to a legislative priority could undermine those efforts. Third, but somewhat related, was the concern that Congress itself had a limited spectrum of health care-related issues that it would be willing to consider, but this would not be viewed by lawmakers as significantly relevant during their efforts to repeal and replace the ACA. Finally, it was believed that Congress would view an effort by emergency physicians to alter the current system of how co-insurance amounts are collected in the current political environment as self-serving and not necessarily in the best interest of patients.

The committee did consider whether a recommendation by the unified physician community (such as through an AMA resolution) would be more favorably received, but later learned that the AMA Board of Trustees adopted a similar resolution in November 2016. The AMA Board of Trustees was directed to make a decision and provide a report at the June 2017 AMA Annual meeting. At their April 2017 meeting, the AMA Board of Trustees determined:

> Health Insurance Companies Should Collect Deductible From Patients After Full Payment to Physicians – The Board received a report in response to Resolution 805-I-16 which was referred for decision at the 2016 Interim Meeting of the House of Delegates. Resolution 805, sponsored by the Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont delegations, asks our AMA to "seek federal and state legislation that requires health insurers to reimburse physicians the full negotiated payment rate for services to enrollees in high deductible plans and that the health insurers collect any patient financial responsibility, including deductibles and co-insurance, directly from the patient."
>
> Those in support of Resolution 805-I-16 argued that such legislative action was necessary to address the potential increase in bad debt as a result of patient collections becoming more challenging due to the growth in high-deductible health plans. Conversely, others expressed concern over the unintended consequences to physician practices and the larger political challenges of successfully enacting such legislation.
>
> In lieu of Resolution 805-I-16, the Board voted to approve that the AMA: 1. Reaffirm Policies H-165.849, "Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans," and D-190.974, "Administrative Simplification in the Physician Practice;" 2. Engage in a dialogue with health plan representatives (e.g., America's Health Insurance Plans, Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in high-deductible health plans.

References

[1] RAND Corporation; "Flattening the Trajectory of Health Care Spending: Insights from RAND Health Research;" Arthur L. Kellerman, Mary E. Vaiana, Peter S. Hussey, Ramya Chari, David Lowsky, Andrew W. Mulcahy; 2012
[2] Peterson-Kaiser Health System Tracker: Measuring The Performance Of The U.S. Health System; "Payments for cost sharing increasing rapidly over time;" Gary Claxton, Larry Levitt, Michelle Long; Kaiser Family Foundation; April 12, 2016
[3] Kaiser Family Foundation and Health Research & Educational Trust; Employer Health Benefits 2015 Annual Survey; Exhibit 7.8: Percentage of Covered Workers Enrolled in a Plan with a High General Annual Deductible for Single Coverage, by Firm Size, 2015

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Unbudgeted staff and consultant resources to convey ACEP's position to federal and state lawmakers and regulators in favor of insurance company mandate to collect deductibles directly from patients. The total cost is difficult to predict.

Prior Council Action

Amended Resolution 17(16) Insurance Collection of Beneficiary Deductibles referred to the Board of Directors.

Prior Board Action

October 2017, approved taking no further action on Referred Amended Resolution 17(16) Insurance Collection of Beneficiary Deductibles.

June 2017, approved the ACEP/EDPMA Joint Task Force Model Legislation on out of network service payments and the supporting document "Guiding Principles and Annotations of OON Model Legislation."

April 2016, approved the "Strategies to Address Balance Billing and Out of Network (OON) Benefits for Professional Emergency Care Services" and "Situation Report: Balance Billing Legislation."

April 2016, approved the revised policy statement, "Fair Payment for Emergency Department Services;" originally approved April 2009.

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

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).

RESOLUTION: 30(18)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Naloxone Layperson Training

PURPOSE: Support state chapters in drafting and advocating for legislation to recommend naloxone training in schools and work with national advocacy and capacity-building organizations to advocate for increased naloxone training by laypersons.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The World Health Organization (WHO) published guidelines in 2014 to expand the availability of naloxone to lay people to further manage the opioid epidemic; and

WHEREAS, Naloxone has few known adverse side effects, has no potential for abuse, remains available at a reasonably low cost, and is entirely time dependent and should be used before overdose symptoms cause death; and

WHEREAS, Service providers often arrive on-scene too late to revive overdose deaths as bystanders are often reluctant to call 911 for fear of police involvement; and

WHEREAS, Studies have found that naloxone availability does NOT increase reckless drug abuse nor increase opiate use; and

WHEREAS, One study found that from 1996 through 2014, naloxone kits prevented 26,463 drug overdoses through reversals using naloxone (following kit distribution to 152,283 laypersons); and

WHEREAS, As of July 2017, 40 states have passed Good Samaritan laws/protections safeguarding individuals that report an overdose "in good faith" from certain criminal sanctions; and

WHEREAS, The 2015 American Heart Association (AHA) Guidelines emphasized the importance of placing lay rescuers in the chain of survival for all patients with suspected opiate toxicity – to administer IM or IN naloxone if appropriately trained (Class IIa); and

WHEREAS, The Harm Reduction Coalition (HRC) is a widely recognized organization that operates national training and capacity building services for enhancing naloxone administration by laypersons and other individuals; therefore, be it

RESOLVED, That ACEP support state chapters in drafting and advocating for state legislation to recommend naloxone training in schools; and be it further

RESOLVED, That ACEP work with national advocacy and capacity-building organizations to advocate for increased naloxone training by laypersons.

References

[i] World Health Organization. Community management of opioid overdose. Geneva, Switzerland: World Health Organization. 2014

[ii] Expanded access to naloxone: options for critical response to the epidemic of opioid overdose mortality. *Kim D, Irwin KS, Khoshnood K*

Am J Public Health. 2009 Mar; 99(3):402-7.
[iii] Naloxone distribution and cardiopulmonary resuscitation training for injection drug users to prevent heroin overdose death: a pilot intervention study. *Seal KH, Thawley R, Gee L, Bamberger J, Kral AH, Ciccarone D, Downing M, Edlin BR J Urban Health. 2005 Jun; 82(2):303-11.*
[iv] Wheeler E, Jones TS, Gilbert MK, Davidson PJ. Opioid Overdose Prevention Programs Providing Naloxone to Laypersons — United States, 2014. *MMWR Morbidity and Mortality Weekly Report*. 2015;64(23):631-635.
[v] Davis C, Chang S, Hernandez-Delgado H. Legal interventions to reduce overdose mortality: naloxone access and overdose Good Samaritan Laws. Edina: The Network for Public Health Law; 2017.
[vi] http://www.jems.com/articles/print/volume-41/issue-3/special-focus-resuscitation-recommendations/in-depth-summary-of-2015-aha-guidelines-updates-for-ems-providers.html

Other resources
1. http://www.jems.com/articles/print/volume-41/issue-3/special-focus-resuscitation-recommendations/prehospital-naloxone-administration-for-opioid-related-emergencies.html
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4584734/

Background

The resolution calls for ACEP to support state chapters in drafting and advocating for legislation to recommend naloxone training in schools and work with national advocacy and capacity-building organizations to advocate for increased naloxone training by laypersons.

Illicit and prescription opioid addiction and dependency remains a top priority issue and leading cause of death in the United States, and local, state, and federal government agencies, as well as private sector entities, are devoting significant resources to combating the epidemic. Since 1999, the amount of opioids sold has nearly quadrupled and deaths from prescription opioids have had a corresponding increase.

ACEP's policy statement, "Naloxone Prescriptions by Emergency Physicians," recognizes the role of bystander use of naloxone in reversing opioid toxicity and referenced U.S. Substance Abuse and Mental Health Services Administration recommendations for physicians prescribing naloxone. It also called for continued research on more effective approaches to prescribing naloxone.

The EMS Committee, in collaboration with the National Association of EMS Physicians (NAEMSP) and the American College of Medical Toxicology (ACMT), developed the policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses," that supports use of naloxone by EMS personnel and first responders and supports dispensing by pharmacists over the counter.

The Trauma & Injury Prevention Section (TIPS) hosted a webinar on distribution of naloxone in April 2014 that included the ONDCP Director as well as ACEP members with expertise in this area. The section also developed several resources regarding naloxone that are available on the section web page. These include a video on prescribing pain medications that highlights the opioid abuse issue, a link to the ONDCP webinar on distribution of naloxone, a document with key considerations and implementation strategies for an ED naloxone distribution plan, and a list of links to other resources such as Good Samaritan laws by state and overdose prevention programs.

The Public Health & Injury Prevention Committee has developed talking points, or "smart phrases," for discharge summaries/educational resources that will include topics such as opioid overdose and naloxone use.

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

Amended Resolution 29(16) The Opioid Epidemic – A Leadership Role for ACEP adopted. Directed ACEP to advocate and support training and equipping all first responders to use injectable and nasal spray Naloxone and advocate and support that appropriately trained pharmacists be able to dispense Naloxone without prescription, and develop a comprehensive policy statement on the prevention and treatment of the opioid use disorder epidemic including innovative treatments.

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 39(14) Naloxone Prescriptions by Emergency Physicians adopted. Directed ACEP to develop a clinical policy on the clinical conditions for which it is appropriate for emergency physicians to prescribe naloxone.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to review solutions to decrease the death rate from prescription drug overdoses and create a document offering best practice solutions.

Resolution 39(13) Naloxone Prescriptions in the ED not adopted. The resolution called for supporting and advising emergency physicians to dispense and/or prescribe Naloxone for victims of opioid overdose treated in the ED and promote the ability of emergency physicians to prescribe Naloxone lawfully and explicitly for potential future opiate overdose through legislative or regulatory advocacy.

Resolution 38(13) Naloxone as an Over the Counter Drug not adopted. The resolution called for adoption of a policy in support of Naloxone becoming available as an OTC drug and promote education and safeguards for its use.

Prior Board Action

Amended Resolution 29(16) The Opioid Epidemic – a Leadership Role for ACEP 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."

November 2014, reviewed the information paper, "Opioid Prescribing Legislation," that identified legislative and other developments related to opioid prescribing, prescription monitoring programs, naloxone availability, and Good Samaritan protection for drug overdoses.

October 2014, approved the Public Health & Injury Prevention Committee's recommendation for ACEP to advocate for further research into ED-specific interventions to address prescription drug overdose deaths with the goal of reducing mortality while treating pain for patients seen in the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted.

Amended Resolution 39(14) Naloxone Prescriptions by Emergency Physicians adopted.

Amended Resolution 44(13) "Prescription Drug Overdose Deaths" adopted.

Background Information Prepared by: Harry J. Monroe, Jr.
Chapter & State 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

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).

RESOLUTION: 31(18)

SUBMITTED BY: Yemi Adebayo, MD,
Stephen Schenkel, MD, FACEP
Maryland Chapter
New Jersey Chapter

SUBJECT: Payment of Opioid Sparing Pain Treatment Alternatives

PURPOSE: Advocate for mandated guidelines for insurance coverage of opioid sparing therapies, such as lidocaine patches and NSAID topical creams, and/or physical therapy without requiring preauthorization or outright denial of these prescribed therapies/

FISCAL IMPACT: Unbudgeted staff and/or consultant resources. Costs will depend on the type and degree of advocacy contemplated.

WHEREAS, Opioid addiction has been declared a national emergency; and

WHEREAS, Emergency department staff are being called upon for direction in mitigating new victims of opioid dependence through alternative prescribing practices, especially of non-opioid medications; and

WHEREAS, Insurance companies often fail to adequately cover costs of non-opioid analgesic therapies and medications, or create deterring and cumbersome barriers to authorize payment of said treatments; therefore, be it

RESOLVED, That ACEP advocate for mandated guidelines for insurance coverage of opioid sparing therapies, be they medications such as lidocaine patches and NSAID topical creams, and/or physical therapy without requiring preauthorization or outright denial of these prescribed therapies.

Background

This resolution calls for ACEP to advocate for mandated guidelines for insurance coverage of opioid sparing therapies such as lidocaine patches and NSAID topical creams, and/or physical therapy without requiring preauthorization or outright denial of these prescribed therapies.

The opioid crisis has been a high priority item on ACEP's regulatory and advocacy agenda for the past few years with a few significant advances in the past few months, including the enactment of two bills:

- **The Alternatives to Opioids (ALTO) in the Emergency Department Act**
  (H.R. 5197 – Pascrell/McKinley; S. 2516 – Booker/Capito)
  - Provides grants to help emergency departments and hospitals implement non-opioid, evidence-based pain management protocols, based on the successful and proven ALTO program developed at St. Joseph's in Paterson, New Jersey.
  - In New Jersey, the ALTO program at St. Joseph's Hospital saw opioid prescriptions drop by 82 percent over two years. These results were recently replicated at 10 hospitals in Colorado, where hospital systems noted a 36 percent drop in opioid prescriptions in the first six months of the program.

- **The Preventing Overdoses While in Emergency Rooms (POWER) Act**
  (H.R. 5176 – McKinley/Doyle; S. 2610 – Capito/Murphy)

- Provides grants to establish policies and procedures for initiating Medication-Assisted Treatment (MAT) in the emergency department, and to develop best practices to provide a "warm handoff" to appropriate community resources and providers to keep patients engaged in treatment. MAT is a proven medical treatment that can relieve withdrawal symptoms and psychological cravings of opioid use disorder.
- Studies show success for this model – after one month, 78 percent of patients remained in addiction treatment programs with ED-initiated MAT, compared to 37 percent when given only a simple referral in the ED to treatment in the community.

Achieving this resolution mandating specific coverage for opioid sparing therapies would require Congress to adopt legislation (which would then need to be signed by the President) to apply to governmental programs and commercial plans. The current national attention on the opioid crisis may make this request for coverage more favorably received than other similar requests; however, obtaining a national mandate for coverage is always a very difficult task.

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.

4. Develop and promote to members best practices and clinical tools for caring for patients with important clinical conditions including: Sepsis, Mental Illness, Opioid Dependency, Pain Management.

Monitor implementation and funding of federal and state legislation that seeks to reduce/eliminate prescription drug abuse and facilitates appropriate treatment for those addicted to prescription opioids or illicit substances.

Monitor and support chapter efforts to pursue legislative and regulatory initiatives that ensure fair payment.

Fiscal Impact

Unbudgeted staff and/or consultant resources. Costs will depend on the type and degree of advocacy contemplated

Prior Council Action

The Council has adopted multiple resolutions regarding opioids, but none specific to mandated guidelines for insurance coverage of opioid sparing therapies.

Prior Board Action

April 2017, revised and approved the policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009.

June 2012, approved the "Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department."

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: 32(18)

SUBMITTED BY: Indiana Chapter
Palliative Medicine Section

SUBJECT: POLST Forms

PURPOSE: Advocate and assist chapters for broad recognition of POLST, support state legislation recognizing and honoring POLST forms adopted by other states, and encourage appropriate stakeholders to incorporate POLST into their products to encourage widespread use and national availability and adoption.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, There were 136 million visits to emergency departments in 2015; and

WHEREAS, 1.5 million of these ED visits resulted in an admission to a critical care unit; and

WHEREAS, Emergency physicians need to make timely, informed clinical decisions based on the most accurate and up to date information; and

WHEREAS, The National POLST Paradigm is a voluntary approach to end-of-life planning that emphasizes eliciting, documenting, and honoring the treatment preferences of seriously ill or frail individuals using a portable medical order called a POLST form; and

WHEREAS, A POLST form is a medical order for the specific medical treatments desired by the patient during a medical emergency; and

WHEREAS, 46 states currently have or are developing a version of the POLST form; therefore, be it

RESOLVED, That ACEP advocate and assist chapters for broad recognition of POLST; and be it further

RESOLVED, That ACEP support legislation where states recognize and honor POLST forms from other states; and be it further

RESOLVED, That ACEP encourage appropriate stakeholders (e.g., medical record systems, health information exchanges) to incorporate POLST into their products thus encouraging widespread national availability and adoption.

Background

The resolution calls ACEP to advocate and assist chapters for broad recognition of POLST, support state legislation recognizing and honoring POLST forms adopted by other states, and encourage appropriate stakeholders to incorporate POLST into their products in order to encourage widespread use and national availability and adoption.

According to the National POLST Paradigm organization, the POLST program exists in some form in all 50 states, ranging from the bare passage of legislation to statewide recognition as a standard of care. The program goes under a variety of names across the country. Such variations have created challenges for emergency physicians and others seeking to interpret and apply POLST documents.

State laws reflect a variety of approaches (see in particular p. 27) to the question of portability across state lines. New Jersey and Iowa will honor the originating state's POLST if it complies with their respective laws. Other states, including Colorado, Idaho, and Utah, will honor another state's POLST as long as it reasonably or substantially complies with the requirements of the receiving state. In contrast, Rhode Island requires that the POLST be honored if it complies with the requirements of the originating state. West Virginia will honor the form if it complies with the requirements of either the originating or receiving state.

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.

8. Promote resources for palliative and end-of-life care, including promotion of Physician Orders for Life Sustaining Treatment (POLST), to support education of emergency physicians, patients, and their families in the emergency department, including exploration of partnerships with healthcare organizations, policy, and physician groups.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Substitute Resolution 36(15) Establishing State and National POLST/EOL Registries adopted. Directed ACEP to support the use and implementation of POLST (or equivalent) programs; partner with other stakeholder organizations to advocate and support creation of state and/or national POLST/EOL databases, provide education for emergency physicians on utilization of POLST forms and encourage members to become familiar with their state's POLST (or equivalent) program; and continue to promote advanced care and end-of-life planning and coordination.

Resolution 21(13) End-of-life Care Public Hearings adopted. Directed ACEP to work with other relevant stakeholders to engage in a national conversation and make recommendations on end-of-life issues.

Amended Resolution 31(11) End of Life Care adopted. Directed ACEP to study how emergency medicine can positively affect end of life care; work with other stakeholders to address patient-focused, compassionate end of life care; and update the membership regarding actions being taken by ACEP on the important topic of end of life care.

Prior Board Action

April 2017, approved the policy statement "Guidelines for Emergency Physicians on the Interpretation of Physician Orders for Life-Sustaining Therapy (POLST)."

Amended Substitute Resolution 36(15) Establishing State and National POLST/EOL Registries adopted.

June 2015, reviewed recommendations from the End of Life Task Force regarding current end of life initiatives and resources and discussed additional resources ACEP could develop.

Resolution 21(13) End-of-life Care Public Hearings adopted.

Resolution 31(11) End-of-Life Care adopted.

Background Information Prepared by: Harry J. Monroe, Jr.
Director, Chapter and State Relations

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

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RESOLUTION: 33(18)

SUBMITTED BY: John Corker, MD, FACEP
Hillary Fairbrother, MD, FACEP
Young Physicians Section

SUBJECT: Separation of Migrating Children from Their Caregivers

PURPOSE: Oppose separating migrant children from caregivers; support families and health and well-being of separated children; and advocate for immediate family reunification.

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

WHEREAS, ACEP has publicly stated that it recognizes the right of the United States to secure its borders; and

WHEREAS, Existing federal law is applied and enforced dynamically between administrations; and

WHEREAS, The Department of Homeland Security announced a "zero tolerance" policy in April 2018 that requires all unlawful border crossers be referred to the Department of Justice for prosecution for misdemeanor illegal entry, including caregivers seeking asylum from persecution who enter the U.S. with their dependent children; and

WHEREAS, These dependent children will be treated as if they were "unaccompanied minors," separated from their caregivers, and sent into facilities administered by the federal government[1]; and

WHEREAS, A policy of universally separating dependent children from their caregivers entering U.S. borders portends great harm to children, their caregivers, and their families[2]; and

WHEREAS, Childhood trauma and adverse childhood experiences create negative health impacts that can last an individual's entire lifespan[3]; and

WHEREAS, Many migrating children remain separated from their caregivers at the U.S. border due to burdensome administrative red-tape and bureaucratic delay[4]; therefore, be it

RESOLVED, That ACEP opposes the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being; and be it further

RESOLVED, That ACEP give priority to supporting families and protecting the health and well-being of the migrating children within those families where the children have been removed; and be it further

RESOLVED, That ACEP work with appropriate authorities to encourage and facilitate the reunification of separated migrating children with their caregivers immediately.

[1] https://www.washingtonpost.com/news/fact-checker/wp/2018/06/19/the-facts-about-trumps-policy-of-separating-families-at-the-border/?noredirect=on&utm_term=.ab55ce48654a
[2] https://www.nytimes.com/2018/06/22/health/migrant-families-immigration-detention.html
[3] https://www.tandfonline.com/doi/abs/10.1080/10911359.2018.1435328
[4] https://www.reuters.com/article/us-usa-immigration/us-says-still-working-to-reunite-2053-children-with-families-idUSKBN1JK01L

Background

This resolution directs ACEP to oppose separating migrant children from caregivers; support families and health and well-being of separated children; and advocate for immediate family reunification

Prior to the Trump Administration's "zero tolerance" policy, families arriving at the United States' border without authorization to enter but claiming a credible fear if returned home were permitted to enter the country so they could apply for asylum. Several factors, such as court rulings, legislation, and available space, determined whether the families would be detained during the application process.

A 1997 court settlement (*Flores v. Reno*) requires the government to release children from immigration detention without unnecessary delay to guardians in the following order of preference: parents, other adult relatives, or licensed programs willing to accept custody. If children cannot be released, *Flores* requires the government to hold them in the "least restrictive" setting available. In 2015, a federal judge in California ruled that the *Flores* requirements apply not only to unaccompanied minors but also to children apprehended with their parents.

Amid surges in families crossing the U.S. border in recent years, especially those from Central America seeking to escape from violence and gang activity, there were not enough detention beds (system currently has capacity for about 2,700 people) available to hold families even for the 20 days allowed under the court settlement, which caused many of them to be released.

The change in U.S. procedure implemented by the Trump Administration revolves around a zero-tolerance policy at the U.S.-Mexico border that initiates criminal prosecution of all people who seek to cross illegally between ports of entry. Until recently, first-time offenders were deported instead of being criminally prosecuted. While no actual written policy has been issued by the Trump Administration codifying this position, the effect of this plan essentially ensures parents will be separated from their children because minors cannot be kept in federal criminal detention facilities. Parents are now being transferred from the Border Patrol to the U.S. Marshals Service and then tried in court for the misdemeanor of illegal entry or the felony charge of illegal re-entry. Their children are placed in the custody of the Department of Health and Human Services' (HHS) Office of Refugee Resettlement (ORR). On June 19, 2018, ACEP issued a press release opposing the current DHS "Zero Tolerance" Immigration Policy.

The Trump Administration's policy to prosecute all illegal crossers, including family groups, is new, but builds upon earlier efforts by the (George W.) Bush and Obama Administrations. In 2005, the Bush Administration began a program in Texas that aimed to criminally prosecute illegal crossers. Criminal prosecutions of first-time unauthorized crossers for illegal entry or re-entry more than quadrupled by 2005 to 16,500 and reached 44,000 by 2010. This program was expanded to other Border Patrol sectors and continued under the Obama Administration, reaching a peak 97,000 criminal prosecutions in 2013. However, the phenomenon of families arriving together at the U.S.-Mexico border has occurred in just the past few years and was not one that the Bush or early Obama Administrations confronted in any significant numbers and few children were separated from their families during this time because of criminal prosecution of the parents.

Many families seeking entry into the U.S. are fleeing dangerous environments where children may have witnessed or experienced violence or gone without basic needs. According to the American Academy of Pediatrics (AAP) and others, exposing children to traumatic events and prolonged or toxic stress, such as separation from a parent, disrupts a child's healthy development and can lead to physiologic changes that result in short- and long-term negative effects on physical, mental, and behavioral health

In the short-term, toxic stress can increase the risk and frequency of infections in children as high levels of stress hormones suppress the body's immune system. It can also result in developmental issues due to reduced neural connections to important areas of the brain. Toxic stress is associated with damage to areas of the brain responsible for learning and memory.

Over the long-term, toxic stress may manifest as poor coping skills and stress management, unhealthy lifestyles, adoption of risky health behaviors, and mental health issues, such as depression. Toxic stress is also associated with

increased rates of physical conditions into adulthood, including chronic obstructive pulmonary disease, obesity, ischemic heart disease, diabetes, asthma, cancer, and post-traumatic stress disorder.

Background References

1. "Key Health Implications of Separation of Families at the Border (as of June 27, 2018)." Kaiser Family Foundation. June 27, 2018. https://www.kff.org/disparities-policy/fact-sheet/key-health-implications-of-separation-of-families-at-the-border/
2. "The remarkable history of the family separation crisis." Chris Cillizza. CNN. June 18, 2018. https://www.cnn.com/2018/06/18/politics/donald-trump-immigration-policies-q-and-a/index.html
3. "Family Separation and "Zero-Tolerance" Policies Rolled Out to Stem Unwanted Migrants, But May Face Challenges. Muzaffar Chishti and Jessica Bolter. Migration Policy Institute. May 24, 2018. https://www.migrationpolicy.org/article/family-separation-and-zero-tolerance-policies-rolled-out-stem-unwanted-migrants-may-face
4. "Potential Child Health Consequences of the Federal Policy Separating Immigrant Children From Their Parents." Howard A. Zucker, MD, JD; Danielle Greene, DrPH. *JAMA*. July 19, 2018. https://jamanetwork.com/journals/jama/fullarticle/2688769
5. "How Trump's Family Separation Policy Has Affected Parents." PBS. Frontline. August 2, 2018. https://www.pbs.org/wgbh/frontline/article/how-trumps-family-separation-policy-has-affected-parents/

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP position to federal Executive and Legislative Branch officials.

Prior Council Action

Resolution 33(17) Immigrant and Non-Citizen Access to Care referred to the Board of Directors. The resolution requested that ACEP develop model hospital policy language similar to the "Delivery of Care to Undocumented Persons" policy statement for physicians to access and present to their hospital systems for implementation and make available online for public use, in multiple languages, a "Safe Zone" statement that notifies patients of an implemented hospital policy regarding immigrant and non-citizen access to care so that physician can ensure the policy is communicated in the language most relevant to their patient populations.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. Directed ACEP to develop a paper addressing the impact of foreign nationals on the American health care safety net and develop proposals seeking legislative, regulatory, and/or judicial remedies for uncompensated health care services provided to foreign nationals in U.S. emergency departments.

Prior Board Action

June 2018, approved the revised policy statement "Delivery of Care to Undocumented Persons;" reaffirmed February 2018, April 2012, October 2006, and July 2000; originally approved January 1995.

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

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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 34(18) Violence Is a Health Issue

SUBMITTED BY: Trauma & Injury Prevention Section

SUBJECT: Violence is a Health Issue

PURPOSE: Recognize violence as a health issue addressable through medical and public health interventions, and to pursue policies, legislation, and funding for health and public-health-based approaches to reduce violence.

FISCAL IMPACT: Budgeted committee and staff resources to develop and pursue legislative efforts and potential funding resources to develop and implement hospital-based violence intervention models.

WHEREAS, An estimated 64,876 Americans died as a result of violent injuries in 2016; and

WHEREAS, Violence affects the lives of all Americans as it comes in many forms: peer violence, suicide, intimate partner violence, child abuse, elder abuse, and mass casualty events; and

WHEREAS, For patients who survive violent injury, risk of reinjury and mortality is high, with studies indicating a 5-year mortality of approximately 20%; and

WHEREAS, Violent injury leads to long-term health sequelae such as post-traumatic stress disorder and alcohol and substance abuse; and

WHEREAS, Research demonstrates health and public health approaches to violence can reduce the risk or reinjury and other adverse health effects following injury; and

WHEREAS, Models such as Hospital-based Violence Intervention and Cure Violence reduce violence and its patient-level effects by addressing factors leading to injury, connections to community services, and linkage to mental health services; therefore, be it

RESOLVED, That ACEP will recognize violence as a health issue addressable through both the medical model of disease and public health interventions; and be it further

RESOLVED, That ACEP will pursue policies, legislation, and funding for health and public-health-based approaches to reduce violence.

Background

The resolution calls for ACEP to recognize violence as a health issue addressable through both the medical model of disease and public health interventions, and directs ACEP to pursue policies, legislation, and funding for health and public-health-based approaches to reduce violence.

ACEP has a long history of developing policies and resources for members addressing a wide variety of violence-related issues and prevention for emergency care providers and their patients, including "Domestic Family Violence," "Firearm Safety and Injury Prevention," "Human Trafficking," "Protection from Violence in the Emergency Department," "Violence-Free Society," and several others.

The "Violence-Free Society" policy statement "strongly supports the goal, and acknowledges the health and economic benefits, of a society free from violence…" and further, "Improved violence prevention programs as well as the development of mechanisms for the emergency department (ED) to treat patients (either as victims or perpetrators) presenting with the mental and physical consequences of violence will be important achievements."

Understanding violence as a public health issue gained traction in 1979 with the U.S. Surgeon General's report, "Healthy People: The Surgeon General's report on health promotion and disease prevention" that identified violence as one of the 15 priority areas for addressing the nation's health. Following shortly thereafter in 1983, the Centers for Disease Control (CDC) established a Violence Epidemiology Branch, and in 1996, the World Health Assembly passed a resolution declaring violence as a "leading worldwide public health problem."

According to 2016 CDC data, homicide is the third leading cause of death (only behind unintentional injuries and suicide) for Americans 15-34 years old.[1] It is the fourth leading cause of death for Americans 1-14, and the fifth leading cause of death for the 35-44 age range.

The Hospital-Based Violence Intervention Model is a concept based on using a hospital violent injury encounter as a window for intervention to reduce future violence, prevent retaliation, and limit recurrence of violence. HVIPs address both the psychological and physical effects of violence, focusing on "teachable moments" to intervene with social workers or other intervention specialists, link patients with community services, and provide access to longer-term solutions and case management.[2] Such models have been implemented in various forms over the past two decades, such as the Youth ALIVE! "Caught in the Crossfire" program that connects intervention specialists with traumatized young victims of violence to prevent them from retaliating and offer help towards safety and healing, or the University of Maryland Medical Center's "Violence Intervention Program" that connects patients with a social worker at the bedside.

The Cure Violence model describes itself as a "teaching, training, research, and assessment NGO (non-governmental organization) focused on a health approach to violence prevention." According to the organization's website, this model has been implemented in cities worldwide, such as New York City, Chicago, Baltimore, Kansas City, Syracuse, as well as San Pedro Sula in Honduras or Cape Town in South Africa, among many others.

HVIPs have received support at the federal level and were explicitly referenced in a 1998 U.S. Department of Justice Office for Victims of Crime recommended establishment of these programs. The DOJ Office for Victims of Crime provides funding opportunities for HVIPs through "Advancing Hospital-based Victim Services" grants.

The National Network of Hospital-based Violence Intervention Programs (NNHVIP) works with existing, new and emerging hospital-based violence intervention programs to provide resources including technical assistance, webinars, publications and e-bulletins. They have compiled a list of key components for hospital-based violence intervention programs including patient evaluation procedures, referral, aftercare, prevention, and program assessment.

The Council and the Board adopted Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs that called for ACEP to promote awareness of hospital-based violence intervention programs (HVIPs) as evidence-based solutions for violence reduction and to coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs. In response to the resolution, the Public Health & Injury Prevention Committee reviewed materials available and compiled information and resources on HVIPs. The resources are available on the ACEP Website, including CME lectures, podcasts, *Annals* articles, policy statements, and several information papers: ED Violence: An Overview and Compilation of Resources, Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED; Hospital-based Violence Intervention Programs; Violence in the ED: Resources for a Safer Workplace.

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[1] https://www.cdc.gov/injury/images/lc-charts/leading_causes_of_death_age_group_2016_1056w814h.gif
[2] https://pdfs.semanticscholar.org/d1f0/65d1776b8759ec28c1df992f894ec59b21b8.pdf

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
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 and staff resources to develop and pursue legislative efforts and potential funding resources to develop and implement hospital-based violence intervention models.

Prior Council Action

Resolution 55(17) Workplace Violence adopted.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. Directed ACEP to promote awareness of HVIPs as evidence-based solutions for violence reduction and to coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 14(99) Domestic Violence adopted. Directed the College to encourage screening patients for domestic violence and provide appropriate referral.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on this issue and that ACEP encourage the National Institute of Mental Health and Centers for Disease Control and Prevention among others to make financial support available for research into this area.

Amended Resolution 26(93) Violence in Emergency Departments adopted. Directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 11(93) Violence Free Society adopted. Directed the College to develop a policy on a violence free society and to educate members about the preventable nature of violence and the important role physicians can play in violence prevention.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action

Resolution 55(17) Workplace Violence adopted.

April 2016, approved the policy statement "Human Trafficking."

April 2016, approved the revised policy statement "Protection from Violence in the Emergency Department;" revised and approved June 2011; revised and approved with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

June 2013, reaffirmed the policy statement "Domestic Family Violence;" originally approved October 2007 replacing six other separate policy statements.

June 2013, reaffirmed the policy statement "Violence-Free Society;" revised and approved January 2007; reaffirmed October 2000; originally approved January 1996.

April 2013, approved the revised policy statement with the revised title "Firearm Safety and Injury Prevention" replacing the rescinded policy statement "Firearm Injury Prevention;" revised and approved January 2011 and October 2012; reaffirmed October 2007; originally approved February 2001 replacing 10 other separate firearm related policy statements.

April 2014, reaffirmed the policy statement "Role of the Emergency Physicians in Injury Prevention and Control for Adult and Pediatric Patients;" revised and approved June 2008 replacing the policy statement "Role of Emergency Physicians in the Prevention of Pediatric Injury;" reaffirmed October 2002; originally approved March 1998 with the title "The Role of the Emergency Physician in Injury Prevention and Control."

Amended Resolution 14(99) Domestic Violence adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 11(93) Violence-Free Society adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 35(18)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: ACEP Policy Related to Immigration

PURPOSE: Affirm the right for all patients to receive emergency medical care; encourage establishment of policies of non-collaboration between hospital staff and immigration authorities, unless required by warrant; and oppose modifications to U.S. public charge policies.

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

WHEREAS, ACEP opposes federal and state initiatives that require physicians and health care facilities to refuse care to undocumented persons or to report suspected undocumented persons to immigration authorities[1]; and

WHEREAS, ACEP believes that resources should be made available to emergency departments and emergency physicians to assure they are able to respond to the needs of all patients regardless of their respective cultural backgrounds[2]; and

WHEREAS, 13.1% of the population of the United States is foreign born[3]; and

WHEREAS, Access to emergency care is an essential component of maintaining the public health, particularly in populations that had decreased access to other health services; and

WHEREAS, Fear of immigration enforcement can discourage immigrant patients from seeking necessary medical care[4]; and

WHEREAS, Immigration and Customs Enforcement holds a policy that enforcement actions are not to occur at or be focused on sensitive locations, including medical treatment and health care facilities[5]; and

WHEREAS, Revised instructions for the U.S. Department of State Foreign Affairs Manual (FAM) allow the receipt of noncash benefits, such as healthcare coverage or nutrition assistance, to be considered as part of the considerations relevant to public charge[6,7]; and

WHEREAS, Expanding the definition of public charge considerations to include healthcare and nutrition benefits would act as a deterrent for many immigrants in accessing health and nutrition services, and deter them from seeking these services for their family members, including those with permanent legal status or U.S. citizenship; therefore, be it

RESOLVED, That ACEP affirms the right for all patients to access and receive emergency care regardless of country of origin or immigration status; and be it further

RESOLVED, That ACEP encourages emergency departments to establish policies forbidding collaboration between hospital staff and immigration authorities, unless required by signed warrant; and be it further

RESOLVED, That ACEP opposes determination of "public charge" used in determining eligibility for legal entry into the United States or legal permanent residency that would include health benefits or coverage.

References
1. ACEP policy on Delivery of Care to Undocumented Persons. https://www.acep.org/patient-care/policy-statements/delivery-of-care-to-undocumented-persons/
2. ACEP Policy on Cultural Awareness and Emergency Care. https://www.acep.org/patient-care/policy-statements/cultural-awareness-and-emergency-care/
3. Lopez, Gustavo and Radford, Jynnah. Facts on U.S. Immigrants, 2015. Pew Research Center. May 3, 2017. http://www.pewhispanic.org/2017/05/03/facts-on-u-s-immigrants-current-data/
4. Hoffman, Jan. Sick and Afraid, Some Immigrants Forgo Medical Care. The New York Times, June 26, 2017. https://www.nytimes.com/2017/06/26/health/undocumented-immigrants-health-care.html
5. Morton, John. Memorandum on Enforcement Actions at or Focused on Sensitive Locations. October 24, 2011. https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf
6. United States State Department Foreign Office Manual. https://fam.state.gov/fam/09fam/09fam030208.html
7. Changes to "Public Charge" Instructions in the U.S. State Department's Manual. National Immigration Law Center. February 8, 2018. https://www.nilc.org/issues/economic-support/public-charge-changes-to-fam/

Background

This resolution calls for ACEP to affirm the right for all patients to receive emergency medical care; encourage establishment of policies of non-collaboration between hospital staff and immigration authorities, unless required by warrant; and oppose modifications to U.S. public charge policies

Some non-U.S. citizens who seek to enter the U.S. or who seek lawful permanent resident status must show that they are not likely to become a "public charge." For purposes of determining inadmissibility, "public charge" means an individual who is likely to become primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense.

Several factors, and the totality of the circumstances, must be considered when deciding that a person is likely to become a public charge. At minimum, the U.S. Citizenship and Immigration Services (USCIS) officer must consider the following factors when making a public charge determination: age, health, family status, assets, resources, financial status, and education and skills. The officer may also consider any affidavit of support filed on behalf of the individual.

Cash assistance for income maintenance and institutionalization for long-term care at government expense may be considered for public charge purposes. However, receipt of such benefits must still be considered in the context of the totality of the circumstances before a person will be deemed inadmissible on public charge grounds. Non-cash benefits, other than institutionalization for long-term care, are generally not considered for purposes of a public charge determination.

The government has historically recognized that health coverage and nutrition assistance (such as Medicaid, the Children's Health Insurance Program, and the Supplemental Nutrition Assistance Program,) should not be considered in the public charge determination, as these help people remain healthy and productive, therefore less likely to become dependent on the government for subsistence. Thus, the use of these services has not been considered relevant in public charge determinations.

On January 3, 2018, the U.S. Department of State published revised sections of its Foreign Affairs Manual (FAM) that deal with public charge, which is used by officials in U.S. embassies and consulates abroad to make decisions about whether to grant a person permission to enter the U.S. as an immigrant or on a non-immigrant visa. It does not govern decisions made by immigration officials inside the U.S. The revised instructions allow the receipt of non-cash benefits such as health care coverage or nutrition assistance to be considered as part of the considerations relevant to public change. The new instructions also allow State Department officials to consider whether an applicant's family member has received pubic benefits as part of the public charge test.

According to numerous news reports, the Trump Administration has been contemplating expanding their public charge directive (to consider non-cash benefits) to U.S. immigration officials at the Department of Homeland

Security. It is possible, if not likely, this policy shift would act as a significant deterrent for many immigrants in accessing health and nutrition services and deter them from seeking these services for their family members as well, including those with permanent legal status or U.S. citizenship.

Background References

1. "Changes to 'Public Charge' Instructions in the U.S. State Department's Manual." National Immigration Law Center. February 8, 2018. https://www.nilc.org/issues/economic-support/public-charge-changes-to-fam/
2. "Public Charge." U.S. Citizenship and Immigration Services. https://www.uscis.gov/greencard/public-charge

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP's position to federal Executive and Legislative Branch officials.

Prior Council Action

Resolution 33(17) Immigrant and Non-Citizen Access to Care referred to the Board of Directors. The resolution requested that ACEP develop model hospital policy language similar to the "Delivery of Care to Undocumented Persons" policy statement for physicians to access and present to their hospital systems for implementation and make available online for public use, in multiple languages, a "Safe Zone" statement that notifies patients of an implemented hospital policy regarding immigrant and non-citizen access to care so that physician can ensure the policy is communicated in the language most relevant to their patient populations.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. Directed ACEP to develop a paper addressing the impact of foreign nationals on the American health care safety net and develop proposals seeking legislative, regulatory, and/or judicial remedies for uncompensated health care services provided to foreign nationals in U.S. emergency departments.

Prior Board Action

June 2018, approved the revised policy statement "Delivery of Care to Undocumented Persons;" reaffirmed February 2018, April 2012, October 2006, July 2000; originally approved January 1995.

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

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

2018 Council Meeting
Reference Committee Members

Reference Committee C
Emergency Medicine Practice
Resolutions 36-48

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Melissa W. Costello, MD, FACEP (AL)
Carrie de Moor, MD, FACEP (TX)
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American College of Emergency Physicians
ADVANCING EMERGENCY CARE

RESOLUTION: 36(18)

SUBMITTED BY: Arizona College of Emergency Physicians
Connecticut College of Emergency Physicians
Massachusetts College of Emergency Physicians
Missouri College of Emergency Physicians
North Carolina College of Emergency Physicians
South Carolina College of Emergency Physicians
Utah Chapter
West Virginia Chapter

SUBJECT: ACEP Policy Related to Medical Cannabis

PURPOSE: Align ACEP policy on medical use of cannabis with current AMA Policy on the subject.

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

WHEREAS, "Cannabis use remains a critical issue in the United States"[1,2,3,4,5,6]; and

WHEREAS, The AMA has established policy on the topic of medical cannabis[7,8]; and

WHEREAS, While there is no current medically recognized use of cannabis in emergency care, states continue to adopt laws to allow its use for medical purposes; and ACEP should join the "House of Medicine" in adopting a formal policy to direct ACEP's approach on these issues; and

WHEREAS, Without such a policy, it leaves a void creating confusing & conflicting messages[9]; and opens ACEP up to criticism; therefore, be it

RESOLVED, That ACEP align with and adopt as ACEP policy the following relevant sections of the American Medical Association's Policy: "Cannabis and Cannabinoid Research H-95.952":

(1) ACEP supports further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.

(2) ACEP supports that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.

References

1. Hill KP. Cannabis Use and Risk for Substance Use Disorders and Mood or Anxiety Disorders. JAMA. March 14, 2017, Vol 317, #10: 1070-1071.
2. Cully Stimson. 7 Harmful Side Effects Pot Legalization Has Caused in Colorado. The Daily Signal. Aug 20, 2014 [http://dailysignal.com/2014/08/20/7-harmful-side-effects-pot-legalization-caused-colorado/]
3. The Adverse Effects of Marijuana (for healthcare professionals). California Society of Addiction Medicine, 2011 [http://www.csam-asam.org/adverse-effects-marijuana-healthcare-professionals]
4. http://www.nejm.org/doi/full/10.1056/NEJMra1402309

5. Dangers of Marijuana Experienced Firsthand - ACEP Now - May 15, 2017: http://www.acepnow.com/article/dangers-marijuana-experienced-firsthand/
6. *"It is fair to say this is more than tricky. This is about the hardest, most complicated thing in public life that I've ever had to work on. I urge caution. My recommendation has been that they should go slowly and probably wait a couple of years. And let's make sure that we get some good vertical studies to make sure that there isn't a dramatic increase in teenage usage, that there isn't a significant increase in abuse like while driving. We don't see it yet but the data is not perfect. And we don't have enough data yet to make that decision."* John Hickenlooper, Governor, Colorado - 60 Minutes – Sunday, October 30, 2016 http://www.cbsnews.com/news/60-minutes-five-states-to-vote-on-recreational-pot/
7. AMA Policy: Cannabis and Cannabinoid Research H-95.952 (Updated November 2017)

> *1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.*
> *2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.*
> *3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.*
> *4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.*
> *5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.*

8. Cannabis Legalization for Medicinal Use D-95.969 (Adopted June 2018)

> *Our AMA:*
> *1. believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use;*
> *2. believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process;*
> *3. will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process.";*
> *4. supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws;*
> *5. believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; and*
> *6. will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians.*

9. ACEP17 Educational Program: MO-151- *The Great Debates: Weed Wars and Gun Violence*, Monday, October 30, 2017. Several outrageous and unsupported statements were made by a former ACEP leader, which were not challenged or corrected by the session moderator. For example, speaking to a room of emergency physicians, this individual said (note audio time stamp):
09:07 "First of all, let me tell you what my goals are. One, if you are in a state where cannabis is not legal for medicinal purposes or has not been decriminalized, I think you have an ethical obligation to get involved and change the law."
09:56 "At the end of this, I can tell you, you have an ethical obligation to learn about cannabis, because I think you are obligated to give your chronic pain patients an alternative as oppose to Oxycontin, or particularly for neuropathic pain, I think you need to learn about and give them the option then the patient has the right to choose."

Further reading:

Marijuana – National Institute on Drug Abuse (NIDA) – August 2017
https://www.drugabuse.gov/sites/default/files/1380-marijuana.pdf

Adverse Health Effects of Marijuana Use – NEJM - June 5, 2014
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4827335/pdf/nihms762992.pdf

Background

This resolution calls for ACEP to align with and adopt as ACEP policy relevant sections of the American Medical Association's policy on Cannabis and Cannabinoid Research.

The legalization of both recreational and medicinal use of cannabis continues to be highly controversial, enhanced by conflicting studies demonstrating various effects experienced in states where marijuana use has been legalized. Nine states and the District of Columbia have legalized recreational use of marijuana for adults over the age of 21. Vermont became the latest state to take that step this year, and the first state to do so through the legislative process. All other states that have legalized recreational use have done so through ballot initiatives. Thirty-one states have legalized marijuana for medicinal use, with Oklahoma becoming the latest state to do so this year. In addition, 15 other states only allow use of low THC, high cannabidiol products for limited medical conditions such as seizure disorders. Marijuana continues to be illegal on the federal level. In 2013, the U.S. Justice Department announced it would defer enforcing marijuana laws to states where marijuana had been legalized, but earlier this year that policy was rescinded and federal prosecutors were empowered to decide how to enforce federal marijuana laws.

Within the last year, the American Medical Association has modified its position on recreational and medicinal use of marijuana through the adoption of new and revised policies that include:

- Cannabis and Cannabinoid Research (H-95.952)
- Cannabis Legalization for Medicinal Use (D-95.969)
- Cannabis Legalization for Recreational Use (H-95.924)

The full contents of these policies are provided in the References provided for this resolution.

From 2009 to 2017, the Council has discussed 14 resolutions related to advocacy, legalization, regulation, research, and decriminalization of marijuana. Fourteen of these resolutions were not adopted by the Council and two resolutions were referred to the Board of Directors.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted resources for development and distribution of policy statements.

Prior Council Action

Resolution 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency not adopted. Called for ACEP to adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis as recommended by their physician.

Resolution 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders not adopted. Directed ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

Resolution 42(17) ACEP Policy Related to Cannabis not adopted. Directed that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board of Directors. Directed ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana

intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. The resolution directed ACEP to adopt and support a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 15(15) CARERS Act of 2015 not adopted. Directed ACEP to endorse S. 683 and require the AMA Section Council on Emergency Medicine to submit a resolution directing the AMA to endorse this legislation.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19 (14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23 (13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25 (11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 20(10) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 16 (10) Classification Schedule of Marijuana as a Controlled Substance not adopted. The resolution requested ACEP to convene a Marijuana Technical Advisory Committee to advocate for change in the classification status of marijuana from a DEA Schedule I to a Schedule II drug.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

Prior Board Action

June 2017, approved the Emergency Medicine Practice Committee's recommendation to take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolved 3 (assign to the Tox Section or other body for additional work) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication).

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy and Finance

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).

RESOLUTION: 37(18)

SUBMITTED BY: Arizona College of Emergency Physicians
Connecticut College of Emergency Physicians
Massachusetts College of Emergency Physicians
North Carolina College of Emergency Physicians
South Carolina College of Emergency Physicians
Utah Chapter
West Virginia Chapter

SUBJECT: ACEP Policy Related to "Recreational" Cannabis

PURPOSE: Align ACEP policy on recreational use of cannabis with current AMA policy on the issue.

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

WHEREAS, "Cannabis use remains a critical issue in the United States"[1]; and

WHEREAS, Cannabis remains illegal throughout the entire Unites States, despite certain individual states choosing to decriminalize cannabis (largely by referendum) despite evidence of its deleterious effect and thereby tolerating open commercial production, distribution, and public use with few restrictions; and

WHEREAS, The broadened availability and dramatic increases in THC concentrations of commercially produced cannabis has resulted in untoward negative medical, social, societal, and economic impact of cannabis in the United States (such as accidental ingestion by children and others; cyclical vomiting syndrome; increasing addiction, etc.)[2,3,4,5,6]; and

WHEREAS, The American Medical Association has established policy on the topic of cannabis[7,8]; ACEP should join the "House of Medicine" in adopting a formal policy related to cannabis to direct ACEP's approach on these issues; and

WHEREAS, Without such a policy, it leaves a void creating confusing & conflicting messages[9] and opens ACEP up to criticism; therefore, be it

RESOLVED, That ACEP align with and adopt as ACEP policy the following relevant section of the American Medical Association's Policy: "Cannabis and Cannabinoid Research H-95.952":

ACEP urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use; and be it further

RESOLVED, That ACEP align with and adopt as ACEP policy the following relevant sections of the American Medical Association's Policy: "Cannabis Legalization for Recreational Use H-95.924":

ACEP believes that the sale of cannabis for recreational use should not be legalized; and discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding.

References

1. Hill KP. Cannabis Use and Risk for Substance Use Disorders and Mood or Anxiety Disorders. JAMA. March 14, 2017, Vol 317, #10: 1070-1071.

2. Cully Stimson. 7 Harmful Side Effects Pot Legalization Has Caused in Colorado. The Daily Signal. Aug 20, 2014 [http://dailysignal.com/2014/08/20/7-harmful-side-effects-pot-legalization-caused-colorado/]
3. The Adverse Effects of Marijuana (for healthcare professionals). California Society of Addiction Medicine, 2011 [http://www.csam-asam.org/adverse-effects-marijuana-healthcare-professionals]
4. http://www.nejm.org/doi/full/10.1056/NEJMra1402309
5. Dangers of Marijuana Experienced Firsthand - ACEP Now - May 15, 2017: http://www.acepnow.com/article/dangers-marijuana-experienced-firsthand/
6. *"It is fair to say this is more than tricky. This is about the hardest, most complicated thing in public life that I've ever had to work on. I urge caution. My recommendation has been that they should go slowly and probably wait a couple of years. And let's make sure that we get some good vertical studies to make sure that there isn't a dramatic increase in teenage usage, that there isn't a significant increase in abuse like while driving. We don't see it yet but the data is not perfect. And we don't have enough data yet to make that decision."* John Hickenlooper, Governor, Colorado - 60 Minutes – Sunday, October 30, 2016 http://www.cbsnews.com/news/60-minutes-five-states-to-vote-on-recreational-pot/
7. AMA Policy: Cannabis and Cannabinoid Research (H-95.952) (Updated November 2017)

> *1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.*
> *2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.*
> *3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.*
> *4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.*
> ***5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.***

8. *AMA Policy: Cannabis Legalization for Recreational Use (H-95.924) Adopted November 2017*

> *Our AMA:*
> 1. *believes that cannabis is a dangerous drug and as such is a serious public health concern;*
> 2. ***believes that the sale of cannabis for recreational use should not be legalized;***
> 3. ***discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding;***
> 4. *believes states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness;*
> 5. *encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis use; and*
> 6. *supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use."*

9. ACEP17 Educational Program: MO-151- *The Great Debates: Weed Wars and Gun Violence*, Monday, October 30, 2017. Several outrageous and unsupported statements were made by a former ACEP leader, which were not challenged or corrected by the session moderator. For example, speaking to a room of emergency physicians, this individual said (note audio time stamp):

> *09:07 "First of all, let me tell you what my goals are. One, if you are in a state where cannabis is not legal for medicinal purposes or has not been decriminalized, I think you have an ethical obligation to get involved and change the law."*
> *09:56 "At the end of this, I can tell you, you have an ethical obligation to learn about cannabis, because I think you are obligated to give your chronic pain patients an alternative as oppose to Oxycontin, or particularly for neuropathic pain, I think you need to learn about and give them the option then the patient has the right to choose."*

Further reading:

Marijuana – National Institute on Drug Abuse (NIDA) – August 2017
https://www.drugabuse.gov/sites/default/files/1380-marijuana.pdf
Adverse Health Effects of Marijuana Use – NEJM - June 5, 2014
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4827335/pdf/nihms762992.pdf

Background

This resolution calls for ACEP to align with and adopt as ACEP policy relevant sections of the American Medical Association's policies on recreational use of cannabis.

The legalization of both recreational and medicinal use of cannabis continues to be highly controversial, enhanced by conflicting studies demonstrating various effects experienced in states where marijuana use has been legalized. Nine states and the District of Columbia have legalized recreational use of marijuana for adults over the age of 21. Vermont became the latest state to take that step this year, and the first state to do so through the legislative process. All other states that have legalized recreational use have done so through ballot initiatives. Thirty-one states have legalized marijuana for medicinal use, with Oklahoma becoming the latest state to do so this year. In addition, 15 other states only allow use of low THC, high cannabidiol products for limited medical conditions such as seizure disorders. Marijuana continues to be illegal on the federal level. In 2013, the U.S. Justice Department announced it would defer enforcing marijuana laws to states where marijuana had been legalized, but earlier this year that policy was rescinded and federal prosecutors were empowered to decide how to enforce federal marijuana laws.

Within the last year, the American Medical Association has modified its position on recreational and medicinal use of marijuana through the adoption of new and revised policies that include:

- Cannabis and Cannabinoid Research (H-95.952)
- Cannabis Legalization for Medicinal Use (D-95.969)
- Cannabis Legalization for Recreational Use (H-95.924)

The full contents of these policies are provided in the References provided for this resolution.

From 2009 to 2017, the Council has discussed 14 resolutions related to advocacy, legalization, regulation, research, and decriminalization of marijuana. Fourteen of these resolutions were not adopted by the Council and two resolutions were referred to the Board of Directors.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted resources for development and distribution of policy statements.

Prior Council Action

Resolution 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency not adopted. Called for ACEP to adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis as recommended by their physician.

Resolution 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders not adopted. Directed ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

Resolution 42(17) ACEP Policy Related to Cannabis not adopted. Directed that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board of Directors. Directed ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. The resolution directed ACEP to adopt and support a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 15(15) CARERS Act of 2015 not adopted. Directed ACEP to endorse S. 683 and require the AMA Section Council on Emergency Medicine to submit a resolution directing the AMA to endorse this legislation.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19 (14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23 (13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25 (11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 20(10) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 16 (10) Classification Schedule of Marijuana as a Controlled Substance not adopted. The resolution requested ACEP to convene a Marijuana Technical Advisory Committee to advocate for change in the classification status of marijuana from a DEA Schedule I to a Schedule II drug.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

Prior Board Action

June 2017, approved the Emergency Medicine Practice Committee's recommendation to take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolved 3 (assign to the Tox Section or other body for additional work) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and

subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication).

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy and Finance

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: 38(18)

SUBMITTED BY: California Chapter
Washington Chapter
Wisconsin Chapter

SUBJECT: Antimicrobial Stewardship

PURPOSE: 1) Issue a public statement on the public health implications of antimicrobial resistance and the importance of antimicrobial stewardship in the ED. 2) Offer education aimed at ED providers on the hazards of antimicrobial overuse and strategies to prescribe antimicrobials appropriately. 3) Disseminate an evidence-based resource and/or toolkit for ED providers to identify and implement provider-level and system-level opportunities for antimicrobial avoidance.

FISCAL IMPACT: Budgeted committee/task force and staff resources.

WHEREAS, ACEP has previously supported the development of a public educational campaign on appropriate antimicrobial use [Substitute Resolution 23(98) Appropriate Use of Antibiotics]; and

WHEREAS, ACEP has previously supported the development of educational materials for emergency department providers and patients on the dangers of antimicrobial overuse [Substitute Resolution 23(98) Appropriate Use of Antibiotics]; and

WHEREAS, The epidemic of antimicrobial resistance and resistant bacterial infections has significantly worsened since the ACEP Council last addressed this issue 20 years ago; and

WHEREAS, Substantial advancements have been made in the emergency medicine literature regarding provider-level and system-level interventions for antimicrobial avoidance and slowing the spread of resistant bacterial infections; and

WHEREAS, Grant funding for specialty-specific antimicrobial stewardship implementation research is more accessible when the specialty society has publically supported antimicrobial stewardship principles; and

WHEREAS, There are evidence-based antimicrobial stewardship toolkits for EDs and urgent care facilities in existence based on CDC-funded research; therefore, be it

RESOLVED, That ACEP issue a public statement on the public health implications of antimicrobial resistance and the importance of antimicrobial stewardship in the emergency department; and be it further

RESOLVED, That ACEP offer education aimed at emergency department providers on the hazards of antimicrobial overuse and strategies to prescribe antimicrobials appropriately; and be it further

RESOLVED, That ACEP disseminate an evidence-based resource and/or toolkit for emergency department providers to identify and implement provider-level and system-level opportunities for antimicrobial avoidance.

Background

This resolution calls for the College to issue a public statement on the public health implications of antimicrobial

resistance and the importance of antimicrobial stewardship in the emergency department; offer education aimed at emergency department providers on the hazards of antimicrobial overuse and strategies to prescribe antimicrobials appropriately; and disseminate an evidence-based resource and/or toolkit for emergency department providers to identify and implement provider-level and system-level opportunities for antimicrobial avoidance.

Inappropriate use of antibiotics has been an ongoing issue for the public health and medical communities. From 2000 to 2010, antimicrobial use increased by 36% worldwide coinciding with a substantial increase in global rates of human infections related to resistant pathogens.[1] The US prescribes a disproportionate amount of antimicrobials per capita, ranking third in the world for total antimicrobial consumption.[1] Antimicrobials are one of the emergency department's most commonly prescribed drug classes with a recent CDC estimate that in 2015 US emergency departments generated over 28 million antimicrobial prescriptions.[2] The emergency department has traditionally been underrepresented as a focus for antimicrobial stewardship efforts. However, policy changes such as The Joint Commission's antibiotic stewardship accreditation standard (effective January 1, 2017) and inclusion of stewardship quality metrics in the Centers for Medicare & Medicaid Services Physician Quality Reporting System will increasingly require ED providers to engage in these efforts.[3,4,5]

ACEP is a content development partner in the Choosing Wisely campaign, an initiative by the American Board of Internal Medicine Foundation to advance the dialogue between physicians and patients to avoid unnecessary medical tests, treatments and procedures. ACEP has contributed two recommendations on avoiding the prescribing of antibiotics for uncomplicated sinusitis and uncomplicated skin and soft tissue abscesses. ACEP also contributed the Patient Resource Avoid Unnecessary Treatments in the ER which provides information for patients on the risks and costs of antibiotics.

An *ACEP Frontline* podcast from October 2016 featuring Brian Levine, MD, FACEP emphasized the importance of antibiotic stewardship and providing education to patients on the appropriateness of antibiotics for their condition. The podcast is available free on demand through the ACEP website, ACEP eCME, or iTunes.

ACEP currently offers three free CME opportunities on antibiotic stewardship through ACEP eCME: Balancing Antibiotic Stewardship with Sepsis, Uncomplicated Diverticulitis: No More Antibiotics, and Antibiotics for Abscesses. The content for the "Balancing Antibiotic Stewardship with Sepsis" CME was developed as part of ACEP's Emergency Quality Network (E-QUAL) Sepsis Initiative and is also available without need for login through the Sepsis Webinar Series webpage.

Additional educational and CME opportunities on antibiotic stewardship can be found at VirtualACEP. VirtualACEP contains recordings of presentations made at ACEP annual meetings going back to 2012. VirtualACEP currently contains 13 active CME opportunities on antibiotic stewardship recorded at the 2015, 2016, and 2017 annual meetings.

Provider and system-level information on antibiotic stewardship is embedded in ACEP's Clinical Emergency Data Registry (CEDR) 2018 Performance Measures on acute bronchitis, acute otitis externa, adult sinusitis, and sepsis management. The CEDR performance measures qualify for the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) measures and allow emergency physicians to receive credit for CMS Merit-based Incentive Payment System reporting (MIPS). CEDR also offers a quality improvement measure on the implementation of an antibiotic stewardship program, however this program is not eligible for MIPS quality reporting at this time.

ACEP endorsed the Implementing an Antibiotic Stewardship Program: Guidelines by the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America on February 4, 2016. The IDSA/SHEA guidelines were prepared by a multidisciplinary expert panel which included representation from emergency medicine.

Reference materials on antibiotic stewardship are available through the ACEP Bookstore. The 17th edition of the EMRA Antibiotic Guide is available in print through the ACEP bookstore or as an online application through iTunes and Google Play.

The CDC has released the Core Elements of Hospital Antibiotic Stewardship Programs, an evidence-based antimicrobial stewardship toolkit for hospitals and for long-term care centers.[6] An emergency department specific tool kit, based on CDC funded research and designed by emergency physicians, is anticipated to be released this year.

References

1. Van Boeckel TP, Gandra S, Ashok A, et al. Global antibiotic consumption 2000 to 2010: an analysis of national pharmaceutical sales data. *Lancet Infect Dis*. 2014;14(8):742-750.
2. United States, Department of Health and Human Services, Centers for Disease Control and Prevention. 2015 NHAMCS Emergency Department Summary Tables. Available at: www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf. Accessed March 25, 2018.
3. American College of Emergency Physicians. ACEP PQRS Quality Details: 2016 Regulatory Highlights. Available at: www.acep.org/Legislation-and-Advocacy/Federal-Issues/Quality-Issues/2016-Regulatory-Highlights/. Accessed April 7, 2016.
4. United States, Department of Health and Human Services, Centers for Medicare and Medicaid Services. 2016 Physician Quality Reporting System Measures List. Available at: www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/PQRS_2016_Measure_List_01072016.xlsx. Accessed March 26, 2018.
5. Joint Commission on Hospital Accreditation. New Antimicrobial Stewardship Standard. *Jt Comm Perspect*. 2016;36(7):1, 3-4, 8.
6. Pollack LA, Srinivasan A. Core elements of hospital antibiotic stewardship programs from the Centers for Disease Control and Prevention. *Clinical Infectious Diseases*. 2014;59 Suppl 3:S97-S100.

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 D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

Substitute Resolution 23(98) Appropriate Use of Antibiotics adopted. Directed ACEP to develop a public educational campaign on the unnecessary use of antibiotics and develop educational materials for physicians and patients on the dangers of inappropriate use of antibiotics.

Prior Board Action

Substitute Resolution 23(98) Appropriate Use of Antibiotics adopted.

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

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RESOLUTION: 39(18)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Care of the Boarded Behavioral Health Patient

PURPOSE: Drects ACEP to create a behavioral health toolkit for bedside practice.

FISCAL IMPACT: Budgeted staff, coalition, and committee resources. Additional grant funding may be needed to develop the toolkit. The initiation of mental health treatment while boarding could be costly and difficult to accomplish.

WHEREAS, The number of chronic psychiatric conditions seen in the emergency department represents a national crisis[2]; and

WHEREAS, Emergency departments have become the safety net for schools, communities, and law enforcement because of the lack of access to both inpatient and outpatient psychiatric care; and

WHEREAS, The average patient waits greater than six hours, and in most rural emergency departments this wait for inpatient treatment often exceeds 12-24 hours; and

WHEREAS, The practice of boarding psychiatric patients:

- causes stress on patients who may already be in depressed or psychotic states
- delays mental health treatment
- consumes scarce resources in the ED
- worsens crowding
- delays treatment for other emergency patients
- has a significant financial impact on ED reimbursement
- generates significant numbers of injury to emergency department staff[2]; and

WHEREAS, Current systems lead to higher rates of medication usage and worse outcomes for this patient population; and

WHEREAS, There are sparse clinical guidelines or best practices on how to care for this patient population in emergency medicine literature to improve clinical outcomes and decrease overall length of stay; therefore, be it

RESOLVED, That ACEP develop a toolkit to help physicians at the bedside address the following:

- patient handoff and frequency of evaluation while boarding;
- activities of daily living for the boarded patient; and
- initiation of mental health treatment while boarding.

References

1. The Joint Commission. 2014. Care of psychiatric patients boarded in EDs, Quick Safety, Issue 19, December 2015 (accessed June 15, 2018)
2. American College of Emergency Physicians. 2014. ACEP Member Testifies Before Congress About “National Crisis” in Regard to America’s Mental Health Patients.

Background

This resolution directs ACEP to develop a toolkit for implementation at the bedside to address psychiatric boarding. Patients with acute mental health disorders are common patients in an emergency department. In the past, many of these patients were admitted to psychiatric hospitals for diagnosis and treatment during their acute decompensation. However, over the past few decades, there has been interest in moving the treatment of patients with acute psychiatric disorders away from inpatient facilities and into the community. This has led the majority of states to decrease the number of beds available for patients with psychiatric disorders. At the same time, in many areas of the country, community care remains fragmented and difficult to access. Patients who would benefit from acute care of their condition often end up in the emergency department.

The Agency for Healthcare Research and Quality (AHRQ) estimates that about one in every eight ED visits is related to psychiatric care or substance use disorder. Studies have shown that patients with a psychiatric condition have increased odds of being in the ED for more than 24 hours and consistently wait longer in EDs compared to non-psychiatric patients. Insurance authorization allowing psychiatric patients to be admitted to the hospital from the ED can often take long amounts of time. In addition, due to low reimbursements, hospitals often have inadequate resources for psychiatric care. Funding for the care of patients with psychiatric illness is complex. Many psychiatric facilities do not fall under EMTALA and can, therefore, legally refuse admission. Most are already full and have no place for additional patients. In many states, Medicaid reimburses little or nothing for the care of inpatients between 18 and 64. Finally, many psychiatric facilities lack the ability to provide basic medical care for patients with insulin-dependent diabetes, dialysis-dependent renal failure, or pregnancy. Without the ability to care for such patients, facilities may refuse transfer even when they have the capacity.

The growing influx of patients, limited availability of treatment facilities and barriers to appropriate treatment have combined to put significate pressures on ED resources and exacerbate boarding problems. Boarding times on average are between 15-30 hours for psychiatric patients. A 2016 survey of emergency physicians conducted by ACEP revealed numerous challenges associated with psychiatric boarding.

Findings included:

- More than half of the respondents said that the mental health system in their community has worsened.
- Almost half (48%) reported psychiatric patients boarded in their ED waiting for an in-patient bed one or more times a day.
- More than half (57%) reported increases in boarding and wait times for children with psychiatric illness.
- More than 10% reported having 6-10 patients waiting for an inpatient psychiatric bed on their last shift.
- Only 16.9% reported having a psychiatrist to call to respond to psychiatric emergencies in their ED.

As a response to the mutual dissatisfaction with acute mental health care, a multidisciplinary group met in December 2014 and formed the Coalition on Psychiatric Emergencies. The Coalition includes more than 30 leaders in emergency medicine, psychiatry, and patient advocacy who are focused on improving the treatment of psychiatric emergencies for patients and emergency providers. Partners in the Coalition include the American Psychiatric Association, Depression and Bipolar Support Alliance, the Emergency Nurses Association, and the National Alliance on Mental Illness, among others. ACEP and the Emergency Medicine Foundation have been supporting the Coalition and funding provided from several pharmaceutical companies. The overarching goal of the Coalition is to bring awareness to the national challenges surrounding psychiatric emergencies in the U.S. and to work collaboratively to address these problems. The Coalition established four working groups, which have met frequently since January 2015. Their work products include a basic and advanced curriculum on emergency medicine for psychiatrists and emergency psychiatrists, a basic and advanced curriculum on emergency psychiatry for emergency physicians, bedside tools (i.e. ADEPT – which addresses agitation in the elderly) informational materials and a series of podcasts under development on best practices in the general and psychiatric EDs. The Coalition will continue to produce educational sessions, work products, tools, and other resources to improve the care of patients with psychiatric emergencies. The Coalition is holding an interactive workshop on Critical Issues in Behavioral Emergencies for Emergency Physicians on September 30, 2018, in San Diego.

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, coalition, and committee resources. Additional grant funding may be needed to develop the toolkit. The initiation of mental health treatment while boarding could be costly and difficult to accomplish

Prior Council Action

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

Amended Resolution 35(15) Emergency Department Detox Guidelines adopted. Directed ACEP to create a clinical practice guideline on detoxification of patients presenting to the ED in opioid or benzodiazepine addiction.

Amended Resolution 28(13) Support for Decriminalization of Behavioral Issues adopted. Directed ACEP to study emerging alternatives to incarceration for non-violent behavioral and mental health problems in Texas and support the delivery of mental health, psychiatric, and substance abuse treatment options as alternatives to incarceration.

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 21(12) Support of Non-Punitive Sobering Centers and Community Recovery Services adopted. Directed ACEP to explore the development of sobering centers, identify medical and professional needs for these community centers, and promulgate efforts to support the development of these entities.

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."

Resolution 28(06) Psychiatric Bed Availability adopted. Directed ACEP to study the issue of psychiatric bed availability and the impact on EMS in order to determine the scope of the problem and develop appropriate solutions.

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. Directed ACEP to support legislative efforts that grant the emergency physician authority to involuntarily hold and/or transfer psychiatric patients to an appropriate facility when medically indicated.

Prior Board Action

May 2018 and May 2017, ACEP sponsored the Hospital Flow Conference in Boston, MA. The conference focused on improving hospital efficiency, capacity, and flow and provided participants with the knowledge and tools needed to eliminate ED boarding, improve hospital capacity, enhance patient safety, shorten length of stay, and improve patient and staff satisfaction. The American Hospital Association cosponsored the 2018 conference.

June 2017, the Board approved the Quality & Patient Safety Committee's recommendation to develop a toolkit for reporting of behavioral health patients that can be implemented independently in EDs. 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," which replaced the September 2005 clinical policy "Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department." The September 2005 clinical policy replaced the October 1998 "Clinical Policy for the Initial Approach to Patients Presenting with Altered Mental Status."

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.

June 2016, reviewed the updated information paper, "Emergency Department Crowding High-Impact Solutions."

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

Amended Resolution 35(15) Emergency Department Detox Guidelines adopted.

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."

April 2014, conducted an all member poll on ED trends; the poll included questions on psychiatric patients.

Amended Resolution 28(13) Support for Decriminalization of Behavioral Issues adopted.

Substitute Resolution 22(12) Behavioral Health Patients in the Emergency Department adopted.

Amended Resolution 21(12) Support for Non-Punitive Sobering Centers and Community Recovery Services adopted.

April 2012, reaffirmed the policy statement "Pediatric Mental Health Emergencies in the Emergency Medical Services System." Originally approved April 2006.

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.

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."

In addition, the Board has approved several chapter grants that address psychiatric boarding at the state level.

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

Reviewed by: John McManus, MD, FACEP, Speaker
Gary Katz, MD, 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).

RESOLUTION: 40(18)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Care of Individuals with Autism Spectrum Disorder in the Emergency Department

PURPOSE: Develop educational materials for emergency physicians to improve treatment and management of patients with Autism Spectrum Disorder in the ED.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Autism Spectrum Disorder (ASD) is a neuro-developmental condition that causes significant impairments in communication and social interactions and difficulties with repetitive and restrictive patterns of behavior[1]; and

WHEREAS, the Centers for Disease Control reports that as of 2014, the prevalence of ASD is one in 59 births in the U.S., a prevalence that has increased overall approximately 6-15 percent each year between 2002 and 2010 and 119.4 percent among U.S.-born children between 2000 and 2010[1]; and

WHEREAS, There are approximately 3.5 million individuals in the US affected by ASD[2]; and

WHEREAS, Approximately 50,000 individuals with ASD reach adulthood each year[3]; and

WHEREAS, The emergency department is the gateway to the acute health care system in the U.S.; and

WHEREAS, Emergency department visits by adults with ASD more than doubled between 2006 and 2011 per data from the Nationwide Emergency Department Sample[4]; and

WHEREAS, Individuals with ASD have significant challenges in receiving emergency care related to their particular impairments and the emergency department environment[5-7]; and

WHEREAS, Current availability of scholastic materials and opportunities for emergency physicians to receive education on the care of the ASD population are limited and sporadic; therefore, be it

RESOLVED, That ACEP work with relevant stakeholders to develop and disseminate educational materials for emergency physicians on the common conditions that cause individuals with Autism Spectrum Disorder to present to the emergency department, their assessment and management, and best practices in adapting the existing emergency department treatment environment to meet the needs of this population.

References

1. Centers for Disease Control and Prevention. Autism Spectrum Disorder. https://www.cdc.gov/ncbddd/autism/index.html. Accessed May 7, 2018
2. Autism Society. Facts and Statistics. https://www.autism-society.org/what-is/facts-and-statistics/. Accessed May 7, 2018
3. Autism Speaks. Mounting Evidence of Critical Need for Adult Transition Support. https://www.autismspeaks.org/science/science-news/top-ten-lists/2012/mounting-evidence-critical-need-adult-transition-support. Accessed May 7, 2018
4. Vohra, R, Madhavan, S, Sambamoorthi, U. Emergency Department Use Among Adults with Autism Spectrum Disorders (ASD). *Journal of Autism and Developmental Disorders*. 2016. 46(4). 1441-1454.
5. Nicholas, D. B., Zwaigenbaum, L., Muskat, B., Craig, W. R., Newton, A. S., Cohen-Silver, J., et al. Toward practice advancement in emergency care for children with autism spectrum disorder. *Pediatrics*. 2016. 137(Suppl 2), S205–S211.

6. Lunsky, Y., Paquette-Smith, M., Weiss, J. A., Lee, J. Predictors of emergency service use in adolescents and adults with autism spectrum disorder living with family. *Emergency Medicine Journal*. 2015. 32(10), 787–792.
7. Feil, M., Wallace, S. C., & Venkat, A. Improving care for patients with autism spectrum disorder in the acute care setting. *Pennsylvania Patient Safety Advisory*. 2014. 11(4), 141–148.

Background

This resolution calls on ACEP to develop educational materials for emergency physicians on the common conditions that cause individuals with ASD to present to the emergency department, assessment and management resources to improve the quality of care provided, and collect and disseminate best practices for adapting the existing ED environment to one that meets the needs of the patients.

Most studies on ED usage by individuals with ASD have focused on the pediatric/adolescent population. Other studies have indicated that adults with ASD are more likely to use the ED than adults without ASD. Additional studies have shown that there may be some evidence of high risk for suicidality in patients with ASD, however, more research in this area is needed.

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 statement to better help physicians treat and manage children with special needs, such as those with ASD.

ACEP is a sub-recipient of a Bureau of Justice grant through the Vera Institute called "Serving Safely." This grant is targeted toward improving policing responses to individuals with autism or intellectual developmental disabilities (IDD). ACEP was brought on as a partner because of the ED's frequent role in the coordination of treatment and referral for these patients.

ACEP's eCME catalog does not include any eCME activities related to ASD. There were limited pediatric emergency medicine resources on the website in the form of pediatric quizzes.

Some EDs have developed special accommodations (e.g. providing iPads or toys, quieter waiting rooms), specific protocols, and specialized training for providers. Others have childcare workers who are skilled in the care of special needs children.

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 0 Enhance Membership Value and Member Engagement
Objective C – Provide robust communications and educational offerings, including novel delivery methods.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders not adopted. Called for ACEP to support scientific research to evaluate the risks and benefits for

cannabidiol (CBD) in children with seizure disorders. One state currently allows the use of CBD for qualifying conditions, one of which includes autism.

Prior Board Action

June 2018, approved the revised joint policy statement "Pediatric Readiness in the Emergency Department" (pending approval by the American Academy of Pediatrics and the Emergency Nurses Association before publication); revised April 2009, approved also by AAP, ENA; originally approved December 2000.

April 2012, reaffirmed the joint policy statement "Pediatric Mental Health Emergencies in the Emergency Medical Services System;" originally approved April 2006 with the American Academy of Pediatrics.

April 2010, approved the revised "Emergency Information Form for Children with Special Health Care Needs" reaffirmed October 2008 and October 2002; originally approved December 1998.

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

Reviewed by: John McManus, MD, FACEP, Speaker
Gary Katz, MD, 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).

RESOLUTION: 41(18)

SUBMITTED BY: New York Chapter

SUBJECT: Emergency Department and Emergency Physician Role in the Completion of Death Certificates

PURPOSE: Develop a policy statement addressing the roles and responsibilities of emergency physicians and hospitals for the completion of death certificates for patients who die in the ED under their care.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The declaration of death often occurs in the emergency department and is the responsibility of the emergency physician; and

WHEREAS, Patients in cardiac arrest often arrive to the emergency department without the availability of information regarding their recent past medical history; and

WHEREAS, The emergency physician often does not have a previously established doctor-patient relationship with the patient in their care; and

WHEREAS, The duration of the emergency department encounter for the resuscitation of a patient in full arrest is often not long enough to definitively establish the cause of death; and

WHEREAS, The requirement for completion of the death certificate varies between states, counties, and individual hospitals; and

WHEREAS, Emergency physicians are often being required to sign death certificates without adequate knowledge of the patient's cause of death; and

WHEREAS, ACEP does not currently have a policy regarding the emergency physician's role and responsibility for the completion of death certificates; therefore, be it

RESOLVED, That ACEP develop a policy statement addressing the emergency department and the emergency physician role and responsibility for the completion of death certificates for patients who have died in the emergency department under their care.

Background

This resolution calls for the College to develop a policy statement addressing the roles and responsibilities of emergency physicians and hospitals for the completion of death certificates for patients who die in the ED under their care.

State laws and regulations addressing the signing of the death certificate differ. According to a 2003 CDC document, Physicians' Handbook on Medical Certification of Death: "In a few States, when the attending physician (physician in charge of the patient's care for the condition that resulted in death) is not available at the time of death to certify the cause of death, another physician on duty at the hospital or other institution may pronounce the decedent legally dead; and, with the permission of the attending physician, the ''pronouncing physician'' may authorize release of the body to the funeral director. In such cases, the attending physician will certify the cause of death at a later time. In all cases,

the attending physician is responsible for certifying the cause of death. In most cases, he or she will both pronounce death and certify the cause of death. Only in the instances when the attending physician is unavailable to certify the cause of death at the time of death, and State law provides for a pronouncing physician, will a different physician pronounce death."

The issue of signing the death certificate is periodically raised on ACEP list serves. While many agree that the patient's primary care physician is in the best position to make an educated guess on the probable cause of death, in practice, this does not always happen. It is common practice for hospital staff to check the person's medical records to determine if they had an established relationship with a primary care physician (PCP) or other physician. If so, the hospital will generally ask the decedent's physician to certify the death. In reality not all patients have a PCP or the PCP may refuse because they have not seen the patient recently. If a PCP is not identified or refuses to sign then the ED physician is asked to sign. Some emergency physicians cite pressure from funeral homes, families and medical examiners to sign the death certificate and when they have no prior knowledge of the patient's medical history. Concerns about liability are also sometimes raised.

The North Carolina Medical Board addressed this issue in a 2013 newsletter article: "Regardless of the reason, delaying the completion of a death certificate or refusing to sign a death certificate creates unnecessary complications with funeral arrangements, estate proceedings, and other legal and personal matters. This makes an already difficult time for surviving family members and other loved ones even more so."

ACEP does not have a policy on the emergency physician completing the death certificate. A cursory legal review was conducted and no cases were found where legal action was taken against an emergency physician for completing a death certificate.

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 and staff resources.

Prior Council Action

None

Prior Board Action

March 2013, approved the revised policy statement "Death of a Child in the Emergency Department;" reaffirmed October 2008; originally approved February 2002.

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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 42(18)

SUBMITTED BY: Kerry Forrestal, MD, FACEP
Orlee Panitch, MD, FACEP
Maryland Chapter

SUBJECT: Expert Witness Testimony

PURPOSE: Revise ACEP's policy statement "Expert Witness Guidelines for the Specialty of Emergency Medicine" to define an expert witness as a person actively engaged in the practice of medicine during the year prior to the initiation of litigation who has the same or greater level of training in the same field as the subject of the tort for a majority of their professional time.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Patients who are pursuing a medical tort action are best served by testimony from people who are actively practicing medicine at the credentialed level, or above, of the subject of the tort, and further that the person giving expert testimony should practice in the field specific to the tort; and

WHEREAS, The outcomes of these tort actions influence the active practice of medicine both personally and systemically; and

WHEREAS, By extension, the whole of the medical system is best served by testimony given in medical tort cases if given by those actively practicing medicine at the credentialed level, or above, in the field of the subject of the tort; therefore, be it

RESOLVED, That ACEP revise the "Expert Witness Guidelines for the Specialty of Emergency Medicine" policy statement to define an expert witness as a person actively engaged in the practice of medicine during the year prior to the initiation of litigation who has the same level or greater training in the same field as the subject of the tort for a majority of their professional time.

References

1. American College of Emergency Physicians. "ACEP Recognized Certifying Bodies in Emergency Medicine" policy statement; revised June 2014. *Ann Emerg Med*. 1998;32:529.
2. American College of Emergency Physicians. "Code of Ethics for Emergency Physicians" policy statement approved June 2008. *Ann Emerg Med*. 2008;52(5):581-590.
3. American College of Emergency Physicians. Procedures for addressing charges of ethical violations and other misconduct. In: College Manual. American College of Emergency Physicians Web site. Accessed May 26, 2010.

Background

This resolution directs the College to revise the policy statement "Expert Witness Guidelines for the Specialty of Emergency Medicine" to define an expert witness as a person actively engaged in the practice of medicine during the year prior to the initiation of litigation who has the same level or greater training in the same field as the subject of the tort for a majority of their professional time.

ACEP's current policy statement "Expert Witness Guidelines for the Specialty of Emergency Medicine" was last revised and approved by the Board of Directors in June 2015. The policy was originally adopted in 1990. Regarding qualifications for an expert witness, the policy reads in part:

> "To qualify as an expert witness in the specialty of emergency medicine, a physician shall:
>
> - Be currently licensed in a state, territory, or area constituting legal jurisdiction of the United States as a doctor of medicine or osteopathic medicine;
> - Be certified by a recognized certifying body in emergency medicine;
> - Be in the active clinical practice of emergency medicine for at least three years (exclusive of training) immediately preceding the date of the occurrence giving rise to the case. A physician serving as an expert witness who is not currently engaged in the clinical practice of emergency medicine shall be considered to have met this requirement if he or she was so engaged during the three years immediately preceding the date of the occurrence giving rise to the case."

The policy then lists other guidelines that experts must abide by, including that "the expert witness should possess current experience and ongoing knowledge in the area in which he or she is asked to testify."

ACEP's "Code of Ethics for Emergency Physicians" contains a section on relationships with the legal system as an expert witness. It reiterates that ACEP believes that expert witnesses in cases involving emergency physicians should be certified by ABEM, AOBEM or, in cases involving pediatric emergency medicine, by the American Board of Pediatrics. It also states that experts should have been "actively practicing clinical emergency medicine for at least three years prior to the date of the incident under review."

The Maryland Chapter indicates that during the last state legislative session, it opposed legislation (SB 30) that would have amended state law to remove a limitation on the amount of time a health care provider can devote to working as an expert witness each year. The current statute limits experts from devoting more than 20 percent of their time annually on activities that directly involve testimony in personal injury claims. The legislation to repeal that provision passed the Senate but was ultimately defeated in the House late in the session, thanks to an intense 11th hour lobbying effort. Supporters of the bill have vowed to reintroduce the legislation next year and the chapter believes that its efforts to stop it will be bolstered by the revision to ACEP's policy as proposed in this resolution by requiring that expert witnesses spend the majority of their professional time during the previous year actively engaged in the practice of medicine.

Requirements that expert witnesses must devote a majority of their time to active practice are not unique to Maryland. For example, Ohio's expert witness statute states that a qualified expert witness must devote "three-fourths of the person's professional time to the active clinical practice of medicine or surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, or to its instruction in an accredited university."

The resolution would further amend ACEP's policy by requiring that expert witnesses have "the same level or greater training in the same field as the subject of the tort." Some state laws have similar requirements. Arizona's law on expert witness qualifications in medical malpractice actions states a licensed health professional can testify as an expert in a case involving a specialist if the expert "…specializes at the time of the occurrence that is the basis for the action in the same specialty or claimed specialty as the party against whom or on whose behalf the testimony is offered. If the party against whom or on whose behalf the testimony is offered is or claims to be a specialist who is board certified, the expert witness shall be a specialist who is board certified in that specialty or claimed specialty."

ACEP's policy statement "Reform of Tort Law" "endorses in principle federal laws, state legislation or constitutional amendments to implement tort legal reforms," including "qualifications for expert witnesses."

In 1986, the Board approved "Criteria for an Expert Witness in the Specialty of Emergency Medicine." The criteria included that an expert witness should "be in the active practice of emergency medicine for three years prior to the date of the incident." Active practice was defined as "the practice of emergency medicine on an average of 80 hours per month, at least 40 hours of which are spent in: 1. Patient care in an emergency facility as defined in the Emergency Care Guidelines; or 2. Academic emergency medicine."

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective E – Achieve meaningful liability reform at the state and federal levels.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

There have been numerous resolutions related to expert witness testimony. Only resolutions related specifically to the qualifications of expert witnesses are provided.

Amended Resolution 46(85) "Ethics of Expert Witness Testimony" adopted. The resolution called for ACEP to establish criteria that would include the requirement that only clinically active emergency physicians participate as expert witnesses in cases related to care rendered by an emergency physician.

Amended Resolution 27(85) "Malpractice Premiums and Tort Legal Reforms" adopted. The resolution called for ACEP to endorse state legislation or constitutional amendments to implement tort legal reforms including qualifications for expert witnesses.

Prior Board Action

June 2017, reaffirmed the policy statement "Reform of Tort Law;" revised and approved April 2011 and August 2009; reaffirmed policy October 1998; originally approved as Council Resolution CR027 "Reform of Tort Law" September 1985.

January 2017, approved the revised "Code of Ethics for Emergency Physicians;" revised and approved June 2016 and June 2008; revised with current title June 1997; originally approved January 1991 as "Ethics Manual."

June 2015, approved revised policy statement "Expert Witness Guidelines for the Specialty of Emergency Medicine;" revised and approved June 2010, August 2000, and September 1995; originally approved September 1990.

March 1986, adopted "Criteria for an Expert Witness in the Specialty of Emergency Medicine" in response to Council Resolution 46(85).

September 1985, Resolution 27(85) Reform of Tort Law adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy & Finance

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).

RESOLUTION: 43(18)

SUBMITTED BY: Arjun Chanmugam, MD, FACEP
Orlee Panitch, MD, FACEP

SUBJECT: Fair Remuneration in Health Care

PURPOSE: Study whether the income of certain health care workers should be based on a pre-fixed fraction of the highest income health care executives and physicians and report to the Council on whether such a policy would be beneficial.

FISCAL IMPACT: Significant unbudgeted staff resources and/or an external academic research study at an estimated cost of $50,000 – $200,000.

WHEREAS, The healthcare industry is one of the largest sectors of the U.S. economy and healthcare is predicated on the principle of providing service to others; and

WHEREAS, The cost of healthcare is steadily rising and the disparity between high income earners and low-income earners is growing; and

WHEREAS, Healthcare delivery is dependent on a team approach, involving many types of providers; therefore, be it

RESOLVED, That in order to help contain costs and improve the lives of the lowest paid health care workers, that ACEP study whether the income of the lowest paid health care workers is not to be below some pre-fixed fraction of the highest income for health care executives and physicians and to determine if such a policy would be beneficial to society and serve as an important example for other industries.

Background

This resolution directs ACEP to study whether the income of certain health care workers should be established based on a pre-fixed fraction of the highest income health care executives and physicians and provide a report to the Council on whether such a policy would be beneficial.

Average national salaries in the health care industry show a wide disparity between top-level executives and other staff. According to the Bureau of Labor Statistics (BLS), in 2014 hospital executives earned on average $386,000 compared to other hospital administrators ($237,000), emergency physicians ($326,000), general surgeons ($306,000), primary care physicians ($185,000), and staff nurses ($62,000). At the lowest salary level, home health/ nursing aides earned on average $23,000, EMTs earned $28,000, and non-clinical support staff, such as custodians, earned slightly more than federal minimum wage ($22,000).

The proposed study is inclusive of all health care workers, including non-clinical staff. Primarily focused on health care economics, the study seeks to understand the true costs of labor within the health care industry. The study should provide a detailed look at compensation of both clinical and non-clinical staff to provide emergency physicians with a better understanding of how they can work towards positive health care industry reform.

The scope of this type of research goes beyond emergency medicine and may require retaining an outside research firm.

ACEP Strategic Plan Reference

None

Fiscal Impact

Significant unbudgeted staff time and/or an external academic research study at an estimated cost of $50,000 – $200,000.

Prior Council Action

None

Prior Board Action

None

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: 44(18)

SUBMITTED BY: Social Emergency Medicine Section
Trauma & Injury Prevention Section

SUBJECT: Firearm Safety and Injury Prevention Policy Statement

PURPOSE: Revise ACEP's policy statement, "Firearm Safety and Injury Prevention" to emphasize the importance of research in firearm injury; emphasize the relationship of firearm use in suicide attempts; and include specific language clarifying that after-market modifications to firearms should be addressed in the ACEP policy.

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

WHEREAS, Firearm injury is perhaps the least well-understood of the major sources of premature mortality and morbidity in the US; and

WHEREAS, ACEP recognizes as a policy matter that firearm injury is a public health problem and have an important role in promoting injury prevention and public health; and

WHEREAS, ACEP Policy supports research and evidence-based interventions to prevent injury; therefore, be it

RESOLVED, That ACEP amend its firearm policy to emphasize the importance of research in firearm injury; clarify the range of firearm injuries that ought be subject to greater research; emphasize the role of suicide in the U.S. firearm injury landscape; and contain specific language clarifying that after-market modifications to firearms should qualify as subject to ACEP policy; and be it further

RESOLVED, That ACEP's policy statement "Firearm Safety and Injury Prevention" be amended to read:

The American College of Emergency Physicians abhors the current level of intentional and accidental firearm injuries ~~and finds that it poses a threat to the health and safety of the public.~~ **and deaths in the United States of America. We believe that firearm injuries are a public health concern, and one that is particularly relevant to us as the first physicians to treat its victims. This pertains not only to mass shootings, which often attract media attention, but also to the much larger number of persons who are injured or killed in daily incidents of interpersonal violence, and to suicidal patients who reach for a firearm. Above all, we support research into firearm violence and strive to promote policy that is evidence-based.**

ACEP supports legislative, regulatory, and public health efforts that:

- Encourage ~~the change of societal norms that glorify a culture of violence to one of social civility;~~ **research into the societal norms that contribute to violence, including media that glorify violence;**

- **Eliminate real and implied legal and financial barriers to research into firearm safety and violence prevention in the public and private arena. Encourage private funding for firearm safety and injury prevention research as a complement to public funding but not a replacement for it;**

- Investigate the effect ~~of socioeconomic and other cultural risk factors on firearm injury and provide public and private funding for firearm safety and injury prevention research;~~ **of the social determinants of health on patterns of firearm injury, such as the influence of poverty, the relationship between communities and law enforcement, and the role of firearms in intimate partner violence;**

- Create a confidential national firearm injury research registry while encouraging states to establish a uniform approach to tracking and recording **all U.S.** firearm related injuries, **regardless of the circumstances leading to the event, including personal defense, officer-involved, and line-of-duty injuries among law enforcement and EMS personnel;**

- Promote access to effective, affordable, and sustainable mental health services **for our patients, such that suicidal patients with access to firearms would have timely mental health intervention;**

- ~~Protect the duty of physicians and encourage health care provider discussions with patients on firearm safety;~~ **Recognizing that guns have the highest suicide case fatality rate, protect the duty of physicians to discuss firearm safety with patients, with particular emphasis on lethal means counseling in patients with suicidal ideation;**

- Promote **research in, and** the development of technology that increases firearm safety;

- Support universal background checks for firearm transactions **and transfers**;

- Require the enforcement of existing laws and support new legislation that prevents high risk and prohibited individuals from obtaining firearms by any means;

- Restrict the sale and ownership of weapons, munitions, and large capacity magazines that are designed for military or law enforcement use, **as well as after-market modifications that increase the lethality of otherwise legal weapons.**

Background

This resolution calls for ACEP to revise the current policy statement "Firearm Safety and Injury Prevention." Specific revisions requested include an emphasis on the importance of research in firearm injury, the relationship of firearm use in suicide attempts, and include additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons.

Note: Resolution 46(18) Support for Extreme Risk Protection Orders to Minimize Harm also calls for amending ACEP's current policy statement "Firearm Safety and Injury Prevention."

The College has addressed firearms multiple times over the years through Council resolutions (23 resolutions since 1983) and policy statements. A task force of diverse opinions was appointed in February 2013 to review ACEP's policy statement on firearms and their work resulted in the current "Firearm Safety and Injury Prevention" policy statement. ACEP policies are reviewed on a 5 to 7-year cycle. Committees and sections are assigned specific policies for review and recommendations are then made to the Board to revise, rescind, or sunset the policy statement. The current "Firearm Safety and Injury Prevention" policy statement has been assigned as part of the Policy Sunset Review process to the Public Health & Injury Prevention Committee (PHIPC) for the 2018-19 committee year.

ACEP recently distributed an all-member survey and three of the survey questions concern 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 with 3,415 responses as of August 6, 2018. The survey has not yet closed at the time of this writing. Currently, 69% of the respondents support the current ACEP policy statement with 21.2 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.9% of the respondents and not supported by 25.2%. 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 and advocating for change consistent with the College's policies, 62.5% were in support of making public statements while 28.2% did not support such action.

During the 2017-18 committee year, the PHIPC compiled resources on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs, and listings of community-based firearm violence prevention programs by state. ACEP has 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.

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 and staff resources for development and distribution of policy statements.

Prior Council Action

Resolution 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for the funding of research on firearm injury prevention and to work with the AMA and other medical societies in achieving this 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. Directed the College to condemn the recent massacres in Aurora, CO and WI and firearm violence and states its commitment against gun violence including advocating for public and private funding to study firearm violence prevention.

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. Calls for collaborate with other medical specialty organizations on firearms issues, adopted.

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

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 the EM-PRN) to perform firearm research

June 2014, 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 ACEP's Emergency Medicine Practice Research Network (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.

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.

Resolution 27(13) Studying Firearm Injuries adopted.

June 2013, reaffirmed the policy statement "Violence-Free Society;" revised and approved January 2007, reaffirmed October 2000; originally approved January 1996.

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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 45(18)

SUBMITTED BY: California Chapter
Social Emergency Medicine Section
Trauma & Injury Prevention Section

SUBJECT: Support for Extreme Risk Protection Orders to Minimize Harm

PURPOSE: Amend the "Firearm Safety and Injury Prevention" policy statement to support extreme risk protection orders (ERPOs); support ERPO legislation at the federal level; promote and assist state ACEP chapters to enact ERPOs by creating a toolkit and other appropriate resources to provide to chapters; and encourage and support research of the effectiveness and ramifications of ERPOs and Gun Violence Restraining Orders (GVROs).

FISCAL IMPACT: Budgeted committee, staff and consultant resources to advocate for ERPO legislation at federal and state levels and assist state chapters in advocacy efforts; staff and consultant time to develop toolkit to assist states; potential resources to support/encourage research efforts.

WHEREAS, Emergency physicians regularly treat patients with firearm injury and conduct risk assessments of patients at risk of perpetrating firearm violence; and

WHEREAS, Emergency physicians and ACEP recognize that firearm injury is a public health problem and have an important role in promoting injury-prevention and public health; and

WHEREAS, ACEP's policy statement "Firearm Safety and Injury Prevention" supports research and evidence-based interventions to prevent injury; and

WHEREAS, ACEP's policy statement "Firearm Safety and Injury Prevention" supports legislative, regulatory, and public health efforts to prevent high-risk individuals from obtaining firearms; and

WHEREAS, Red flag laws such as Extreme Risk Protection Orders (ERPO) and Gun Violence Restraining Orders (GVRO) have shown to reduce the risk of firearm injury; and

WHEREAS, ERPO and GVRO utilize existing databases and reporting mechanisms to prevent firearm acquisition throughout the duration of their enforcement; and

WHEREAS, ERPO and GVRO also include mechanisms for legal due process and counsel, restoration of firearm ownership, and penalties for those who misuse these orders; and

WHEREAS, Six states have enacted red flag laws, ERPO and GVRO; and

WHEREAS, Six states have passed gun violence restraining orders and several others are considering similar legislation; therefore, be it:

RESOLVED, That ACEP amend its "Firearm Safety and Injury Prevention" policy statement to support extreme risk protection orders; and be it further

RESOLVED, That ACEP support extreme risk protection orders legislation at the national level; and be it further.

RESOLVED, That ACEP promote and assist state chapters in the passage of state legislation to enact extreme risk protection orders by creating a toolkit and other appropriate resources to disseminate to state chapters; and be it further

RESOLVED, That ACEP encourage and support research of the effectiveness and ramifications of extreme risk protection orders (ERPO) and Gun Violence Restraining Orders (GVRO).

Background

The resolution calls for ACEP to amend its "Firearm Safety and Injury Prevention" policy statement to support extreme risk protection orders (ERPOs), support ERPO legislation at the federal level, promote and assist state ACEP chapters to enact ERPOs by creating a toolkit and other appropriate resources to provide to chapters, and encourage and support research of the effectiveness and ramifications of ERPOs and Gun Violence Restraining Orders (GVROs).

Note: Resolution 45(18) Firearm Safety and Injury Prevention Policy Statement also calls for amending ACEP's current policy statement "Firearm Safety and Injury Prevention."

As of August 2018, thirteen states now have some version of a "red flag" law that allows law enforcement or family members to seek a legal protective order to temporarily remove firearms from an individual who may be a danger to themselves or others.[1] Terminology varies by state, as red flag laws can also be known as Extreme Risk Protection Orders (ERPOs), Gun Violence Restraining Orders (GVROs), risk warrants, etc., though their purposes are generally the same.

Subjects of an ERPO may have firearms removed by law enforcement, or may be required to surrender firearms, and are prohibited from purchasing firearms until an expedited hearing is held to determine the necessity of the order – usually within a few days or potentially a few weeks. If a court determines the ERPO to be necessary, the order can be extended for several months or in some cases, up to one year. The subject of the order can seek to terminate the order prior to its expiration by providing evidence to the court that they are not a significant danger. Petitioners can also seek to extend an ERPO via written request (requiring another hearing).

ERPO laws have become more popular policy options in recent months, particularly in response to the mass shooting at Stoneman Douglas High School in Parkland, FL, in February 2018. Prior to 2018, only five states had ERPO laws in place: California, Connecticut, Indiana, Oregon, and Washington. So far this year, eight additional states have enacted ERPOs: Delaware, Florida, Illinois, Maryland, Massachusetts, New Jersey, Rhode Island, and Vermont.

Proponents of ERPOs argue that these orders give families and law enforcement necessary and reasonable tools to prevent self-harm or harm to others before it is too late. There is also evidence that ERPOs are effective in reducing suicides: one 2018 study showed a 7.5 percent reduction in firearm suicides over a ten-year period in Indiana, and a 13.7 percent reduction in firearm suicides in Connecticut.[2] Another study of Connecticut's law suggests that one suicide is averted for every ten to eleven firearms seizures.[3]

Opponents of ERPOs cite concerns with infringing upon constitutional due process rights for individuals who are the subject of the order, as well as violations of Second Amendment rights, arguing that subjects of an ERPO are presumed guilty until proven innocent. Opponents also argue that there are questions about what kinds of actions are sufficient to issue an ERPO and that judges or courts may be overzealous in issuing these orders. Under Indiana law, for example, police officers may determine whether or not an individual is a danger to themselves or others and can confiscate an individual's firearms without a warrant, though a hearing with a judge must be scheduled within days to

[1] https://www.thetrace.org/2018/03/red-flag-laws-pending-bills-tracker-nra/
[2] https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700250?utm_source=TrendMD&utm_medium=cpc&utm_campaign=Craig_Bryan_TrendMD_0&
[3] https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=4830&context=lcp

determine the legitimacy of the red flag.

While many firearms-related policies tend to be polarizing, ERPOs generally receive bipartisan support[4]. Notably, in a public statement issued on YouTube on March 14, 2018, Chris Cox, Executive Director for the National Rifle Association (NRA) Institute for Legislative Action, reversed course on the NRA's opposition to ERPO laws, saying that Congress "should provide funding for states to adopt risk protection orders." Cox added, "To be effective and constitutional, they should have strong due process protections and require that the person get treatment." [5] The Trump Administration has also publicly supported ERPO laws by encouraging all states to adopt such laws as part of the Administration's school safety initiative announced in March 2018.[6]

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, staff, and consultant resources to advocate for ERPO legislation at federal and state levels and assist state chapters in advocacy efforts; staff and consultant time to develop toolkit to assist states; potential resources to support/encourage research efforts.

Prior Council Action

The Council has debated and adopted many resolutions related to firearms. The resolutions listed below are related to ACEP's efforts on firearms-related injury prevention with respect to limitations on possession of firearms or ammunition.

Resolution 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for the funding of research on firearm injury prevention and to work with the AMA and other medical societies in achieving this 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. Directed the College to condemn the recent massacres in Aurora, CO and WI and firearm violence and states its commitment against gun violence including advocating for public and private funding to study firearm violence prevention.

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 22(96) National Center for Injury Prevention and Control adopted. Calls for support for continued funding for Injury Prevention and Control in the CDC, in which firearms research was included.

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[4] https://www.washingtonpost.com/news/the-fix/wp/2018/04/20/has-parkland-changed-americans-views-on-guns/?noredirect=on&utm_term=.f300e0f2a235
[5] https://www.youtube.com/watch?v=7sNiklO506A
[6] https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-taking-immediate-actions-secure-schools/

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. Directed ACEP to support 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.

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 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 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

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.

Resolution 27(13) Studying Firearm Injuries 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.

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 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.

Substitute Resolution 45(94) Firearm Possession adopted.

Substitute Resolution 44(94) Firearm Legislation 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 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: 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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 46(18)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Law Enforcement Information Gathering in the ED Policy Statement

PURPOSE: Revise the policy statement "Law Enforcement Information Gathering in the Emergency Department" to provide clarification and guidance on the ethical and legal obligations for searches, with or without a warrant, in investigations involving DUI.

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

WHEREAS, Emergency Department personnel are obligated to protect patient confidentiality under HIPAA regulations; and

WHEREAS, All states have enacted versions of so called "implied consent" laws where a motorist is "deemed to have given consent" to chemical testing to determine whether he or she is driving under the influence of alcohol or a controlled substance ("DUI"), provided that a police officer first develops "reasonable grounds" to suspect such impairment (http://www.impliedconsent.org/impliedconsentlaws.html); and

WHEREAS, Pennsylvania Statutes Title 75 Pa.C.S.A. Vehicles § 3755. "Reports by emergency room personnel further" requires emergency department personnel (without police request) to draw blood for testing for alcohol and controlled substances if probable cause exists to believe any patient under their care was driving under the influence of alcohol or a controlled substance even if no warrant exists for drawing blood for this testing; and

WHEREAS, This statute applies to any occupant of the vehicle as well; and

WHEREAS, The results of these studies will be in the patient's medical record that can be discovered through due process of law without the patient's consent; and

WHEREAS, This statute further states that no physician, nurse, or technician, or hospital employing such physician, nurse, or technician, and no other employer of such physician, nurse, or technician can refuse to draw or order testing for alcohol and controlled substances; and

WHEREAS, In Myers v Commonwealth of Pennsylvania (July 2017) the Supreme Court of Pennsylvania ruled that when a motorist drives on a road in Pennsylvania, the motorist is "deemed to have given consent" to chemical testing to determine whether he or she is driving under the influence of alcohol or a controlled substance ("DUI"), provided that a police officer first develops "reasonable grounds" to suspect such impairment, but nonetheless, also ruled that this "implied consent" statute in addition grants DUI arrestees the right to refuse chemical testing with consequences, however when an unconscious state prevents DUI suspects from consenting or refusing chemical testing, search warrants must be obtained; and

WHEREAS, Other states' implied consent or warrantless search laws, such as Utah Code § 41-6a-520, have resulted in law enforcement confrontation with health care providers including arrest of a nurse who refused to comply with a warrantless blood draw (Nurse Alex Wubbels, Salt Lake City Utah, 2017); and

WHEREAS, In Birchfield v. North Dakota (combined with cases of Beylund v. Levi and Bernard v. Minnesota June 2016), the Supreme Court of the United States held that the search-incident-to-arrest doctrine permits law enforcement to conduct warrantless breath tests but not blood tests on suspected drunk drivers; and

WHEREAS, In Missouri v McNeely (April 2013), the Supreme Court of the United States held that in drunk-driving investigations, the natural dissipation of alcohol in the bloodstream does not constitute an exigency in every case sufficient to justify conducting a blood test without a warrant; therefore, be it

RESOLVED, That ACEP revise the policy statement "Law Enforcement Information Gathering in the Emergency Department" to take into account the recent relevant court decisions regarding consent for searches with or without a warrant in investigations of driving under the influence to provide clarification and guidance to emergency physicians on their ethical and legal obligations on this issue.

Background

This resolution requests that ACEP expand the "Law Enforcement Information Gathering in the Emergency Department" policy statement to provide clarification and guidance on the ethical and legal obligations for searches, with or without a warrant, in investigations of driving under the influence.

The Fourth Amendment to the United States Constitution provides in relevant part that "[t]he right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause…" A search that involves an "invasion of bodily integrity implicates an individual's 'most personal and deep-rooted expectations of privacy.'"[1] This expectation of privacy, the needs of law enforcement, and the duty of a physician to honor a patient's wishes regarding his/her own body, come into conflict in situations in which a court orders a physician to collect evidence from a patient who has refused to consent to such a search or treatment.

All states have their own version of implied consent laws when determining what tests are or are not permitted when law enforcement officers suspect drivers of driving under the influence. Drivers may be requested to submit to chemical tests of their breath, blood, or urine to determine alcohol or drug content. Emergency department personnel are obligated to protect patient confidential information and comply with HIPAA.

In the face of such requests, emergency physicians also weigh the moral and ethical obligations they have to the patient. ACEP's "Code of Ethics for Emergency Physicians" provides, in part, that "Emergency Physicians Shall:

- Embrace patient welfare as their primary professional responsibility.
- Respect the rights and strive to protect the best interests of their patients, particularly the most vulnerable and those unable to make treatment choices due to diminished decision-making capacity.
- Communicate truthfully with patients and secure their informed consent for treatment, unless the urgency of the patient's condition demands an immediate response.
- Respect patient privacy and disclose confidential information only with the consent of the patient or when required by an overriding duty such as the duty to protect others or to obey the law."[2]

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
Objective D – Promote quality and patient safety, including development and validation of quality measures.

Fiscal Impact

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

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[1] *Missouri v. McNeely*, 133 S.Ct. 1552, 1557, 185 L.Ed.2d 696 (2013) (quoting *Winston v. Lee*, 470 U.S. 753, 760, 105 S.Ct. 1611, 84 L.Ed.2d 662 (1985))
[2] American College of Emergency Physicians, Principles of Ethics 1,3,4, and 5, *Code of Ethics for Emergency Physicians* (2016)

Prior Council Action

Resolution 22(16) Court Ordered Forensic Evidence Collection in the ED adopted. Directed ACEP to study the ethical and moral implications for emergency physicians acting in compliance with court orders requiring collection of evidence from a patient in the absence of consent and develop a policy statement addressing the issue.

Amended Resolution 20(97) Permissive Reporting of Blood Alcohol Content (BAC) to Law Enforcement Authorities adopted. Directed the BAC Reporting Task Force to develop a position paper, policy, and/or PREP.

Prior Board Action

June 2017, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" originally approved September 2003.

January 2017, reaffirmed the policy statement "Physician Reporting of Potentially Impaired Drivers;" originally approved April 2011.

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 titled "Ethics Manual" January 1991.

Resolution 22(16) Court Ordered Forensic Evidence Collection in the ED adopted.

Resolution 20(97) Permissive Reporting of Blood Alcohol Content (BAC) to Law Enforcement Authorities adopted.

Background Information Prepared by: Leslie P. Moore, JD
General Counsel

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: 47(18)

SUBMITTED BY: Pain Management & Addiction Medicine Section
Social Emergency Medicine Section
California Chapter
Washington Chapter

SUBJECT: Supporting Medication for Opioid Use Disorder

PURPOSE: Support the expansion of outpatient opioid treatment programs and partnership with addiction medicine specialists to improve ED to outpatient care transitions.

FISCAL IMPACT: Budgeted committee, section, and staff resources.

WHEREAS, Deaths from opioid overdose continue to increase, causing the Department of Health and Human Services (HHS) to declare the opioid crisis a public health emergency in 2017; and

WHEREAS, Opioid-related ED visits also continue to rise, increasing 109% over 10 years for patients age 25-44, with over 140,000 annual emergency department visits for opioid overdose[1]; and

WHEREAS, Access to treatment for opioid use disorder is limited, and is particularly challenging to access for some patient groups such as rural and low-income patients[2]; and

WHEREAS, There is a substantial body of evidence demonstrating that medication for opioid use disorder improves patient outcomes including reductions in mortality; and

WHEREAS, ED-initiated medication for opioid use disorder results in higher uptake of treatment for opioid use disorder than referral to treatment without starting medication[3-4]; and

WHEREAS, The current regulations that mandate all physicians obtain a Drug Enforcement Administration X License, requiring 8 hours of training, before being allowed to prescribe opioid-based addiction treatment medications presents another barrier to providing care; therefore, be it

RESOLVED, That ACEP promotes the use of medication for opioid use disorder, where clinically appropriate, for emergency department patients with opioid use disorder; and be it further

RESOLVED, That ACEP works with the Pain Management & Addiction Medicine section to develop a clinical policy on the initiation of medication for opioid use disorder for emergency department patients; and be it further

RESOLVED, That ACEP advocates for policy changes that lower the regulatory barriers to initiating medication for opioid use disorder in the emergency department; and be it further

RESOLVED, That until barriers to initiating medication for opioid use disorder in the emergency department are lowered, ACEP partners with the Substance Abuse and Mental Health Services Administration (SAMSHA) to create training that fulfills the existing requirement for 8-hour buprenorphine training while being more relevant to the emergency department context; and be it further

RESOLVED, That ACEP supports the expansion of outpatient opioid treatment programs and partnership with addiction medicine specialists to improve ED to outpatient care transitions.

References

1. Vivolo-Kantor AM, Seth P, Gladden RM, et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses - United States, July 2016-September 2017. *MMWR Morb Mortal Wkly Rep.* 2018;67(9):279-285.
2. Kampman K, Jarvis M. American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. J Addict Med. 2015;9:358-367.
3. D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA. 2015;313:1636-1644.
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Background

This resolution supports the expansion of outpatient opioid treatment programs and partnership with addiction medicine specialists to improve ED to outpatient care transitions

The scope of this resolution is similar to Resolution 25(18) and Resolution 26(18); therefore, the content of the background information is similar for all three 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. 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 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. Perhaps, most importantly Gail D'Onofrio and her research group at the 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 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.

The ACEP 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. As a college, ACEP should both promote its use and work to lessen the regulatory barriers stopping it from being widely adopted. This resolution aims to be the first step in that process.

Numerous ACEP chapters have worked to address the opioid prescribing issue in their states. For example, the Washington and Oregon chapters, working with other organizations within their states, have developed statewide ED opioid prescribing guidelines. The Florida College of Emergency Physicians has developed guidelines about chronic nonmalignant pain management in the ED that have been adopted at numerous hospitals in Florida. The Ohio chapter provided input into the Opioids and Other Controlled Substances Prescribing Guidelines for Ohio and endorsed the guidelines. The Kentucky chapter developed an informational guidance document on narcotics and sedatives usage in

the ED for use in Kentucky.

ACEP has been awarded two federal grants to help support the efforts in response to the opioid crisis. These are the Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response (STR) Technical Assistance (TA) Grant and the Providers Clinical Support System (PCSS) grant. Through the SAMSHA-STR grant ACEP has conducted an Emergency Medicine Practice Research Network survey on Buprenorphine practice, awareness around the 3-day rule and MAT Waiver training and will be providing educational training sessions at various ACEP Chapter meetings around the waiver training and 3-day rule. Also, through this grant and the STR-TA Consortium ACEP is identifying local resources and members to serve as subject matter experts and provide education on various opioid related topics, including podcasts and webinars. As part of the PCSS grant, ACEP is working to identify local resources for education and awareness and moving forward ACEP will be hosting MAT Waiver training sessions. The first session will occur Sunday, September 20, 2018, in San Diego, CA.

ACEP also recently launched the ACEP E-QUAL Network Opioid Initiative, The Opioid Management Learning Collaborative, with the aim to collaborate on opioid-focused interventions, develop a best-practice toolkit, collect data on quality, assess the state of ED and hospital care, study the effectiveness of engaging EDs in quality improvement and help EDs implement alternatives to opioids (ALTO), improve opioid prescribing, and adopt harm reduction strategies such as naloxone prescribing and medication assisted therapies. Also, in June 2018, ACEP issued a press release Emergency Departments Help Close Gaps in Opioid Abuse and Addiction Treatment.

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.
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

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

February 2018, revised and approved the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment;" originally approved October 2012.

April 2017, revised and approved the 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."

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, revised and approved the 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 *Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department*.

Background Information Prepared by: 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 2018 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 48(18)

SUBMITTED BY: Emergency Medicine Informatics Section

SUBJECT: Surreptitious Recording in the Emergency Department

PURPOSE: Requests ACEP to explore implications, solutions and education/training to address surreptitious recording in the ED and ACEP work with other stakeholders to coordinate regulatory and legislative efforts to address the implications of surreptitious recording in the ED.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Technology can be used for both good and ill; and

WHEREAS, Smartphones readily enable surreptitious audio/video recording in the Emergency Department and other healthcare settings, without proper consent and often in violation of hospital policy[1,2]; and

WHEREAS, ACEP's current policy statement "Recording Devices in the Emergency Department"[3] does not specifically address patient/family use of such devices, nor does it outline implications, solutions, and necessary education/training to address this use (for example, if a patient or family member refuses to comply with hospital policy, what appropriate actions can be taken, including EMTALA considerations?); and

WHEREAS, Other medical organizations (e.g., the American Medical Association) may have relevant polices and informational documents to assist in expanding ACEP's approach to this important issue, as well as coordinate relevant regulatory/legislative efforts; and

WHEREAS, Recent surveys[1] and incidents[4] have garnered national attention to this issue; therefore, be it

RESOLVED, That ACEP explore implications, solutions, and education/training to address surreptitious (audio/video) recording in the emergency department; and be it further

RESOLVED, That ACEP work with other interested parties, such as the American Medical Association and American Hospital Association, to coordinate regulatory and legislative efforts to address the implications of surreptitious (audio/video) recording in the emergency department.

References

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3. https://www.acep.org/patient-care/policy-statements/recording-devices-in-the-emergency-department/#sm.00018qx8kj13scf5npgep1ufqo94t
4. https://www.msn.com/en-us/news/us/emergency-room-doctor-suspended-after-being-caught-on-video-mocking-patient-suffering-anxiety-attack-are-you-dead-sir/ar-AAyPghw?ocid=spartandhp

Background

The resolution requests that ACEP explore implications, solutions and education/training to address surreptitious

recording in the emergency department and work with other stakeholders, such as the American Medical Association (AMA) and the American Hospital Association (AHA) to coordinate regulatory and legislative efforts to address the implications of surreptitious recording in the ED.

With the availability of smartphone technology, patients have more opportunities to create recordings in the ED and other healthcare settings. There are many reasons patients may do so, including for manipulative reasons. Recording physician encounters can also be helpful to patients, particularly elderly patients or those undergoing treatment for life-threatening or chronic diseases who may forget the information provided by the physician. Patients who record interactions with physicians and other hospital staff risk violating the privacy rights of other patients and create concerns regarding violation of laws in certain states regarding two-party consent prior to any video recording.

ACEP has provided brief education/training to address surreptitious recordings in the emergency department at prior Emergency Department Directors Academy (EDDA) programs and should consider providing additional education/training at *Scientific Assembly*, as well as within print materials.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
Objective D – Promote quality and patient safety, including development and validation of quality measures.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 30(15) Use of Body Cameras Worn by Law Enforcement in the Emergency Department referred to the Board of Directors.

Amended Substitute Resolution 28(01) Filming in the Emergency Department referred to the Board of Directors. The resolution called for ACEP to discourage the filming of television programs in EDs except when patients and staff members can give fully informed consent prior to their participation.

Prior Board Action

January 2017, approved the revised policy statement "Recording Devices in the Emergency Department" (in response to Referred Resolution 30(15) Use of Body Cameras Worn by Law Enforcement in the Emergency Department); originally approved April 2011.

June 2015, approved the revised policy statement "Commercial Filming of Patients in the Emergency Department;" revised and approved February 2009; originally approved February 2002 with the title "Filming in the Emergency Department" (in response to Referred Amended Substitute Resolution 28(01) Filming in the Emergency Department).

November 2015, assigned Referred Resolution 30(15) Use of Body Cameras Worn by Law Enforcement in the Emergency Department to the Ethics Committee.

Background Information Prepared by: Leslie P. Moore, JD
General Counsel

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).

Late Resolution

RESOLUTION: 49(18)

SUBMITTED BY: New York Chapter
Pennsylvania Chapter

SUBJECT: In Memory of C. Christopher King, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a compassionate physician, dedicated educator, mentor, researcher, and colleague in C. Christopher King, MD, FACEP, who passed away on March 26, 2018, at the age of 58; and

WHEREAS, Dr. King served as the Chair of Emergency Medicine at Albany Medical College where he was instrumental in creating the region's only dedicated pediatric emergency department; and

WHEREAS, Dr. King previously served as a faculty member in the department of adult and pediatric emergency medicine at the Children's Hospital of Philadelphia, St. Christopher's Hospital for Children, UPMC, and The Children's Hospital of UPMC; and

WHEREAS, Dr. King wrote and lectured extensively on pediatric airway management; and

WHEREAS, Dr. King performed significant research in adult and pediatric traumatic brain injury; and

WHEREAS, Dr. King trained hundreds of emergency medicine residents and pediatric emergency medicine fellows; and

WHEREAS, Dr. King touched the lives of countless individuals as an educator, physician, role model, mentor, colleague, pioneer, friend, and devoted husband and father; and

WHEREAS, Dr. King shaped the future of emergency medicine in Pennsylvania and New York with his leadership, vision, enthusiasm, and dedication; therefore, be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by C. Christopher King, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of C. Christopher King MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine, and to the patients and physicians of Pennsylvania, New York, and the United States.

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).

RESOLUTION: 50(18)

SUBMITTED BY: Alabama Chapter
Arizona Chapter
California Chapter
Florida College of Emergency Physicians
Illinois College of Emergency Physicians
Missouri College of Emergency Physicians
New York Chapter
Ohio Chapter
Texas College of Emergency Physicians
West Virginia College of Emergency Physicians

SUBJECT: In Memory of John Emory Campbell, MD, FACEP

WHEREAS, Emergency Medicine lost a passionate leader, teacher, and visionary when John Emory Campbell, MD, FACEP, passed away on August 29, 2018, at the age of 75; and

WHEREAS, Dr. Campbell dedicated his life and career to the improvement of emergency medicine and emergency medical services in the State of Alabama and around the world; and

WHEREAS, Dr. Campbell distinguished himself by serving as the State of Alabama EMS Medical Director for 23 years, and through his efforts, assisted in creating one of the best EMS systems in the country; and

WHEREAS, Dr. Campbell was known worldwide for his groundbreaking work in developing prehospital trauma education and founding the Basic Trauma Life Support (BTLS) (now International Trauma Life Support) program in 1982, the first course and curriculum dedicated to prehospital trauma assessment and trauma care; and

WHEREAS, ITLS is now a worldwide organization offering 15 types of trauma courses and teaching more than 30,000 students annually in more than 40 countries across the globe, and Dr. Campbell's work has touched more than 750,000 trauma care providers worldwide and the millions of patients they care for; and

WHEREAS, Dr. Campbell authored eight editions of the ITLS textbook, which is now a legacy publication in its 36th year of circulation with 14 international translations; and

WHEREAS, Dr. Campbell's humble servant leadership earned the respect and admiration of all who worked with him locally, nationally, and internationally as he aimed tirelessly to better prehospital emergency care; and

WHEREAS, Dr. Campbell leaves behind a legacy of unfailing dedication and excellence in trauma care, and will be missed by the thousands of students, instructors, colleagues and friends whose lives he touched, personally and professionally, through the reach of ITLS training and education; therefore, be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by John Emory Campbell MD, FACEP, as one of the leaders in Emergency Medicine and a pioneer of prehospital trauma education; and be it further

RESOLVED, That the American College of Emergency Physicians extends its condolences to Dr. Campbell's family, friends, and colleagues for his tremendous service to Emergency Medicine and Emergency Medical Services.

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).

RESOLUTION: 51(18)

SUBMITTED BY: Rhode Island Chapter

SUBJECT: In Memory of Adib Mechrefe, MD, FACEP

WHEREAS, The specialty of emergency medicine and the Rhode Island Chapter of the American College of Emergency Physicians (RI ACEP) lost a staunch advocate, compassionate physician, dedicated educator, and dear friend and colleague in Adib Mechrefe, MD, FACEP, who passed away on July 30, 2018, at the age of 76; and

WHEREAS, Dr. Mechrefe was lucky to be surrounded by his loving family and was the beloved husband of Mary (Freij) Mechrefe; and

WHEREAS, Dr. Mechrefe was born in Damascus, Syria, a son of the late Mtarios and Wahebah Mechrefe, and had lived in Lincoln, Rhode Island for the past 42 years; and

WHEREAS, Dr. Mechrefe devoted his life to taking care of others and was a general surgeon and emergency medicine specialist who owned Garden City Treatment Center in Cranston, the only privately-owned emergency department licensed by the RI Department of Health, since 1986; and

WHEREAS, Over his extensive 49-year medical career, Dr. Mechrefe was responsible for treating more than one million patients and was well-loved by all those he encountered in his medical community; and

WHEREAS, Besides his beloved wife, he is survived by his loving children Anthony Mechrefe, MD, and his wife Etienne; Tanya Gaudioso and her husband Janathan; and Tara Cavanagh and her husband Robert; all his dear grandchildren including Yasmine, Lillia, Anthony, Jordan, Samara, Jack, Charles, Henry, and Vivian; and

WHEREAS, Dr. Mechrefe touched the lives of countless individuals as a physician, role model, mentor, colleague, consultant, friend, and devoted father and husband; therefore, be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Adib Mechrefe, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife, Mary (Freij) Mechrefe, his family, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine and to the patients and physicians of Rhode Island and the United States.