American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

COUNCIL MEETING

September 29-30, 2018

Manchester Grand Hyatt Hotel
San Diego, CA

acep Scientific Assembly SAN DIEGO, CA 18

ACEP 50 YEARS

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved June 2013

Antitrust

Reaffirmed by the ACEP Board of Directors June 2013, October 2007

Revised and approved by the ACEP Board of Directors October 2001

Revised and approved by the ACEP Board of Directors June 1996

Approved by the ACEP Board of Directors April 1994

The American College of Emergency Physicians is a national not-for-profit professional organization that exists to support quality emergency medical care and to promote the interest of emergency physicians. The College is not organized to and may not play any role in the competitive decisions of its members or their employees, nor in any way restrict competition among members or potential members. Rather it serves as a forum for a free and open discussion of diverse opinions without in any way attempting to encourage or sanction any particular business practice.

The College provides a forum for exchange of ideas in a variety of settings including its annual meeting, educational programs, committee meetings, and Board meetings. The Board of Directors of the College recognizes the possibility that the College and its activities could be viewed by some as an opportunity for anti-competitive conduct. Therefore, the Board is promulgating this policy statement to clearly and unequivocally support the policy of competition served by the antitrust laws and to communicate the College's uncompromising policy to comply strictly in all respects with those laws.

While recognizing the importance of the principle of competition served by the antitrust laws, the College also recognizes the severity of the potential penalties that might be imposed on not only the College but its members as well in the event that certain conduct is found to violate the antitrust laws. Should the College or its members be involved in any violation of federal/state antitrust laws, such violation can involve both civil as well as criminal penalties that may include imprisonment for up to 3 years as well as fines up to $350,000 for individuals and up to $10,000,000 for the College plus attorney fees. In addition, damage claims awarded to private parties in a civil suit are tripled for antitrust violations. Given the severity of such penalties, the Board intends to take all necessary and proper measures to ensure that violations of the antitrust laws do not occur.

In order to ensure that the College and its members comply with the antitrust laws, the following principles will be observed:

- The American College of Emergency Physicians or any committee, section, chapter, or activity of the College shall not be used for the purpose of bringing about or attempting to bring about any understanding or agreement, written or oral, formal or informal, expressed or implied, among two or more members or other competitors with regard to prices or terms and conditions of contracts for services or products. Therefore, discussions and exchanges of information about such topics will not be permitted at College meetings or other activities.
- There will be no discussions discouraging or withholding patronage or services from, or encouraging exclusive dealing with any health care provider or group of health care providers, any supplier or purchaser or group of suppliers or purchasers of health care products or services, any actual or potential competitor or group of actual potential competitors, any patients or group of patients, or any private or governmental reimburser.
- There will be no discussions about allocating or dividing geographic or service markets, customers, or patients.
- There will be no discussions about restricting, limiting, prohibiting, or sanctioning advertising or solicitation that is not false, misleading, deceptive, or directly competitive with College products or services.
- There will be no discussions about discouraging entry into or competition in any segment of the health care market.
- There will be no discussions about whether the practices of any member, actual or potential competitor, or other person are unethical or anti-competitive, unless the discussions or complaints follow the prescribed due process provisions of the College's bylaws.
- Certain activities of the College and its members are deemed protected from antitrust laws under the First Amendment right to petition government. The antitrust exemption for these activities, referred to as the Noerr-Pennington Doctrine, protects ethical and proper actions or discussions by members designed to influence: 1) legislation at the national, state, or local level; 2) regulatory or policy-making activities (as opposed to commercial activities) of a governmental body; or 3) decisions of judicial bodies. However, the exemption does not protect actions constituting a "sham" to cover anticompetitive conduct.
- Speakers at committees, educational meetings, or other business meetings of the College shall be informed that they must comply with the College's antitrust policy in the preparation and the presentation of their remarks. Meetings will follow a written agenda approved in advance by the College or its legal counsel.

- Meetings will follow a written agenda. Minutes will be prepared after the meeting to provide a concise summary of important matters discussed and actions taken or conclusions reached.

At informal discussions at the site of any College meeting all participants are expected to observe the same standards of personal conduct as are required of the College in its compliance.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

POLICY STATEMENT

Conflict of Interest

Approved January 2017

Revised by the ACEP Board of Directors January 2017, June 2011, June 2008

Reaffirmed by the ACEP Board of Directors October 2001

Revised by the ACEP Board of Directors September 1997

Approved by the ACEP Board of Directors January 1996

Officers, Directors, Committee Chairs and Members, Section Chairs, Task Force Chairs, Annals Editor, staff, and others acting on behalf of the College have a fiduciary duty to the College, including the duties of loyalty, diligence, and confidentiality.

Those in positions of responsibility must act in utmost good faith on behalf of the College. In accepting their positions, they promise to give the College the benefit of their work and best judgment. They should exercise the powers conferred solely in the interest of the College and should not use their role or position for their own personal interest or that of any other organization or entity. Even the perception of conflict can potentially compromise the confidence and trust of ACEP members and the public in the stewardship of its leaders.

Conflicts of interest arise when participants in positions of responsibility have personal, financial, business, or professional interests or responsibilities that may interfere with their duties on behalf of ACEP. The immediacy and seriousness of various conflicts of interest situations may vary. Of basic importance is the degree to which the interest would tend one toward bias or pre-disposition on an issue or otherwise compromise the interests of the College.

A conditional, qualified, or potential conflict of interest can arise when the outside interest is not substantial or does not relate significantly to any contemplated action of the College. For example, a person might hold a minor financial interest in a company wishing to do business with the College. Disclosure is ordinarily sufficient to deal with this type of potential conflict of interest, provided that there is no expectation that one's duty to the College would be affected.

Direct conflicts of interest arise, for example, when an individual engages in a personal transaction with the College or holds a material interest or position of responsibility in an organization involved in a specific transaction with the College or that may have interests at variance or in competition with the College. The appropriate and necessary course of action in such cases is to disclose the conflict and recuse oneself, during the deliberations and the vote on the issue.

In rare circumstances, an individual may have such a serious, ongoing, and irreconcilable conflict, where the relationship to an outside organization so seriously impedes one's ability to carry out the fiduciary responsibility to the College, that resignation from the position with the College or the conflicting entity is appropriate.

Dealing effectively with actual, perceived, or potential conflicts of interest is a shared responsibility of the individual and the organization. The individual and organizational roles and responsibilities with regard to conflicts of interest follow.

A. General

1. All individuals who serve in positions of responsibility within the College need not only to avoid conflicts of interest, but also to avoid the appearance of a conflict of interest. This responsibility pertains to Officers, Directors, Committee Chairs and Members, Section Chairs, Task Force Chairs, Annals Editor and the Executive Director (hereinafter collectively "Key Leaders") and other elected or appointed leaders, and staff. Decisions on behalf of the College must be based solely on the interest of the College and its membership. Decisions must not be influenced by desire for personal profit, loyalty to other organizations, or other extraneous considerations.

2. Key Leaders shall annually sign a statement acknowledging their fiduciary responsibility to the College and pledge to avoid conflicts of interest or the appearance of conflicts of interest. The issue of conflicts of interest with regard to the remainder of the staff shall be the responsibility of the Executive Director. The issue of conflicts of interest with regard to Section and Task Force Members who participate in the development of policy and resources on behalf of the Colleges hall be the responsibility of the Section and Task Force Chairs with the ultimate determination made by the College President as to Section and Task Force Members to be designated as Key Leaders for the purpose of this policy and the related disclosures, acknowledgements, pledges and statements.

3. Key Leaders shall annually complete a form designated by the ACEP Board of Directors that includes the disclosure of pertinent financial and career-related information and shall update that information as necessary to continuously keep it current and active.

4. Key Leaders shall annually sign a statement acknowledging that they may have access to confidential information and pledge to protect the confidentiality of that information.

5. Officers, Board Members, the Executive Director, and the General Counsel shall annually pledge to clarify their position when speaking on their own behalf as opposed to speaking on behalf of the

membership as a whole, or as an officer or member of the Board of Directors or senior staff member.

6. Officers, Board Members, the Executive Director, the General Counsel or their designees will periodically review the conflict of interest disclosure statements submitted to the College to be aware of potential conflicts that may arise with others.

7. When an Officer, Board Member, the Executive Director, or General Counsel believes that an individual has a conflict of interest that has not been properly recognized or resolved, the Officer, Board Member, Executive Director, or General Counsel will raise that issue and seek proper resolution.

8. Any member may raise the issue of conflict of interest by bringing it to the attention of the Board of Directors through the President or the Executive Director. The final resolution of any conflict of interest shall rest with the Board of Directors.

B. Disclosure Form

1. Key Leaders shall annually complete a form that discloses the following:

   a. Positions of leadership in other organizations, chapters, commissions, groups, coalitions, agencies, and entities – eg, board of directors, committees, spokesperson role. Include a brief description of the nature and purposes of the organization or entity.

   b. Positions of employment, including the nature of the business of the employer, the position held, and a description of the daily responsibilities of the employment.

   c. Direct financial interest (other than a less than 1% interest in a publicly traded company) or positions of responsibility in any entity:

      i. From which ACEP obtains substantial amounts of goods or services;

      ii. That provides services that substantially compete with ACEP; and

      iii. That provides goods or services in support of the practice of emergency medicine (e.g. physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company).

d. Industry-sponsored research support within the preceding twenty-four (24) months.

e. Speaking fees from non-academic entities during the preceding twenty-four (24) months.

f. The receipt of any unusual gifts or favors from an outside entity or person, or the expectation that a future gift or favor will be received in return for a specific action, position, or viewpoint taken in regards to ACEP or its products.

g. Any other interest the Key Leader believes may create a conflict with the fiduciary duty to ACEP or that may create the appearance of a conflict of interest.

2. Except as provided in Section 4 below, completed disclosure forms shall be submitted to the President and the Executive Director no later than sixty (60) days prior to commencement of the annual meeting of ACEP's Council. For Officers and Board Members newly elected during a meeting of ACEP's Council, the forms shall be submitted no later than thirty (30) days following their election if they were not previously submitted. Any Key Leader who has not submitted a completed disclosure form by the applicable deadline will be ineligible to participate in those specific College activities for which they have been appointed or elected until their completed disclosure forms have been received and reviewed as set forth in this policy.

3. Information disclosed by Officers, Board Members, and the Executive Director pursuant to this policy will be placed in the General Reference Notebook available at each Board meeting for review by Officers and Board Members. Committee, Section, and Task Force Chairs will have access to the disclosure forms of the members of the entity they chair. In addition, any ACEP member may request a copy of a Key Leader's disclosure form upon written request to the ACEP President.

4. Completed disclosure forms required from Section and Task Force Members will be submitted to the relevant Section or Task Force Chair and the Executive Director within thirty (30) days of appointment or assignment.

5. ACEP may disclose to its members and the public the disclosure forms of its Officers, Board Members, Annals Editor, and the Executive Director.

C. Additional Rules of Conduct

1. Prior to participating in any deliberation or vote on an issue in which they may have a conflict, Key Leaders shall disclose the existence of any actual or possible interest or concern of:

a. The individual;

b. A member of that individual's immediate family; or

c. Any party, group, or organization to which the individual has allegiance that can cause ACEP to be legally or otherwise vulnerable to criticism, embarrassment or litigation.

2. After disclosure of the interest or concern that could result in a conflict of interest as defined in this policy and all material facts, the individual shall leave the Board, Committee, Section, or Task Force meeting while the determination of a conflict of interest is discussed and voted upon. The remaining Board, Committee, Section, or Task Force members shall decide by majority vote if a conflict of interest exists. If a conflict of interest is determined to exist, the individual having the conflict shall retire from the room in which the Board, Committee, Section, or Task Force is meeting and shall not participate in the deliberation or decision regarding the matter under consideration. However, that individual shall provide the Board, Committee, Section, or Task Force with any and all relevant information requested.

3. The minutes of the Board, Committee, Section, or Task Force meeting shall contain:

   a. The name of the individual who disclosed or otherwise was found to have an interest or concern in connection with an actual or possible conflict of interest, the nature of the interest, any action taken to determine whether a conflict of interest was present, and the Board's, Committee's, Section's, or Task Force's decision as to whether a conflict of interest existed;

   b. The extent of such individual's participation in the relevant Board, Committee, Section, or Task Force meeting on matters related to the possible conflict of interest; and

   c. The names of the individuals who were present for discussion and votes relating to the action, policy, or arrangement in question, the content of the discussion including alternatives to the proposed action, policy, or arrangement, and a record of any votes taken in connection therewith.

American College of Emergency Physicians®
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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*

American College of Emergency Physicians
ADVANCING EMERGENCY CARE

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		***7:30 am***
Level 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, October 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

2018 Council Meeting Materials

Table of Contents

2018 Council Steering Committee

Updated May 2018

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

Evans, GA

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

Dublin, OH

Michael J. Baker, MD, FACEP

Ann Arbor, MI

Douglas Char, MD, FACEP

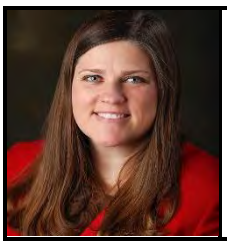
Saint Louis, MO

Kathleen J. Clem, MD, FACEP

Longwood, FL

Melissa W. Costello, MD, FACEP

Mobile, AL



Sarah J. Hoper, MD, JD, FACEP

Cedar Rapids, IA

Tiffany Jackson, MD

Fort Mill, SC

Gabor (Gabe) D. Kelen, MD, FACEP

Baltimore, MD

Chadd K. Kraus, DO, DrPH, MPH, FACEP

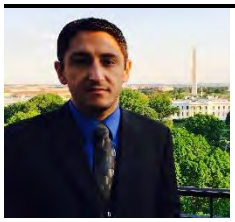
Lewisburg, PA

Jeff F. Linzer, MD, FACEP

Decatur, GA

Heather A. Marshall, MD, FACEP

Houston, TX



Tony B. Salazar, MD, FACEP

Albuquerque, NM

Sullivan K. Smith, MD, FACEP

Cookeville, TN

Annalise Sorrentino, MD, FACEP

Birmingham, AL

Susanne J. Spano, MD, FACEP

Fresno, CA

Procedures for Councillor and Alternate Seating

Councillor Credentialing

All certified councillors and alternates must be officially credentialed at the annual meeting.

1. A master list of all certified councillors and alternates will be maintained at councillor credentialing.

2. If a councillor is not certified on the master list, the following steps will be followed:

    a. Only the component body (chapter president or executive staff, section chair or staff, EMRA president or staff, AACEM president or staff, CORD president or staff, SAEM president or staff), also known as sponsoring body, can certify a member to be credentialed as a councillor. The component body must also identify whom the new councillor will replace. No councillor will be certified without final confirmation from the component body.

    b. If the chapter president, section chair, EMRA president, AACEM president, CORD president, SAEM president, or staff executive of the component body is not available, seating will be denied. Only a certified alternate councillor may be seated on the Council floor.

    c. If no certified councillor or alternate of a component body is present at the meeting, a member of that sponsoring body may be seated as a councillor pro tem by either the concurrence of an officer of the component body or upon written request to the Council secretary with a majority vote of the Council.

As stated in the Bylaws, Article VIII – Council, Section 5 – Voting Rights:

> "Each sponsoring body shall deposit with the secretary of the Council a certificate certifying its councillor(s) and alternate(s). The certificate must be signed the president, secretary, or chairperson of the sponsoring body. No councillor or alternate shall be seated who is not a member of the College. College members not specified in the sponsoring body's certificate may be certified and credentialed at the annual meeting in accordance with the Council Standing Rules.
>
> ACEP Past Presidents, Past Speakers, and Past Chairs of the Board, if not certified as councillors or alternate councillors by a sponsoring body, may participate in the Council in a non-voting capacity. Members of the Board of Directors may address the Council on any matter under discussion but shall not have voting privileges in Council sessions."
>
> Whenever the term "present" is used in these Bylaws with respect to councillor voting, it shall mean credentialed as certified by the chair of the Tellers, Credentials, & Elections Committee."

Only councillors or alternates certified by the component body may be seated on the Council floor. Only the appropriate individual from a component body may authorize seating of their non-certified councillors. All of the College's past presidents and past Council speakers are invited to sit with their delegation on the Council floor. A past president or past Council speaker is only permitted to vote when serving as a certified councillor.

If the appropriate individual from the component body is not present to authorize seating of a non-certified councillor or alternate, then the request for seating must be made directly to the chair of the Tellers, Credentials, & Elections Committee.

Seating of Past Presidents, Past Council Speakers, and Chairs of the Board

1. Past presidents, past Council speakers, and past Chairs of the Board are invited to sit with their delegation on the Council floor.

2. Each past president, Council speaker, and past Chairs of the Board sitting with their delegation should be credentialed and are required to wear the appropriate identification giving them access to the Council floor.

3. Past leaders have the full privilege of the floor, including the proposal of motions and amendments, except that they may not vote unless serving as a regular voting councillor or alternate.

Voting Cards and Electronic Keypads

1. Each credentialed councillor will receive a voting card with their name and component body.

2. Voting will be by voting card, electronic keypad, or voice votes at the discretion of the Speaker.

3. The Tellers, Credentials, & Elections Committee will periodically check the Council delegations to ensure that only the authorized voting cards and keypads are used.

Seating Exchange Between Credentialed Councillors and Alternates

1. No exchange between a councillor and alternate is permitted during the Council meeting while a motion is on the floor of the Council. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed.

2. To make an exchange, the councillor should leave their voting card and keypad on the table. The alternate may then proceed to take the seat of the designated councillor, unless debate is occurring on the Council floor. **No exchange is permitted until final action is taken on a particular issue.**

3. If a councillor is leaving the floor of the Council, and there will **not** be an alternate replacement, the councillor must return the voting card and keypad to councillor credentialing. Once the councillor returns, the voting card and keypad will be returned to the councillor. If debate is occurring on the Council floor, the councillor should wait until final action has been taken on a particular issue before returning to his/her seat on the Council floor.

2018 Councillor Seating Chart

SECRETARY	PARLIAMENTARIAN	SPEAKER	VICE SPEAKER

PROJECTION STAFF

421 Councillors + 42 past leaders = 463 seats

1	AK=1 AL=3 AZ=9 AAWEP=1 Air Med=1	AACEM=1 AR=2 CO=10 DE=2	Careers=1 CT=8 Cruise=1 Critical Care=1 Democratic=1 Event Med=1
2	CA=10 CORD=1 DC=4	Disaster=1 Dual Training=1 FL=13	EMRA=8 HI=2 Informatics=1 KS=3
3	CA=15	FL=8 EMPM=1 EMS=1 Geriatric=1 Freestanding=1	GA=10 ID=2 IA=3
4	CA=10 Med Hum=1 KY=4	IL=13 Intl=1 MT=1	GS=9 ME=3 NE=2
5	IN=8 LA=6 Med Dir=1	MI=12 MS=2	GS=8 NV=3 OK=4
6	MA=10 NM=4 Pain Mgmt=1	MI=11 OBS=1 Peds=1 Palliative=1	NJ=11 NH=2 ND=1 Quality=1
7	NC=13 PR=2	MD=8 MN=7	OH=9 MO=6
8	NY=15	PA=10 OR=5	OH=10 RI=3 SAEM=1
9	NY=15	PA=10 SC=5	TX=15
10	WA=9 Wellness=1 Research=1 Tactical=1	TN=5 UT=4 SD=1 Sports Med=1 Social=1 Tox=1	TX=10 Rural=1 Trauma=1 VT=1
11	WI=6 Undersea=1 Workforce=1 Wilderness=1	VA=13 YPS=1	WV=4 WY=1 Telemed=1 US=1

Board of Directors = 7

Board of Directors = 7

A	B	C
Alternate Councillors	Reserved Staff	Reserved Chapter Staff
Open Seating	Open Seating	Open Seating

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Past Presidents, Past Council Speakers, and Past Chairs of the Board Seating

Past presidents, past Council speakers, and past Chairs of the Board are invited to sit with their delegation on the Council floor (see seating chart). The 2018 councillor seating chart includes the following:

Arizona	8 councillors + 1 past leader attending not serving as councillor = 9 seats
California	30 councillors + 5 past leaders attending not serving as councillors = 35 seats
Colorado	8 councillors + 2 past leader attending not serving as a councillor =10 seats
Connecticut	6 councillors + 2 past leader attending not serving as a councillors = 8 seats
Florida	20 councillors + 1 past leader attending not serving as a councillors = 21 seats
Georgia	9 councillors + 1 past leader attending not serving as a councillors = 10 seats
Government Services	15 councillors + 2 past leader attending not serving as councillor = 17 seats
Indiana	7 councillors + 1 past leader attending not serving as councillor = 8 seats
Louisiana	5 councillors + 1 past leader attending not serving as councillor = 6 seats
Michigan	20 councillors + 3 past leaders attending not serving as councillors = 23 seats
New Jersey	9 councillors + 2 past leader attending and not serving as councilor = 11 seats
New Mexico	2 councillors + 2 past leader attending and not serving as councillor = 4 seats
New York	28 councillors + 2 past leader attending not serving as a councillor = 30 seats
North Carolina	11 councillors + 2 past leaders attending not serving as councillors = 13 seats
Ohio	15 councillors + 4 past leaders attending not serving as councillors = 19 seats
Pennsylvania	17 councillors + 3 past leader attending not serving as a councillor = 20 seats
Texas	22 councillors + 3 past leader attending not serving as a councillor = 25 seats
Virginia	10 councillors + 3 past leader not serving as a councillor = 13 seats
Washington	8 councillors + 1 past leader attending not serving as a councillor = 9 seats
West Virginia	3 councillors + 1 past leader attending not serving as a councillor = 4 seats

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Chapter/Section	Position	Name
ALABAMA CHAPTER	Councillor	Melissa Wysong Costello, MD, FACEP
	Councillor	Muhammad N Husainy, DO, FACEP
	Councillor	Annalise Sorrentino, MD, FACEP
	Alternate	Lisa M Bundy, MD, FACEP
	Alternate	David J Garvey, MD, FACEP
	Alternate	Bobby R Lewis, MD, FACEP
	Alternate	Michael Raphael Salomon, MD, FACEP
ALASKA CHAPTER	Councillor	Nathan Phillip Peimann, MD, FACEP
	Alternate	Anne Zink, MD, FACEP
ARIZONA CHAPTER	Councillor	Patricia A Bayless, MD, FACEP
	Councillor	Paul Andrew Kozak, MD, FACEP
	Councillor	J Scott Lowry, MD, FACEP
	Councillor	Wendy Ann Lucid, MD, FACEP
	Councillor	Michael E Sheehy, DO, FACEP
	Councillor	Casey R Solem, MD, FACEP
	Councillor	Nicholas F Vasquez, MD, FACEP
	Councillor	Dale P Woolridge, MD, PhD, FACEP
ARKANSAS CHAPTER	Councillor	J Shane Hardin, MD, PhD
	Councillor	Brian L Hohertz, MD, FACEP
	Alternate	Robert Thomas VanHook, MD, FACEP
ASSOC OF ACAD CHAIRS OF EM	Councillor	Gabor David Kelen, MD, FACEP
CALIFORNIA CHAPTER	Councillor	Rodney W Borger, MD, FACEP
	Councillor	Andrea M Brault, MD, FACEP
	Councillor	Adam P Dougherty, MD
	Councillor	Carrieann E Drenten, MD, FACEP
	Councillor	Irv E Edwards, MD, FACEP
	Councillor	Jorge A Fernandez, MD
	Councillor	Marc Allan Futernick, MD, FACEP
	Councillor	Michael Gertz, MD, FACEP
	Councillor	Douglas Everett Gibson, MD, FACEP
	Councillor	Vikant Gulati, MD, FACEP
	Councillor	Samantha Jeppsen, MD
	Councillor	Kevin M Jones, DO, FACEP
	Councillor	John Thomas Ludlow, MD, FACEP
	Councillor	William K Mallon, MD, FACEP
	Councillor	Aimee K Moulin, MD, FACEP
	Councillor	Leslie Mukau, MD, FACEP
	Councillor	Karen Murrell, MD, MBA, FACEP
	Councillor	Valerie C Norton, MD, FACEP
	Councillor	Luke J Palmisano, MD, MBA, FACEP
	Councillor	Bing S Pao, MD, FACEP
	Councillor	Mitesh Patel, MD
	Councillor	Chi Lee Perlroth, MD, FACEP

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	Councillor	Melanie T Stanzer, DO
	Councillor	Lawrence M Stock, MD, FACEP
	Councillor	Thomas Jerome Sugarman, MD, FACEP
	Councillor	Patrick Um, MD, FACEP
	Councillor	Andrea M Wagner, MD, FACEP
	Councillor	Lori D Winston, MD, FACEP
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	Alternate	Jeffery J Leinen, MD, FACEP
	Alternate	Roneet Lev, MD, FACEP
	Alternate	Cameron J McClure, MD, FACEP
	Alternate	Anna L Webster, MD, FACEP
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	Councillor	Kevin W McGarvey, MD
	Councillor	Garrett S Mitchell, MD
	Councillor	Carla Elizabeth Murphy, DO, FACEP
	Councillor	Eric B Olsen, MD, FACEP
	Councillor	Donald E Stader, MD, FACEP
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	Alternate	Allison Marie Trop, MD
	Alternate	Erik Janis Verzemnieks, MD
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	Councillor	David Peter John, MD, FACEP
	Councillor	Elizabeth Schiller, MD, FACEP
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	Alternate	Erin E Watson, MD, FACEP
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	Councillor	Kathleen D Keeffe, MD, FACEP
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	Councillor	Paul R Pomeroy, Jr, MD, FACEP
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	Councillor	Larisa May Traill, MD, FACEP
	Councillor	Bradley J Uren, MD, FACEP
	Councillor	Gregory Link Walker, MD, FACEP
	Councillor	Bradford L Walters, MD, FACEP
	Councillor	Mildred J Willy, MD, FACEP
	Councillor	James Michael Ziadeh, MD, FACEP
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	Councillor	Thomas E Wyatt, MD, FACEP
	Councillor	Andrew R Zinkel, MD, FACEP
	Alternate	Timothy James Johnson, MD, FACEP
	Alternate	Donald L Lum, MD, FACEP
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	Alternate	Sebastian A Rueckert, MD, MBA, FACEP
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	Councillor	Robert M Eisenstein, MD, FACEP
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	Councillor	Rachelle Ann Greenman, MD, FACEP
	Councillor	Steven M Hochman, MD, FACEP
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	Councillor	Nilesh Patel, DO
	Councillor	Michael Ruzek, DO
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	Alternate	Justin Matthew Fuehrer, DO
	Alternate	James Gerard Ryan, MD, FACEP
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	Councillor	Thomas Lee Mason, MD, FACEP
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	Councillor	Bret Nicks, MD, MHA, FACEP
	Councillor	Sankalp Puri, MD, FACEP
	Councillor	Stephen A Small, MD, FACEP
	Councillor	David Matthew Sullivan, MD, FACEP
	Councillor	Michael J Utecht, MD, FACEP
	Alternate	Scott W Brown, MD, FACEP
	Alternate	Michael Alfred Gibbs, MD, FACEP
	Alternate	Eric E Maur, MD, FACEP
NORTH DAKOTA CHAPTER	Councillor	Kevin Scott Mickelson, MD, FACEP
	Alternate	K J Temple, MD, FACEP
OHIO CHAPTER	Councillor	Eileen F Baker, MD, FACEP
	Councillor	Dan Charles Breece, DO, FACEP
	Councillor	John Casey, DO, MA, FACEP
	Councillor	Purva Grover, MD, FACEP
	Councillor	Erika Charlotte Kube, MD, FACEP
	Councillor	Thomas W Lukens, MD, PhD, FACEP
	Councillor	John L Lyman, MD, FACEP
	Councillor	Catherine Anna Marco, MD, FACEP
	Councillor	Daniel R Martin, MD, FACEP
	Councillor	Michael McCrea, MD, FACEP
	Councillor	Onyeka Otugo, MD
	Councillor	John R Queen, MD, FACEP
	Councillor	Ryan Squier, MD, FACEP
	Councillor	Travis Ulmer, MD, FACEP
	Councillor	Nicole Ann Veitinger, DO, FACEP
	Alternate	Saurin P Bhatt, MD
	Alternate	Christina Campana, DO, FACEP
	Alternate	Richard N Nelson, MD, FACEP
	Alternate	Bradley D Raetzke, MD, FACEP
	Alternate	Tonatiuh Rios-Alba, MD, FACEP
	Alternate	Jeffrey T Ruwe, MD

2018 COUNCILLORS & ALTERNATE COUNCILLORS

	Alternate	Matthew J Sanders, DO, FACEP
OKLAHOMA CHAPTER	Councillor	Jeffrey Michael Goodloe, MD, FACEP
	Councillor	Cecilia Guthrie, MD, FACEP
	Councillor	Jeffrey Johnson, MD
	Councillor	James Raymond Kennedye, MD, MPH, FACEP
OREGON CHAPTER	Councillor	Samuel H Kim, MD
	Councillor	Michael F McCaskill, MD, FACEP
	Councillor	John C Moorhead, MD, FACEP
	Councillor	Carl Seger, MD
	Councillor	Michelle R Shaw, MD, FACEP
PENNSYLVANIA CHAPTER	Councillor	Smeet R Bhimani, DO
	Councillor	Erik Blutinger, MD
	Councillor	Merle Andrea Carter, MD, FACEP
	Councillor	Ankur A Doshi, MD, FACEP
	Councillor	Maria Koenig Guyette, MD, MPPM, FACEP
	Councillor	Ronald V Hall, MD
	Councillor	Richard Hamilton, MD, FACEP
	Councillor	Marilyn Joan Heine, MD, FACEP
	Councillor	Scott Jason Korvek, MD, FACEP
	Councillor	Chadd K Kraus, DO, DrPH, MPH, FACEP
	Councillor	Jennifer R Marin, MD, MSc
	Councillor	Dhimitri Nikolla, DO
	Councillor	Ericka Powell, MD, FACEP
	Councillor	Shawn M Quinn, DO, FACEP
	Councillor	Anna Schwartz, MD, FACEP
	Councillor	Michael A Turturro, MD, FACEP
	Councillor	Arvind Venkat, MD, FACEP
	Alternate	William Gene Bell, MD
	Alternate	Todd Fijewski, MD, FACEP
	Alternate	Meaghan L Reid, MD
	Alternate	Ralph James Riviello, MD, FACEP
	Alternate	Camilla Sulak, MD
	Alternate	Austin K Williams, MD
PUERTO RICO CHAPTER	Councillor	Miguel F Agrait Gonzalez, MD
	Councillor	Jesus M Perez, MD
RHODE ISLAND CHAPTER	Councillor	L Anthony Cirillo, MD, FACEP
	Councillor	Achyut B Kamat, MD, FACEP
	Councillor	Jessica Smith, MD, FACEP
	Alternate	Nadine T Himelfarb, MD, FACEP
	Alternate	Michael Stephen Siclari, MD, FACEP
	Alternate	Christopher P Zabbo, DO, FACEP
SOCIETY OF ACADEMIC EMERGENCY MEDICINE	Councillor	Kathleen J Clem, MD, FACEP

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SOUTH CAROLINA CHAPTER	Councillor	Matthew D Bitner, MD, MEd, FACEP
	Councillor	Thomas H Coleman, MD, FACEP
	Councillor	Stephen A D Grant, MD, FACEP
	Councillor	Allison Leigh Harvey, MD, FACEP
	Councillor	Christina Millhouse, MD, FACEP
	Alternate	Frank C Smeeks, MD, FACEP
SOUTH DAKOTA CHAPTER	Councillor	Scott Gregory VanKeulen, MD, FACEP
	Alternate	Clay A Smith, MD, FACEP
TENNESSEE CHAPTER	Councillor	Sanford H Herman, MD, FACEP
	Councillor	Sudave D Mendiratta, MD, FACEP
	Councillor	Thomas R Mitchell, MD, FACEP
	Councillor	Matthew Neal, MD
	Councillor	Sullivan K Smith, MD, FACEP
	Alternate	Leon Adelman, MD, FACEP
	Alternate	Jerry L Edwards, DO, FACEP
	Alternate	Kenneth L Holbert, MD, FACEP
	Alternate	John H Proctor, MD, MBA, FACEP
TEXAS CHAPTER	Councillor	Sara Andrabi, MD
	Councillor	Carrie de Moor, MD, FACEP
	Councillor	Justin W Fairless, DO, FACEP
	Councillor	Angela Siler Fisher, MD, FACEP
	Councillor	Diana L Fite, MD, FACEP
	Councillor	Juan Francisco Fitz, MD, FACEP
	Councillor	Andrea L Green, MD, FACEP
	Councillor	Robert D Greenberg, MD, FACEP
	Councillor	Robert Hancock, Jr, DO, FACEP
	Councillor	Justin P Hensley, MD, FACEP
	Councillor	Doug Jeffrey, MD, FACEP
	Councillor	Heidi C Knowles, MD, FACEP
	Councillor	Laura N Medford-Davis, MD
	Councillor	Heather S Owen, MD, FACEP
	Councillor	Daniel Eugene Peckenpaugh, MD, FACEP
	Councillor	R Lynn Rea, MD, FACEP, FACP, FACEP
	Councillor	Richard Dean Robinson, MD, FACEP
	Councillor	Nicholas P Steinour, MD, FACEP
	Councillor	Gerad A Troutman, MD, FACEP
	Councillor	Hemant H Vankawala, MD, FACEP
	Councillor	James M Williams, DO, FACEP
	Councillor	Sandra Williams, DO, MPH, FACEP
	Alternate	Steven B Baker, MD
	Alternate	Marvinia Charles, MD
	Alternate	Katherine A Dowdell, MD
	Alternate	Angela F Gardner, MD, FACEP
	Alternate	Renee C Johnson, MD
	Alternate	Edward Kuo, MD
	Alternate	Thomas J McLaughlin, DO, FACEP

2018 COUNCILLORS & ALTERNATE COUNCILLORS

	Alternate	Georgia J McRoy, MD
	Alternate	Craig Meek, MD, FACEP
	Alternate	Sterling Evan Overstreet, MD
	Alternate	Anant Patel, DO
	Alternate	Miles Raizada, MD
	Alternate	Marcus Lynn Sims, II, DO
	Alternate	Ynhi T Thomas, MD
	Alternate	Theresa Tran, MD
	Alternate	Katie White, MD
	Alternate	Matthew R Williams, MD
UTAH CHAPTER	Councillor	Jim V Antinori, MD, FACEP
	Councillor	Bennion D Buchanan, MD, FACEP
	Councillor	Stephen Carl Hartsell, MD, FACEP
	Councillor	Kathleen Marie Lawliss, MD, FACEP
	Alternate	Ann E Burelbach, MD
	Alternate	David Brent Mabey, MD
	Alternate	Alison L Smith, MD, MPH
	Alternate	Henry T Yeates, DO
VIRGINIA CHAPTER	Councillor	Trisha Danielle Anest, MD
	Councillor	Kenneth Hickey, MD, FACEP
	Councillor	Sarah Klemencic, MD, FACEP
	Councillor	David Matthew Kruse, MD, FACEP
	Councillor	Bruce M Lo, MD, MBA, RDMS, FACEP
	Councillor	Todd Parker, MD, FACEP
	Councillor	Joran Sequeira, MD
	Councillor	Sara F Sutherland, MD, MBA, FACEP
	Alternate	Pamela P Bensen, MD, MS, FACEP
	Alternate	Pamela Andrea Ross, MD, FACEP
WASHINGTON CHAPTER	Councillor	Cameron Ross Buck, MD, FACEP
	Councillor	Catharine R Keay, MD, FACEP
	Councillor	Gregg A Miller, MD, FACEP
	Councillor	Nathaniel R Schlicher, MD, JD, MBA, FACEP
	Councillor	Patrick Solari, MD, FACEP
	Councillor	Jennifer L'Hommedieu Stankus, MD, JD, FACEP
	Councillor	Susan Amy Stern, MD
	Councillor	Liam Yore, MD, FACEP
	Alternate	Enrique R Enguidanos, MD, FACEP
	Alternate	Raul J Garcia-Rodriguez, DO, FACEP
	Alternate	Justin Grisham, DO
	Alternate	Carlton E Heine, MD, PhD, FACEP
	Alternate	John Matheson, MD, FACEP
	Alternate	John S Milne, MD, MBA, FACEP
	Alternate	Karolyn K Moody, DO, MPH, FACEP
	Alternate	Rhadika McCormick Souza, MD

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WEST VIRGINIA CHAPTER	Councillor	Adam Thomas Crawford, DO
	Councillor	Christopher S Goode, MD, FACEP
	Councillor	Thomas Marshall, MD, FACEP
	Alternate	Frederick C Blum, MD, FACEP
	Alternate	David Benjamin Deuell, DO
	Alternate	Erica B Shaver, MD, FACEP
WISCONSIN CHAPTER	Councillor	Howard Jeffery Croft, MD, FACEP
	Councillor	William D Falco, MD, MS, FACEP
	Councillor	William C Haselow, MD, FACEP
	Councillor	Jeffrey J Pothof, MD, FACEP
	Councillor	Robert Sands Redwood, MD, MPH, FACEP
	Councillor	Michael Dean Repplinger, MD, PhD, FACEP
	Alternate	Bradley Burmeister, MD
	Alternate	Lisa J Maurer, MD, FACEP
	Alternate	Jamie Schneider, MD
WYOMING CHAPTER	Councillor	Jessica Kisicki, MD, FACEP
AIR MEDICAL TRANSPORT SECTION	Councillor	Samuel J Slimmer, MD, FACEP
AMERICAN ASSOCIATION OF WOMEN EMERGENCY PHYSICIANS SECTION	Councillor	E Lea Walters, MD, FACEP
	Alternate	Elizabeth Dubey, MD
CAREERS IN EMERGENCY MEDICINE SECTION	Councillor	Constance J Doyle, MD, FACEP
CRITICAL CARE MEDICINE SECTION	Councillor	Evie G Marcolini, MD, FACEP
	Alternate	Ani Aydin, MD, FACEP
CRUISE SHIP MEDICINE SECTION	Councillor	Sydney W Schneidman, MD, FACEP
DEMOCRATIC GROUP PRACTICE SECTION	Councillor	David F Tulsiak, MD, FACEP
	Alternate	Craig Savoy Brummer, MD, FACEP
DISASTER MEDICINE SECTION	Councillor	David Wayne Callaway, MD, FACEP
DUAL TRAINING SECTION	Councillor	Carissa J Tyo, MD, FACEP
	Alternate	De Benjamin Winter, III, MD
EMERGENCY MEDICAL INFORMATICS SECTION	Councillor	Jeffrey A Nielson, MD, FACEP
	Alternate	Nicholas G Genes, MD, FACEP
EMERGENCY MEDICAL SERVICES-PREHOSPITAL CARE SECTION	Councillor	Maia Dorsett, MD
	Alternate	Michael O'Brien, MD

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EMERGENCY MEDICINE PRACTICE MANAGEMENT AND HEALTH POLICY SECTION	Councillor	Heather Ann Heaton, MD, FACEP
	Alternate	Liudvikas Jagminas, MD, FACEP
EMERGENCY MEDICINE RESEARCH SECTION	Councillor	Aaron Brody, MD
	Alternate	James Ross Miner, MD, FACEP
EMERGENCY MEDICINE WORKFORCE SECTION	Councillor	Guy Nuki, MD
	Alternate	Otto J Marquez, MD, FACEP
EMERGENCY ULTRASOUND SECTION	Councillor	Chris Bryczkowski, MD, FACEP
EVENT MEDICINE SECTION	Councillor	John Carlton Maino, II, MD, FACEP
	Alternate	Claire E Melin, MD
FREESTANDING EMEGENCY CENTERS	Councillor	David C Ernst, MD, FACEP
GERIATRIC EMERGENCY MEDICINE SECTION	Councillor	Teresita M Hogan, MD, FACEP
INTERNATIONAL EMERGENCY MEDICINE SECTION	Councillor	Elizabeth L DeVos, MD, FACEP
MEDICAL DIRECTORS SECTION	Councillor	Johnny L Sy, DO, FACEP
MEDICAL HUMANITIES SECTION	Councillor	Seth Collings Hawkins, MD, FACEP
	Alternate	David P Sklar, MD, FACEP
	Alternate	Robert C Solomon, MD, FACEP
OBSERVATION SERVICES SECTION	Councillor	Sharon E Mace, MD, FACEP
	Alternate	Kristy Ziontz, DO, FACEP
PAIN MANAGEMENT SECTION	Councillor	Alexis M LaPietra, DO, FACEP
PALLIATIVE MEDICINE SECTION	Councillor	Eric D Isaacs, MD, FACEP
	Alternate	Rebecca R Goett, MD, FACEP
PEDIATRIC EMERGENCY MEDICINE SECTION	Councillor	Eric R Schmitt, MD, MPH, FACEP
QUALITY IMPROVEMENT AND PATIENT SAFETY SECTION	Councillor	Brian Sharp, MD, FACEP
	Alternate	Venkatesh R Bellamkonda, MD
RURAL EMERGENCY MEDICINE SECTION	Councillor	Darrell L Carter, MD, FACEP
	Alternate	William Ken Milne, MD

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2018 COUNCILLORS & ALTERNATE COUNCILLORS

SOCIAL EVENT MEDICINE SECTION	Councillor	Harrison Alter, MD, FACEP
	Alternate	Aislinn D Black, DO, FACEP
	Alternate	Kelly Doran, MD
SPORTS MEDICINE SECTION	Councillor	Jolie C Holschen, MD, FACEP
	Alternate	William Denq, MD
TACTICAL EMERGENCY MEDICINE SECTION	Councillor	James Phillips, MD
	Alternate	Howard K Mell, MD, MPH, CPE, FACEP
TELEMEDICINE SECTION	Councillor	Edward A Shaheen, MD, FACEP
	Alternate	Hartmut Gross, MD, FACEP
TOXICOLOGY SECTION	Councillor	Jennifer Hannum, MD, FACEP
	Alternate	Eric J Lavonas, MD, FACEP
TRAUMA & INJURY PREVENTION SECTION	Councillor	Gregory Luke Larkin, MD, MPH, FACEP
	Alternate	Mark Robert Sochor, MD, FACEP
UNDERSEA & HYPERBARIC MEDICINE SECTION	Councillor	Robert W Sanders, MD, FACEP
	Alternate	Stephen Hendriksen, MD, FACEP
WELLNESS SECTION	Councillor	Laura H McPeake, MD, FACEP
	Alternate	Susan Theresa Haney, MD, FACEP
	Alternate	Julie Marie Sanicola-Johnson, DO, FACEP
WILDERNESS MEDICINE SECTION	Councillor	Henderson D McGinnis, MD, FACEP
	Alternate	Susanne J Spano, MD, FACEP
YOUNG PHYSICIANS SECTION	Councillor	Hilary E Fairbrother, MD, FACEP
	Alternate	Jessica Ann Best, MD
	Alternate	John R Corker, MD
	Alternate	Puneet Gupta, MD, FACEP

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Councillor Handbook

Councillor Handbook

Table of Contents

I. COMPOSITION OF THE COUNCIL

Introduction

This handbook is updated annually to help councillors understand how they can best be prepared to participate in the annual meeting. The councillor who knows how the Council functions, who takes the time to understand issues affecting the College and the specialty, and who makes a point of talking with individual candidates for office about their objectives is a model representative.

What is the Council?

The Council is a body composed of emergency physicians who directly represent the 53 chartered chapters of the American College of Emergency Physicians, the Emergency Medicine Residents' Association (EMRA), the Association of Academic Chairs in Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors (CORD), the Society for Academic Emergency Medicine (SAEM), and the College's sections of membership. The Council meets annually, just prior to the ACEP annual meeting. The Council may meet more often, but special meetings must be duly called as specified in the ACEP Bylaws.

The number of councillors who represent a chapter in a given year is determined by the number of ACEP members in that chapter on December 31 each year. Each chapter is represented by at least one councillor; an additional councillor is allowed for each 100 members in the chapter. EMRA is allocated four voting councillors; AACEM, CORD, and SAEM are each allocated one voting councillor; and each section of membership is allocated one voting councillor.

What Does the Council Do?

The Council elects the Board of Directors, Council officers, and the president-elect of the College. The Council shares responsibility with the Board of Directors for initiating policy, and councillors shape the strategic plan of the College by providing comments on behalf of the constituencies they represent. The Council also provides a participatory environment where policies already established or under consideration by the Board of Directors can be debated.

So that the Board of Directors can manage change for the good of the membership, the specialty, and the public, the Council serves as a sounding board and communication network. Councillors are expected to be aware of environmental changes, see association goals as essential to the continued vitality of the specialty, and understand the rationale behind decisions made by the Board of Directors.

The Council officers (speaker and vice speaker) chair the annual meeting and participate in all meetings of the Board of Directors as representatives of the Council.

II. COUNCILLOR PREPARATION

How Does a Councillor Prepare for the Annual Meeting?

Councillors are certified by their component body (chapter, EMRA, AACEM, CORD, SAEM, or section) no later than 60 days before the annual meeting. Component bodies are also referred to as sponsoring bodies in the Bylaws.

Comprehensive materials are distributed to councillors at least 30 days before the annual meeting. These materials contain the meeting agenda, current strategic plan, minutes of the previous annual meeting, and annual committee reports. All resolutions submitted by the deadline are also provided with background information and cost implications developed by staff.

Councillors are expected to review the materials carefully and to meet with the leadership of the component bodies they represent to discuss issues that will be addressed at the annual meeting. The component body leadership may want to instruct the councillor on how to vote on various resolutions, but the councillor should be open to receiving additional information at the meeting and then make the best decision on behalf of the College.

How Does the Council Conduct its Business?

Business attire is appropriate for the Council meeting.

Most of the work of the Council is conducted in reference committee hearings. The hearings provide a system for gathering information and expediting business. Each resolution submitted to the Council is referred to a reference committee, which holds a hearing to gather information from all interested councillors and other College members. The reference committees then recommend a specific course of action for the Council on each resolution. Reference committees are composed of councillors selected by the Council officers. Guidelines for reference committee hearings are provided on pages 5-7. All reference committee meetings are open to the membership, except for the executive session. When the executive session is called, the chair will inform the audience of the time frame of the session.

As previously stated, the Council elects the Board of Directors, Council officers, and the president-elect; initiates policy; and shapes the strategic plan of the College. The Council also identifies issues for study and evaluation by the Board and the committees of the Board. There is usually a tremendous amount of business to be conducted during the two-day meeting and several tools are used to facilitate that business.

The Bylaws of the College specifies basic procedures that must be followed by the Council. These procedures include how nominations and elections must be conducted, how resolutions must be submitted and handled, and how the Bylaws may be amended. The most current Bylaws are provided with the Council meeting materials.

Standing Rules for the conduct of the meeting change little, if any, from one year to the next and cover general procedures such as how debate, credentialing, and elections will be handled. The Standing Rules are amendable only by resolution. The most current Standing Rules are provided with the Council meeting materials.

Except when superseded by the Bylaws or the Standing Rules, the rules in *The Standard Code of Parliamentary Procedure 4th edition* (also known as *Sturgis*) govern the Council in all applicable cases. A chart describing parliamentary rules is provided on pages 16-17.

A councillor is not expected to memorize the Bylaws, Standing Rules, or *Sturgis;* however, a quick review of these documents will give the first-time councillor a basic understanding of how business is conducted on the floor of the Council. The most important rule that a councillor should remember is that a "point of personal privilege" is always in order. If a councillor does not understand what is happening, the point of personal privilege should be used to request clarification. An orientation session is always held the night before the Council meeting and the basics of parliamentary procedure are reviewed.

What is a Resolution?

New policies and changes to existing policy are recommended to the Council in the form of resolutions. Resolutions usually pertain to issues affecting the practice of emergency medicine, advocacy and regulatory issues, Bylaws amendments, Council Standing Rules amendments, and College Manual amendments.

"Resolutions" are considered formal motions that if adopted will become official Council policy and will apply not only to the present meeting but also to future business of the Council.

Resolutions must be submitted in writing by at least two members on or before 90-days prior to the annual Council meeting. These resolutions are known as "regular resolutions." Resolutions may also be submitted by chapters, sections, committees, or the Board of Directors. Resolutions sponsored by a chapter or section must be accompanied by an endorsement of the sponsoring body. Resolutions sponsored by national ACEP committees must first be approved by the Board of Directors for submission to the Council. Upon approval by the Board, the resolution will then include the endorsement of the committee and the Board. Regular resolutions will be referred to an appropriate Reference Committee for consideration.

Amendments to Resolutions

All motions for substantial amendments to resolutions must be submitted to the speaker in writing prior to being introduced verbally. When appropriate, the amendment will be projected on a screen for viewing by the Council.

Late Resolutions

Resolutions submitted after the 90-day submission deadline, but not less than 24 hours prior to the beginning of the annual Council meeting, are known as "late resolutions." Late resolutions are considered by the Steering Committee at its meeting on the evening prior to the opening of the annual Council meeting. The Steering Committee is empowered to decide whether a late submission is justified. Late submission is justified when events giving rise to the resolution occur after the filing deadline for resolutions. If a majority of the voting members of the Steering Committee vote to waive the filing and transmittal requirements, the resolution is presented to the Council at its opening session and assigned to a Reference Committee. When the Steering Committee votes unfavorably, the reason for such action shall be reported to the Council at its opening session. Disallowed late resolutions are not considered by the Council unless the Council, by a majority vote of councillors present and voting, overrides the Steering Committee's recommendation**.**

Emergency Resolutions

Resolutions submitted less than 24 hours prior to, or after the beginning of the annual Council meeting, are known as "emergency resolutions." Emergency resolutions are limited to substantive issues that could not have been considered by the Steering Committee prior to the Council meeting because of their acute nature, or resolutions of commendation that become appropriate during the course of the Council meeting. Emergency resolutions must be submitted in writing to the speaker who will then present the resolution to the Council for its consideration. The originator of the resolution, when recognized by the chair, may give a one-minute summary of the emergency resolution to enable the councillors to determine the importance of the resolution. Without debate, a majority vote of the councillors present and voting is required to accept the emergency resolution for floor debate and action. If an emergency resolution is introduced prior to the beginning of the Reference Committee hearings, upon acceptance by the Council, it will be referred to the appropriate Reference Committee. If an emergency resolution is introduced and accepted after the Reference Committee hearings, the resolution will be debated on the floor of the Council at a time chosen by the speaker.

What if I Have Questions About the Council?

Questions about the Council should be directed to national ACEP staff in the Office of the Executive Director. They work closely with the Council officers in planning and executing the annual meeting and helping members to develop resolutions for consideration by the Council.

How are Nominations and Elections Conducted?

Each year the Council elects four members to the Board of Directors to terms of three years. The Council speaker and vice-speaker, who serve two-year terms, are elected by the Council every other year. The Council also elects the president-elect of the College annually for a one-year term.

Nomination procedures and the composition of the nominating committees are specified in the Bylaws. Councillors may submit nominations from the floor at the annual meeting, but nominations are closed on the first day of the annual meeting. Closing the nominations assures that all candidates will have the opportunity to share their viewpoints during an open forum with councillors. The elections are the last item of business on the second day of the Council meeting. The Tellers, Credentials, & Elections Committee, which is appointed by the Council officers, conducts the elections. A majority of votes cast is required for election. Election procedures are described in the Council Standing Rules and the Bylaws.

With the exception of the president-elect, the Board of Directors elects its own officers (chair, vice president, and secretary-treasurer) each year during the first Board meeting after the Council meeting.

Each year a Candidate Forum is held. This year the Candidate Forum will be held from 2:45 – 4:00 pm in each of the Reference Committee meeting rooms with the candidates rotating between rooms. Members of the Candidate Forum Subcommittee will moderate each session with the candidates. Candidates will answer questions and declare their views on issues facing emergency medicine. An informal reception will be held for members to personally meet and speak with candidates. All councillors are encouraged to attend the Candidate Forum and reception.

The Candidate Campaign Rules prohibit the scheduling of candidate receptions by any component body during the annual Council meeting. This position was adopted by the Council and the Board of Directors.

What is the Steering Committee?

The Council officers appoint the Steering Committee. The Steering Committee conducts the business of the Council between annual meetings. Attempts are made to limit service on the committee to two years, with about half of the committee membership replaced each year. Care is taken to assure adequate geographic representation on the committee.

The Steering Committee may identify resolution topics to stimulate discussion of key issues by the Council, plans the Council agenda, and advises and assists the officers with meeting logistics. The Steering Committee has the authority, rarely invoked, to take positions on behalf of the Council subject to ratification by the Council at the next annual meeting.

2018 Council Steering Committee

John G. McManus, Jr., MD, FACEP, Chair
Gary R. Katz, MD, MBA, FACEP, Vice Chair
Michael J. Baker, MD, FACEP (MI)
Douglas M. Char, MD, FACEP (MO)
Kathleen J. Clem, MD, FACEP (FL)
Melissa W. Costello, MD, FACEP (AL)
Sarah Hoper, MD, JD, FACEP (IA)
Tiffany Jackson, MD (SC)
Gabor D. Kelen, MD, FACEP (AACEM)
Chadd K. Kraus, DO, DrPH, MPH, FACEP (YPS)
Jeff F. Linzer, MD, FACEP (GA)
Heather A. Marshall, MD, FACEP (NM)
Tony B. Salazar, MD, FACEP (NM)
Sullivan K. Smith, MD, FACEP (TN)
Annalise Sorrentino, MD, FACEP (AL)
Susanne J. Spano, MD, FACEP (Wilderness)

III. COUNCIL REFERENCE COMMITTEE PROCEEDINGS AND REPORTS

The duty of a Reference Committee is to hold hearings, deliberate on various resolutions and proposals, and recommend a particular course of action on each to the Council.

It may not be possible for each councillor to be fully informed or to have an opinion on every resolution. Therefore, the reference committee is designated to investigate and deliberate on the issues. By dividing the proposals between several Reference Committees, the Council can transact more business than if the entire Council had to discuss all of the pros and cons of each resolution.

Members of the Reference Committees are appointed by the speaker. They are chosen on the basis of their activities in the College and their expertise on particular issues. They are not chosen because of their stand on particular issues.

Procedures

Reference Committee hearings are open to all members of the College, its committees, and invited guests of the Reference Committee. Members of the College, its committees, and/or invited guests are privileged to present written testimony or to speak to the committee on the resolution under consideration. Upon recognition by the chair, non-members may be permitted to speak. The chair is privileged to call upon anyone attending the hearing if, in his/her opinion, the individual called upon may have information that would be helpful to the committee.

The Reference Committee hearings are scheduled from 9:30 am until 12:30 pm Saturday, September 29. Reference Committees may take brief breaks if the chair determines that time is available. The Reference Committee chair is requested to designate a member of the committee to keep track of all pro and con comments pertaining to each resolution.

Proceedings

Equitable hearings are the responsibility of the Reference Committee chair. The committee may establish its own rules on the presentation of testimony with respect to limitations of time, repetitive statements, etc. The Reference Committee hearing is the proper forum for discussion of controversial items of business. Councillors who have not taken advantage of the hearings to present their viewpoints or introduce evidence should be reluctant to do so on the floor of the Council. While it is recognized that the concurrence of Reference Committee hearings creates difficulties in this respect, as does service by councillors on other Reference Committees, the submission of written testimony can alleviate these problems. But there is never compulsion for mute acceptance of Reference Committee recommendations when the report is presented. Written testimony is encouraged. In the event of extensive written testimony, the Reference Committee chair will report to the Reference Committee the number of written testimony received in favor and in opposition to the resolution. The Reference Committee chair has the discretion to read any written testimony, especially testimony that provides information not previously presented in other written or in-person testimony. All written testimony will be made available electronically to the Council unless determined by the Speaker to contain inaccurate information or inappropriate comments. The reading of any written testimony shall not exceed the time limits set by the chair for providing testimony on any particular resolution.

The chair will decide the order and/or grouping of resolutions and will post times to start each discussion. Before beginning discussion on the first resolution, the chair will ask if there is a "pressing need" for any resolutions to be taken out of order to allow individuals to provide testimony to a particular issue. **Determination of a "pressing need" will be left to the discretion of the chair**. The chair will ask if the primary author(s) of the resolution is present or if another individual is present who may speak to the intent of the resolution, and if the individual wishes to provide guidance to the committee.

If an individual arrives to present testimony before or after the time the resolution was scheduled for discussion, it is at the discretion of the chair as to when that member may speak to the resolution. When presenting testimony, the individual should state their name, component body, and whether speaking in support of or against the resolution. No one should speak more than once on a resolution unless it is to clarify a point. Prior to closing debate, the chair will ask Board members, officers, staff, and others with particular expertise for their testimony.

Following the open hearing and after all testimony is given, a Reference Committee will go into executive session to deliberate and construct its report. It may call into such executive session anyone whom it may wish to hear or question. Others are permitted to be in attendance, but may not address the committee unless requested by the chair for clarification of testimony or to answer questions by committee members.

Reports

Reference Committee reports comprise the bulk of the official business of the Council. The reports need to be constructed swiftly and succinctly after completion of the hearing so that they can be processed and made available to the councillors as far in advance of formal presentation as possible. Reference Committees have wide latitude in facilitating expression of the will of the majority on the matters before them and in giving credence to the testimony they hear. They may amend resolutions, consolidate kindred resolutions by constructing substitutes, and recommend the usual parliamentary procedures for disposition of the business before them, such as adoption, not for adoption, amendment, and referral. Minority reports from reference committees are in order.

When the Reference Committee presents its report to the Council, each report or resolution that has been accepted by the Council as its business is the matter which is before the Council for disposition together with the committee's recommendation in that regard. If a number of closely related items have been considered by

the committee and consolidation or substitution is proposed by the committee, the substitute resolution will be the matter before the Council for discussion.

Each item referred to a Reference Committee is reported to the Council as follows:

1. identify the resolution by number and title
2. state concisely the committee's recommendation
3. motions to refer or postpone should be listed at the beginning of the report, after the consent calendar
4. comment, as appropriate, on the testimony presented at the hearing
5. incorporate evidence supporting the recommendation of the committee

Each Reference Committee will make recommendations on each resolution assigned to it in a written report. The speaker will open for discussion each resolution or matter which is the immediate subject of the reference committee report. The effect is to permit full consideration of the business at hand, unrestricted to any specific motion for its disposal. Any appropriate motion for amendment or disposition may be made from the floor. In the absence of such a motion, the speaker will state the question and provide the recommendation of the reference committee. If the recommendation is referral or amended language, the primary motion on the table is the recommendation of the Reference Committee.

Examples of our common variants employing the procedure are:

1. The Reference Committee recommends that a resolution not be adopted. The speaker places the resolution before the Council for discussion. In the absence of other motions from the floor, the speaker places the question on adoption of the resolution, making it clear that the Reference Committee has recommended that it not be adopted (a negative vote).

2. The Reference Committee recommends amending a resolution by adding, striking out, inserting, or substituting. The matter that is placed before the Council for discussion is the amended version as presented by the reference committee together with the recommendation for its adoption. It is then in order for the Council to apply to this reference committee version amendments in the usual fashion. Such procedure is clear and orderly and does not preclude the possibility that an individual may wish to restore the matter to its original unamended form. This may be accomplished quite simply by moving to amend the reference committee version by restoring the original language.

3. The Reference Committee recommends referral of a resolution to the Board of Directors, Council Steering Committee, or Bylaws Interpretation Committee of the College. The speaker places the motion to refer before the Council for discussion. Adoption of the motion to refer removes the matter from consideration by the Council. If the motion to refer is not adopted, the resolution comes before the body for discussion. The Council is then free to adopt, not adopt, or amend the resolution.

4. The Reference Committee recommends consolidation of two or more kindred resolutions into a single resolution, or it recommends adoption of one of these items in its own right as a substitute for the rest. The matter before the Council consideration is the recommendation of the reference committee or the substitute or consolidate version. A motion to adopt this substitute is the main motion. If the Reference Committee's version is not adopted the entire group of proposals has been rejected but it is in order for any councillor to then propose consideration and adoption of any one of the original resolutions or reports.

IV. GUIDELINES AND DEFINITIONS OF COUNCIL ACTIONS TO ASSIST THE COUNCIL IN CONSIDERING REPORTS OF REFERENCE COMMITTEES.

Summary of Council Actions on Reference Committee Reports

Matter Before the Council for Discussion from the Reference Committee's Report	Reference Committee's Recommendation	Speaker Action (Failing Council Action)
Original Resolution	1.To adopt or to not adopt	Puts question on adoption, clearly stating the reference committee's recommendation
Original Resolution	2. To refer	Puts question on referral
Committee Substitute (amending original by adding, striking out, inserting, or substituting)	3. To adopt	Puts question on adoption of the committee's substitute resolution
Committee Substitute Resolution (combining several like resolutions)	4. To adopt	Puts question on adoption of the committee's substitute resolution

Definition of Council Action

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 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) resolution in original or amended form.

V. PRINCIPLE RULES GOVERNING MOTIONS

Order of precedence [1]	Can interrupt	Requires second?	Debatable	Amendable	Vote Required?	Applies to what other motions?	Can have what other motions applied (in addition to withdraw)[4] ?
Privileged Motions							
1. Adjourn	No	Yes	Yes[3]	Yes[3]	Majority	None	Amend
2. Recess	No	Yes	Yes[3]	Yes[3]	Majority	None	Amend[3]
3. Question of privilege	Yes	No	No	No	None	None	None
Subsidiary Motions							
4.Postpone temporarily(table)	No	Yes	No	No	Majority[2]	Main motion	None
5. Close debate	No	Yes	No	No	2/3	Debatable motions	None
6. Limit debate	No	Yes	Yes[3]	Yes[3]	2/3	Debatable motions	Amend[3]
7. Postpone definitely (to a certain time)	No	Yes	Yes[3]	Yes[3]	Majority	Main motion	Amend[3], close debate, limit debate
8. Refer to committee	No	Yes	Yes[3]	Yes[3]	Majority	Main motion	Amend[3], close debate, limit debate
9. Amend	No	Yes	Yes	Yes	Majority	Rewordable motions	Close debate, limit debate, amend
Main Motions							
10.							
a.The main motion	No	Yes	Yes	Yes	Majority	None	Restorative, subsidiary
b. Restorative main motions							
Amend a previous action		No	Yes	Yes	Yes	Majority	Main motion Subsidiary, restorative
Ratify	No	Yes	Yes	Yes	Majority	Previous action	Subsidiary
Reconsider	Yes	Yes	Yes	No	Majority	Main motion	Close debate, limit debate
Rescind	No	Yes	Yes	No	Majority	Main motion	Close debate, limit debate
Resume consideration	No	Yes	No	No	Majority	Main motion	None

[1] Motions are in order only if no motion higher on the list is pending. Thus, if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.
[2] Requires two-thirds vote when it would suppress a motion without debate.
[3] Restricted.
[4] Withdraw may be applied to all motions.

VI. INCIDENTAL MOTIONS

No order of precedence	Can interrupt	Requires second?	Debatable	Amendable	Vote Required?	Applies to what other motions	Can have what other motions applied (in addition to withdraw)?
Motions							
Appeal	Yes	Yes	Yes	No	2/3*	Decision of chair	Close debate, limit debate
Suspend Rules	No	Yes	No	No	2/3	None	None
Consider informally	No	Yes	No	No	Majority	Main motion	None
Requests							
Point of Order	Yes	No	No	No	None	Any error	None
Parliamentary inquiry	Yes	No	No	No	None	All motions	None
Withdraw a motion	Yes	No	No	No	None	All motions	None
Division of question	No	No	No	No	None	Main motion	None
Division of assembly	Yes	No	No	No	None	Indecisive vote	None

* Per the Council Standing Rules.

VII. GUIDELINES FOR WRITING ACEP COUNCIL RESOLUTIONS

Definition

The Council considers items in the form of resolutions. Resolutions set forth background information and propose a course of action.

Submission and Deadline

Resolutions can be submitted by e-mail, fax, or U.S. mail. Receipt of resolutions will be acknowledged by e-mail or phone.

All resolutions should be submitted to:

Sonja Montgomery, CAE
Governance Operations Director
American College of Emergency Physicians
PO Box 619911
Dallas, TX 75261-9911

E-mail: smontgomery@acep.org
Phone: 800-798-1822 x3202
Fax: 972-580-2816

Bylaws and regular resolutions are due 90 days before the annual Council meeting. The 2018 Council meeting will be held on Saturday, September 29 and Sunday, September 30, in San Diego, CA. Therefore, the deadline for resolutions for the 2018 Council meeting is July 1, 2018.

Each resolution must be submitted by at least two members of the College. In the case of a chapter or section, a letter of endorsement must accompany such resolution from the president or chair representing the sponsoring body. If submitting by e-mail, the letter of endorsement can be either attached to the e-mail or embedded in the body of the e-mail.

All resolutions from national ACEP committees must be submitted to the Board of Directors for review prior to the resolution deadline. This usually occurs at the June Board of Directors meeting. If the Board accepts the submission of the resolution, then the resolution carries the endorsement of the committee and the Board of Directors.

Questions

Please contact Sonja Montgomery, CAE, smontgomery@acep.org, at ACEP Headquarters, 800-798-1822, extension 3202, for further information about preparation of resolutions.

Format

The title of the resolution must appropriately reflect the intent. Resolutions begin with "Whereas" statements, which provides the basic facts and reasons for the resolution, and conclude with "Resolved" statements, which identifies the specific proposal for the requestor's course of action.

Whereas Statements

Background, or “Whereas” information provides the rationale for the "resolved" course of action. The whereas statement(s) should lead the reader to your conclusion (resolved).

In writing whereas statements, begin by introducing the topic of the resolution. Be factual rather than speculative and provide or reference statistics whenever possible. The statements should briefly identify the problem, advise the timeliness or urgency of the problem, the effect of the issue, and indicate if the action called for is contrary to or will revise current ACEP policy. Inflammatory statements that reflect poorly on the organization will not be permitted.

Resolved Statements

Resolve statements are the only parts of a resolution that the Council and Board of Directors act upon. Conceptually, resolves can be classified into two categories – policy resolves and directives. A policy resolve calls for changes in ACEP policy. A directive is a resolve that calls for ACEP to take some sort of action. Adoption of a directive requires specific action but does not directly affect ACEP policy.

A single resolution can both recommend changes in ACEP policy and recommend actions about that new policy. The way to accomplish this objective is to establish the new policy in one resolve (a policy resolve), and to identify the desired action in a subsequent resolve (a directive).

Regardless of the type of resolution, the resolve should be stated as a motion that can be understood without the accompanying whereas statements. When the Council adopts a resolution, only the resolve portion is forwarded to the Board of Directors for ratification. The "resolved" must be fully understood and should stand alone.

Bylaws Amendments

In writing a resolve for a Bylaws amendment, be sure to specify an Article number as well as the Section to be amended. Show the current language with changes indicated as follows: new language should be **bolded** (dark green type, bold, and underline text), and language to be deleted should be shown in red, strike-through text (~~delete~~). Failure to specify exact language in a Bylaws amendment usually results in postponement for at least one year while language is developed and communicated to the membership.

General Resolutions

The president, and not the Council, is responsible for determining the appropriate level of committee involvement for resolutions passed by the Council. In addition, the Council cannot "direct" another organization although the College can recommend a course of action to other organizations. For example, Resolution 49(84) directed the ACEP representatives to ABEM to seek ways in which to reduce the fees and associated examinee expenses for the certification examination. Since ACEP does not have representatives to ABEM and since ACEP does not have the authority to direct another organization, it would have been better to state that ACEP ask ABEM to seek ways to reduce examinee expenses.

Council Actions on Resolutions

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 provided 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. A resolution cannot be referred to other College committees.
- **Not Adopt**: Defeat (or reject) the resolution in original or amended form.

Board Actions on Resolutions

According to the Bylaws, Article VIII – Council, Section 2 – Powers of the Council: "The Council shall have the right and responsibility to advise and instruct the Board of Directors regarding any matter of importance to the College by means of Bylaws and non-Bylaws resolutions, including amendments to the College Manual, and other actions or appropriations enacted by the Council. The Board of Directors shall act on all resolutions adopted by the Council no later than the second Board meeting following the annual meeting and

shall address all other matters referred to the Board within such time and manner as the Council may determine.

The Board of Directors shall take one of the following actions regarding a non-Bylaws resolution adopted by the Council:

1. Implement the resolution as adopted by the Council.
2. Overrule the resolution by a three-fourths vote. The vote and position of each Board member shall be reported at the next meetings of the Steering Committee and the Council.
3. Amend the resolution in a way that does not change the basic intent of the Council. At its next meeting, the Steering Committee must either accept or reject the amendment. If accepted, the amended resolution shall be implemented without further action by the Council. If the Steering Committee rejects the amendment, the Board at its next meeting shall either implement the resolution as adopted by the Council, propose a mutually acceptable amendment, or overrule the resolution.

Bylaws amendment resolutions are governed by Article XIII of these Bylaws."

Sample Resolutions

Three resolutions are provided as examples of well-written proposals.

Resolution 9(06) shows how to propose an amendment to the Bylaws. New language is shown in bold with underlining and deleted language is shown in strike-out format. The use of colors in the electronic file (red for strike-out and green for new language) is also helpful.

RESOLUTION 9(06)

WHEREAS, The College Bylaws provides for an Executive Committee of the Board of Directors; and

WHEREAS, The speaker has informally served on the Executive Committee; and

WHEREAS, The Executive Committee would benefit from having more formal and standard composition, including the membership of the speaker and the chair of the Board of Directors; and

WHEREAS, The College would benefit from having an Executive Committee appointed every year; therefore be it

RESOLVED, That the ACEP Bylaws, Article XI – Committees, Section 2 – Executive Committee, be amended to read:

ARTICLE XI – COMMITTEES
Section 2 – Executive Committee

~~The Board of Directors may appoint an Executive Committee~~ **The Board of Directors shall have an Executive Committee,** consisting of the president, president-elect, vice president, secretary-treasurer, ~~and the~~ immediate past president**, and chair. The speaker shall attend meetings of the Executive Committee.** The Executive Committee shall have the authority to act on behalf of the Board**,** subject to ratification by the Board at its next meeting.

Meetings of the Executive Committee shall be held at the call of the **chair or** president. A report of its actions shall be given by the Executive Committee to the Board of Directors in writing within two weeks of the adjournment of the meeting.

Resolution 23(06) shows how communication between the College and another organization can be stated.

RESOLUTION 23(06)

WHEREAS, Emergency medicine is recognized by the American Board of Medical Specialties as an independent specialty with a recognized, unique knowledge base and procedural skill set that is certifiable by board examination; and

WHEREAS, Emergency nursing, within the scope of nursing practice, is also a recognized subspecialty with its own unique knowledge base and skill set that is certifiable by examination, resulting in a Certified Emergency Nurse (CEN); and

WHEREAS, Unlike in emergency medicine, where specialized training and experience are required for a physician to take an emergency medicine board examination, any nurse practicing in an emergency department (ED) is able to sit for the CEN exam; and

WHEREAS, In many EDs throughout the country, the majority of emergency nurses working are not CEN certified; and

WHEREAS, The range of acuity of the emergency patients seen in emergency departments by emergency nurses can be from non-urgent to critically ill; and

WHEREAS, The expectation of patients who utilize emergency departments for their emergency medical care is that there is seamless, high quality medical and nursing care provided; therefore be it

RESOLVED, That the American College of Emergency Physicians works with the Emergency Nurses Association (ENA) to facilitate the development by ENA of a position paper defining a standard of emergency nursing care that includes obtaining CEN certification and outlines a timetable for an emergency nurse to attain such certification; and be it further

RESOLVED, That the American College of Emergency Physicians works with ENA, the American Hospital Association (AHA) and related state hospital organizations to provide resources, support, and incentives for emergency nurses to be able to readily attain CEN certification.

Resolution 16(99) shows how statistics can be used to lead the reader to your conclusion.

RESOLUTION 16(99)

WHEREAS, According to the National Association of State Boating Law Administrators, the number of boating accidents involving alcohol increased 20% over a five-year period; and

WHEREAS, The number of deaths attributed to boating and alcohol has also increased 20% during this same time period; and

WHEREAS, A study of four states found 60% of boating fatalities had elevated blood alcohol levels and 30% were intoxicated with BAL greater than 0.1%; and

WHEREAS, The fault for boating fatalities can not be attributed to the boat operator in almost half of these deaths; and

WHEREAS, In 1991 46% of all boating deaths occurred while the boat was not even underway; and

WHEREAS, It has thus been suggested that intoxicated boat passengers are at independent risk for boating injuries; and this risk is assumed to be due to intoxicated passengers being at increased risk for falls overboard and risk taking behaviors; and

WHEREAS, Educational and enforcement measures have predominantly targeted boat operators and not boat passengers about the dangers of alcohol consumption and boating; therefore be it

RESOLVED, That the American College of Emergency Physicians promote and endorse safe boating practices; and be it further

RESOLVED, That ACEP promote educating both boat passengers and operators about the dangers of alcohol intoxication while boating.

VIII.

ACEP Parliamentary Motions Guide

Based on *Sturgis Standard Code of Parliamentary Procedure (4th Ed.)*[1]

The motions below are listed in order of precedence.
Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
(77) Close meeting	I move that we **adjourn**	No	Yes	No	No	Majority
(75) Take break	I move to **recess** for	No	Yes	Yes	Yes	Majority
(72) Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
(68) Lay aside temporarily	I move that the main motion be **postponed temporarily**	No	Yes	No	No	Varies
(65) Close debate and vote immediately	I move to **close debate**	No	Yes	No	No	2/3
(62) **Limit or extend debate**	I move to limit debate to ...	No	Yes	Yes	Yes	2/3
(58) **Postpone to certain time**	I move to postpone the motion until ...	No	Yes	Yes	Yes	Majority
(55) **Refer** to committee	I move to refer the motion to …	No	Yes	Yes	Yes	Majority
(47) Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
(32) Bring business before assembly (a **main motion**)	I move that …	No	Yes	Yes	Yes	Majority

Jim Slaughter, Certified Professional Parliamentarian – Teacher & Professional Registered Parliamentarian
336/378/1899 (W) 336/378-1850 (Fax) P.O. Box 41027, Greensboro NC 27404-1027 web site: www.jimslaughter.com

[1] As modified by the ACEP Council Standing Rules

Incidental Motions - no order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
(82) Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Yes	No	2/3
(84) Suspend rules	I move to **suspend the rule** requiring	No	Yes	No	No	2/3
(87) Enforce rules	**Point of order**	Yes	No	No	No	None
(90) Parliamentary question	**Parliamentary inquiry**	Yes	No	No	No	None
(94) Request to **withdraw motion**	I wish to withdraw my motion	Yes	No	No	No	None
(96) **Divide motion**	I request that the motion be divided …	No	No	No	No	None
(99) Demand rising vote	I call for a **division of the assembly**	Yes	No	No	No	None

Restorative Main Motions - no order of precedence. Introduce only when nothing else pending.

(36) **Amend a previous action**	I move to amend the motion that was …	No	Yes	Yes	Yes	Varies
(38) Reconsider motion	I move to **reconsider** ...	Yes	Yes	Yes	No	Majority
(42) Cancel previous action	I move to **rescind**...	No	Yes	Yes	No	Majority
(44) Take from table	I move to **resume consideration** of ...	No	Yes	No	No	Majority

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Council Standing Rules

Revised October 2017

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Standing Rules

Revised October 2017

Preamble

These Council Standing Rules serve as an operational guide and description for how the Council conducts its business at the annual meeting and throughout the year in accordance with the College Bylaws, the College Manual, and standing tradition.

Alternate Councillors

A properly credentialed alternate councillor may substitute for a designated councillor not seated on the Council meeting floor. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed. A councillor or an alternate councillor may not serve simultaneously as an alternate councillor for more than one component body.

If the number of alternate councillors is insufficient to fill all councillor positions for a component body, then a member of that component body may be seated as a councillor pro-tem by either the concurrence of an officer of the component body or upon written request to the Council secretary with a majority vote of the Council. Disputes regarding the assignment of councillor pro-tem positions will be decided by the speaker.

Amendments to Council Standing Rules

These rules shall be amended by a majority vote using the formal Council resolution process outlined herein and become effective immediately upon adoption. Suspension of these Council Standing Rules requires a two-thirds vote.

Announcements

Proposed announcements to the Council must be submitted by the author to the Council secretary, or to the speaker. The speaker will have sole discretion as to the propriety of announcements. Announcements of general interest to members of the Council, at the discretion of the speaker, may be made from the podium. Only announcements germane to the business of the Council or the College will be permitted.

Appeals of Decisions from the Chair

A two-thirds vote is required to override a ruling by the chair.

Board of Directors Seating

Members of the Board of Directors will be seated on the floor of the Council and are granted full floor privileges except the right to vote.

Campaign Rules

Rules governing campaigns for election of the president-elect, Board of Directors, and Council officers shall be developed by the Steering Committee and reviewed on an annual basis. Candidates, councillors, and component bodies are responsible for abiding by the campaign rules.

Conflict of Interest Disclosure

All councillors and alternate councillors will be familiar with and comply with ACEP's Conflict of Interest policy. Individuals who have a financial interest in a commercial enterprise, which interest will be materially affected by a matter before the Council, will declare their conflict prior to providing testimony.

Councillor Allocation for Sections of Membership

To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

Councillor Seating

Councillor seating will be grouped by component body and the location rotated year to year in an equitable manner.

Credentialing and Proper Identification

To facilitate identification and seating, councillors are required to wear a name badge with a ribbon indicating councillor or alternate councillor. Individuals without such identification will be denied admission to the Council floor. Voting status will be designated by possession of a councillor voting card issued at the time of credentialing by the Tellers, Credentials, and Elections Committee. College members and guests must also wear proper identification for admission to the Council meeting room and reference committees.

The Tellers, Credentials, and Elections Committee, at a minimum, will report the number of credentialed councillors at the beginning of each Council session. This number is used as the denominator in determining a two-thirds vote necessary to adopt a Bylaws amendment.

Debate

Councillors, members of the Board of Directors, past presidents, past speakers, and past chairs of the Board wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, past chair, etc.), and whether they are speaking "for" or "against" the motion.

Debate should not exceed two minutes for each recognized individual unless special permission has been granted by the presiding officer. Participants should refrain from speaking again on the same issue until all others wishing to speak have had the opportunity to do so.

In accordance with parliamentary procedure, the individual speaking may only be interrupted for the following reasons: 1) point of personal privilege; 2) motion to reconsider; 3) appeal; 4) point of order; 5) parliamentary inquiry; 6) withdraw a motion; or 7) division of assembly. All other motions must wait their turn and be recognized by the chair.

Seated councillors or alternate councillors have full privileges of the floor. Upon written request and at the discretion of the presiding officer, alternate councillors not currently seated, and other individuals may be recognized and address the Council. Such requests must be made in writing prior to debate on that issue and should include the individual's name, organization affiliation, issue to be addressed, and the rationale for speaking to the Council.

Distribution of Printed or Other Material During the Annual Meeting

The speaker will have sole discretion to authorize the distribution of printed or other material on the Council floor during the annual meeting. Such authorization must be obtained in advance.

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot. There shall be no write-in voting.

When voting electronically, the names of all candidates for a particular office will be projected at the same time. Thirty (30) seconds will be allowed for each ballot. Councillors may change votes only during the allotted time. The computer will accept the last vote or group of votes selected before voting is closed. When voting with paper ballots, the chair of the Tellers, Credentials, & Elections Committee will determine the best procedure for the election process.

Councillors must vote for the number of candidates equal to the number of available positions for each ballot. A councillor's individual ballot shall be considered invalid if there are greater or fewer votes on the ballot than is required. The total number of valid and invalid individual ballots will be used for purposes of determining the denominator for a majority of those voting.

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast shall be elected. If more candidates receive a majority vote than the number of positions available, the candidates with the highest number of votes will be elected. When one or more vacancies still exist, elected candidates and their respective positions are removed and all non-elected candidates remain on the ballot for the subsequent vote. If no candidate is elected on any ballot, the candidate with the lowest number of valid votes is removed from subsequent ballots. In the event of a tie for the lowest number of valid votes on a ballot in which no candidate is elected, a run-off will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote* for each open position.

*NOTE: If at any time, the total number of invalid individual ballots added to any candidate's total valid votes would change which candidate is elected or removed, then only those candidates not affected by this discrepancy will be elected. If open positions remain, a subsequent vote will be held to include all remaining candidates from that round of voting.

The chair of the Tellers, Credentials, & Elections Committee will make the final determination as to the validity of each ballot. Upon completion of the voting and verification of votes for all candidates, the Tellers, Credentials, and Elections Committee chair will report the results to the speaker.

Within 24 hours after the close of the annual Council meeting, the Chair of the Tellers, Credentials, & Elections Committee shall present to the Council Secretary a written report of the results of all elections. This report shall include the number of credentialed councillors, the slate of candidates, and the number of open positions for each round of voting, the number of valid and invalid ballots cast in each round of voting, the number needed to elect and the number of valid votes cast per candidate in each round of voting, and verification of the final results of the elections. This written report shall be considered a privileged and confidential document of the College. However, when there is a serious concern that the results of the election are not accurate, the Speaker has discretion to disclose the results to provide the Council an assurance that the elections are valid. Individual candidates may request and receive their own total number of votes and the vote totals of the other candidates without attribution.

Electronic Devices

All electronic devices must be kept in "quiet" mode during the Council meeting. Talking on cellular phones is prohibited in Council meeting rooms. Use of electronic devices for Council business during the meeting is encouraged, but not appropriate for other unrelated activities.

Limiting Debate

A motion to limit debate on any item of business before the Council may be made by any councillor who has been granted the floor and who has not debated the issue just prior to making that motion. This motion requires a second, is not debatable, and must be adopted by a two-thirds vote. ***See also Debate and Voting Immediately.***

Nominating Committee

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 when considering the slate of candidates.

Nominations

A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, past speaker, or past chair of the Board, after which nominations will be closed and shall not be reopened.

Members not nominated by the Nominating Committee may declare themselves "floor candidates" at any time after the release of the Nominating Committee report and before the Speaker closes nominations during the Council meeting. All floor candidates must notify the Council Speaker in writing. Upon receipt of this notification, the candidate becomes a "declared floor candidate," has all the rights and responsibilities of candidates otherwise nominated by the Nominating Committee and must comply with all rules and requirements of the candidates. ***See also Election Procedures.***

Parliamentary Procedure

The current edition of *Sturgis, Standard Code of Parliamentary Procedure* will govern the Council, except where superseded by these Council Standing Rules, the College Manual, and/or the Bylaws. ***See also Limiting Debate and Voting Immediately.***

Any councillor may call for a "point of personal privilege," "point of order," or "parliamentary inquiry" at any time even if it interrupts the current person speaking. This procedure is intended for uses such as asking a question for clarification, asking the person speaking to talk louder, or to make a request for personal comfort. Use of "personal privilege," etc. to interject debate is out of order.

Past Presidents, Past Speakers, and Past Chairs of the Board Seating

Past presidents, past speakers, and past chairs of the Board of the College are invited to sit with their respective component body, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

Policy Review

The Council Steering Committee will report annually to the Council the results of a periodic review of non-Bylaws resolutions adopted by the Council and approved by the Board of Directors.

Reference Committees

Resolutions meeting the filing and transmittal requirements in these Standing Rules will be assigned by the speaker to a Reference Committee for deliberation and recommendation to the Council. Reference Committee meetings are open to all members of the College, its committees, and invited guests.

Reference Committees will hear as much testimony for its assigned resolutions as is necessary or practical and then adjourn to executive session to prepare recommendations for each resolution in a written Reference Committee Report.

A Reference Committee may recommend that a resolution:

A) **Be Adopted or Not Be Adopted:** In this case, the speaker shall state the resolution, which is then the subject for debate and action by the Council.

B) **Be Amended or Substituted:** In this case, the speaker shall state the resolution as amended or substituted, which is then the subject for debate and action by the Council.
C) **Be Referred:** In this case, the speaker shall state the motion to refer. Debate on a Reference Committee's motion to refer may go fully into the merits of the resolution. If the motion to refer is not adopted, the speaker shall state the original resolution.

Other information regarding the conduct of Reference Committees is contained in the Councillor Handbook.

Reports

Committee and officer reports to be included in the Council minutes must be submitted in writing to the Council secretary. Authors of reports who petition or are requested to address the Council should note that the purpose of these presentations are to elaborate on the facts and findings of the written report and to allow for questions. Debate on relevant issues may occur subsequent to the report presentation.

Resolutions

"Resolutions" are considered formal motions that if adopted by a majority vote of the Council and ratified by the Board of Directors become official College policy. Resolutions pertaining only to the Council Standing Rules do not require Board ratification and become effective immediately upon adoption. Resolutions pertaining to the College Bylaws (Bylaws resolutions) require adoption by a two-thirds vote of credentialed councillors and subsequently a two-thirds vote of the Board of Directors.

Resolutions must be submitted in writing by at least two members or by component bodies, College committees, or the Board of Directors. A letter of endorsement is required from the submitting body if submitted by a component body.

All motions for substantive amendments to resolutions must be submitted in writing through the electronic means provided to the Council during the annual meeting, with the exception of technical difficulties preventing such electronic submission, signed by the author, and presented to the Council prior to being considered. When appropriate, amendments will be distributed or projected for viewing.

Background information, including financial analysis, will be prepared by staff on all resolutions submitted on or before 90 days prior to the annual meeting.

• ***Regular Non-Bylaws Resolutions***
Non-Bylaws resolutions submitted on or before 90 days prior to the annual meeting are known as "regular resolutions" and will be referred to an appropriate Reference Committee for consideration at the annual meeting.

Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90 to 45 day window that appear to alter the original intent of a regular resolution or that would render the background information meaningless will be considered as "Late Resolutions."

• ***Bylaws Resolutions***
Bylaws resolutions must be submitted on or before 90 days prior to the annual meeting and will be referred to an appropriate Reference Committee for consideration at the annual meeting. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the author(s), may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

Bylaws resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, revisions during the 90 to 45 day window that appear to alter the original intent of a Bylaws resolution, or are otherwise considered to be out of order under parliamentary authority, will not be permitted.

• ***Late Resolutions***

Resolutions submitted after the 90-day submission deadline, but at least 24 hours prior to the beginning of the annual meeting are known as "late resolutions." These late resolutions are considered by the Steering Committee at its meeting on the evening prior to the opening of the annual meeting. The Steering Committee is empowered to decide whether a late submission is justified due to events that occurred after the filing deadline. An author of the late resolution shall be given an opportunity to inform the Steering Committee why the late submission was justified. If a majority of the Steering Committee votes to accept a late resolution, it will be presented to the Council at its opening session and assigned to a Reference Committee. If the Steering Committee votes unfavorably and rejects a late resolution, the reason for such action shall be reported to the Council at its opening session. The Council does not consider rejected late resolutions. The Steering Committee's decision to reject a late resolution may be appealed to the Council. When a rejected late resolution is appealed, the Speaker will state the reason(s) for the ruling on the late resolution and without debate, the ruling may be overridden by a two-thirds vote.

• ***Emergency Resolutions***
Emergency resolutions are resolutions that do not qualify as "regular" or "late" resolutions. They are limited to substantive issues that because of their acute nature could not have been anticipated prior to the annual meeting or resolutions of commendation that become appropriate during the course of the Council meeting. Resolutions not meeting these criteria may be ruled out of order by the speaker. Should this ruling be appealed, the speaker will state the reason(s) for ruling the emergency resolution out of order and without debate, the ruling may only be overridden by a two-thirds vote. ***See also Appeals of Decisions from the Chair.***

Emergency resolutions must be submitted in writing, signed by at least two members, and presented to the Council secretary. The author of the resolution, when recognized by the chair, may give a one-minute summary of the emergency resolution to enable the Council to determine its merits. Without debate, a simple majority vote of the councillors present and voting is required to accept the emergency resolution for floor debate and action. If an emergency resolution is introduced prior to the beginning of the Reference Committee hearings, it shall upon acceptance by the Council be referred to the appropriate Reference Committee. If an emergency resolution is introduced and accepted after the Reference Committee hearings, the resolution shall be debated on the floor of the Council at a time chosen by the speaker.

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

A "Unanimous Consent Agenda" is a list of resolutions with a waiver of debate and may include items that meet one of the following criteria as determined by the Reference Committee:

1. Non-controversial in nature
2. Generated little or no debate during the Reference Committee
3. Clear consensus of opinion (either pro or con) was expressed at Reference Committee

Bylaws resolutions and resolutions that require substantive amendments shall not be placed on a Unanimous Consent Agenda.

A Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, or defeat for each resolution listed. A request for extraction of any resolution from a Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

Voting Immediately

A motion to "vote immediately" may be made by any councillor who has been granted the floor. This motion requires a second, is not debatable, and must be adopted by two-thirds of the councillors voting. Councillors are out of order who move to "vote immediately" during or immediately following their presentation of testimony on that motion. The

motion to “vote immediately” applies only to the immediately pending matter, therefore, motions to “vote immediately on all pending matters” is out of order. The opportunity for testimony on both sides of the issue, for and against, must be presented before the motion to “vote immediately” will be considered in order. ***See also Debate and Limiting Debate.***

Voting on Resolutions and Motions

Voting may be accomplished by an electronic voting system, voting cards, standing, or voice vote at the discretion of the speaker. Numerical results of electronic votes and standing votes on resolutions and motions will be presented before proceeding to the next issue.

BYLAWS

Revised October 2017

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

BYLAWS

Revised October 2016

ARTICLE I — NAME

This corporation, an association of physicians active in emergency medicine organized under the laws of the State of Texas, shall be known as the AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (hereinafter sometimes referred to as "ACEP" or the "College"). The words "physician" or "physicians" as used herein include both medical and osteopathic medical school graduates.

ARTICLE II — MISSION, PURPOSES, AND OBJECTIVES

Section 1 — Mission

The American College of Emergency Physicians exists to support quality emergency medical care and to promote the interests of emergency physicians.

Section 2 — Purposes and Objectives

The purposes and objectives of the College are:

1. To establish guidelines for quality emergency medical care.
2. To encourage and facilitate the postgraduate training and continuing medical education of emergency physicians.
3. To encourage and facilitate training and education in emergency medicine for all medical students.
4. To promote education in emergency care for all physicians.
5. To promote education about emergency medicine for our patients and for the general public.
6. To promote the development and coordination of quality emergency medical services and systems.
7. To encourage emergency physicians to assume leadership roles in out-of-hospital care and disaster management.
8. To evaluate the social and economic aspects of emergency medical care.
9. To promote universally available and cost effective emergency medical care.
10. To promote policy that preserves the integrity and independence of the practice of emergency medicine.
11. To encourage and support basic and clinical research in emergency medicine.
12. To encourage emergency physician representation within medical organizations and academic institutions.

ARTICLE III — COLLEGE MEETINGS

All meetings of the Board of Directors of the College (the "Board of Directors" or the "Board"), the Council, and College committees shall be open to all members of the College. A closed session may be called by the Board of Directors, the Council, or any College committee for just cause, but all voting must be in open session.

ARTICLE IV — MEMBERSHIP

Section 1 — Eligibility

Membership in the College is contingent upon the applicant or member showing a significant interest in emergency medicine and being of good moral and professional character. Members agree to abide by the "Code of Ethics for Emergency Physicians." No person shall be denied membership because of sex, race, age, political or religious beliefs, sexual orientation, or real or perceived gender identity.

Section 2 — Classes of Membership

All members shall be elected or appointed by the Board of Directors to one of the following classes of membership: (1) regular member; (2) candidate member; (3) honorary member; or (4) international member. The qualifications required of the respective classes, their rights and obligations, and the methods of their election or appointment shall be set forth in these Bylaws or as otherwise determined by the Board of Directors in the extraordinary case of an individual who does not satisfy all of the criteria of any particular class. Benefits for each class of membership shall be determined by the Board of Directors.

Section 2.1 — Regular Members

Regular members of the College are physicians who devote a significant portion of their medical endeavors to emergency medicine. All regular members must meet one of the following criteria: 1) satisfactory completion of an emergency medicine residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA); 2) satisfactory completion of an emergency medicine residency program approved by an ACEP-recognized accrediting body in a foreign country; 3) satisfactory completion of a subspecialty training program in pediatric emergency medicine accredited by the ACGME; 4) primary board certification by an emergency medicine certifying body recognized by ACEP; or 5) eligibility for active membership in the College (as defined by the College Bylaws then in force) at any time prior to close of business December 31, 1999.

Regular members shall be assigned by the Board of Directors to one of the following statuses: (1) active, (2) inactive, or (3) retired. Members who qualify will additionally be assigned to life status. All applicants for regular membership shall, hold a current, active, full, valid, unrestricted, and unqualified license to practice medicine in the state, province, territory, or foreign country in which they practice, or be serving in a governmental medical assignment. All regular members must either continue to maintain a valid license to practice medicine or have voluntarily relinquished the license upon leaving medical practice. A license to practice medicine shall not be considered voluntarily relinquished if it was surrendered, made inactive, or allowed to expire under threat of probation or suspension or other condition or limitation upon said license to practice medicine by a licensing body in any jurisdiction.

Regular members who are unable to engage in medical practice may, upon application to the Board of Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable annually upon re-application.

Regular members who have retired from medical practice for any reason shall be assigned to retired status.

Any regular member who has been a member of the College for a minimum of 30 years in any class shall be assigned to life status. Any member previously designated as a life member under any prior definition shall retain life status.

Regular members, with the exception of those in inactive status, may hold office, may serve on the Council, and may vote in committees on which they serve. Regular members in inactive status shall not be eligible to hold office, to serve on the Council, or serve on committees.

Section 2.2 — Honorary Members

Persons of distinction who are not members of the College, but have rendered outstanding service to the College or to the specialty of emergency medicine may be elected to honorary membership by the Board of Directors. Individual members and Council component bodies may propose candidates for honorary membership in the College to the Board of Directors. Honorary members cannot be eligible for other categories of College membership. Honorary members are considered members for life and shall not be required to pay any dues. Honorary members may not hold office and may not serve on the Council. Honorary members may vote in committees on which they serve.

Section 2.3 — Candidate Members

Candidate members must meet one of the following criteria: 1) medical student or intern interested in emergency medicine; 2) physician participating in an emergency medicine residency training program; 3) physician participating in a fellowship training program immediately following an emergency medicine residency; 4) physician

participating in a pediatric emergency medicine fellowship training program; or 5) physician in the uniformed services while serving as general medical officer. General medical officers shall be eligible for candidate membership for a maximum of four years. All candidate members will be assigned by the Board of Directors to either active or inactive status.

The rights of candidate members at the chapter level are as specified in their chapter's bylaws. At the national level, candidate members shall not be entitled to hold office, but physician members may serve on the Council. Candidate members appointed to national committees shall be entitled to vote in committees on which they serve.

Candidate members whose training is interrupted for any reason may, upon application to the Board of Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable annually upon re-application. Candidate members in inactive status shall not be eligible to hold office, serve on the Council, or serve on committees.

Section 2.4 — International Members

Any physician interested in emergency medicine who is not a resident of the United States or a possession thereof, and who is licensed to practice medicine by the government within whose jurisdiction such physician resides and practices, shall be eligible for international membership. All international members will be assigned by the Board of Directors to either active or inactive status. Members who qualify will additionally be assigned to life status.

International members who are unable to engage in medical practice may, upon application to the Board of Directors, be assigned to inactive status. The inactive status designation shall be for a period of one year, renewable annually upon re-application.

Any international member who has been a member of the College for a minimum of 30 years in any class shall be assigned to life status. Any member previously designated as a life member under any prior definition shall retain life status.

International members may not hold office, and may not serve on the Council. International members, with the exception of those in inactive status, may vote in committees on which they serve.

Section 3 — Agreement

Acceptance of membership in the College shall constitute an agreement by the member to comply with the ACEP Bylaws. The Board of Directors shall serve as the sole judge of such member's right to be or to remain a member, subject to the due process as described in the College Manual.

All right, title, and interest, both legal and equitable, of a member in and to the property of this organization shall cease in the event of any of the following: a) the expulsion of such member; b) the striking of the member's name from the roll of members; c) the member's death or resignation.

Section 4 — Disciplinary Action

Members of the College may be subject to disciplinary action or their membership may be suspended or terminated by the Board of Directors for good cause. Procedures for such disciplinary action shall be stated in the College Manual.

Section 5 — Dues, Fees, and Assessments

Application fees and annual dues shall be determined annually by the Board of Directors. Assessments of members may not be levied except upon recommendation of the Board of Directors and by a majority vote of the Council. Notice of any proposed assessment shall be sent to each member of the College by mail or official publication at least 30 days before the meeting of the Council at which the proposed assessment will be considered. The Board of Directors shall establish uniform policies regarding dues, fees, and assessments.

Any member whose membership has been canceled for failure to pay dues or assessments shall lose all privileges of membership. The Board of Directors may establish procedures and policies with regard to the

nonpayment of dues and assessments.

Section 6 — Official Publications

Each member shall receive *Annals of Emergency Medicine* and *ACEP Now* as official publications of the College as a benefit of membership.

ARTICLE V — ACEP FELLOWS

Section 1 — Eligibility

Fellows of the College shall meet the following criteria:

1. Be regular or international members for three continuous years immediately prior to election.
2. Be certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
    A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;
    B. Satisfaction of at least three of the following individual criteria during their professional career:
        1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
        2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
        3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
        4. active involvement in emergency medicine administration or departmental affairs;
        5. active involvement in an emergency medical services system;
        6. research in emergency medicine;
        7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
        8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
        9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
        10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

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

Section 2 — Fellow Status

Fellows shall be authorized to use the letters FACEP in conjunction with professional activities. Members previously designated as ACEP Fellows under any prior criteria shall retain Fellow status. Maintenance of Fellow status requires continued membership in the College. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

ARTICLE VI — CHAPTERS

Section 1 — Charters

This corporation may grant charters to chapters of the College according to procedures described in the College Manual.

Section 2 — Chapter Bylaws

A petition for the chartering of a chapter shall be accompanied by the proposed bylaws of the chapter. No charter shall be issued until such bylaws are approved by the Board of Directors of the College. Chartered chapters must ensure that their bylaws conform to the College Bylaws and current approved chapter bylaws guidance documents. Proposed amendments to the bylaws of a chapter shall be submitted in a format and manner designated by the College not later than 30 days following the adoption of such proposed amendments by the chapter, pursuant to its bylaws and procedures. No proposed amendment shall have any force or effect until it has been approved by the Board of Directors of the College. A proposed amendment shall be considered approved if the Board of Directors or its designee fails to give written notice of any objection within 90 days of receipt as documented by the College.

No chapter is permitted to act on behalf of, or to appear to third parties to be acting on behalf of, the College. In accepting or retaining a charter as a chapter of the College, the chapter and its members acknowledge the fact that the chapter is not an agent of the College notwithstanding that the College has the authority to establish rules governing actions of the chapter which may give the appearance of a principal-agent relationship.

Section 3 — Qualifications

The membership of a chapter shall consist of members of the College who meet the qualifications for membership in that chapter. To qualify for membership in a chapter, a person must be a member of the College and have residential or professional ties to that chapter's jurisdiction. Likewise, with the exception of members who are retired from medical practice regardless of membership class, each member of the College must hold membership in a chapter in which the member resides or practices if one exists. If membership is transferred to a new chapter, dues for the new chapter shall not be required until the member's next anniversary date.

A member with professional and/or residential ties in multiple chapters may hold membership in these chapters, providing the member pays full chapter dues in each chapter. Such members with multiple chapter memberships shall designate which single chapter membership shall count for purposes of councillor allotment. A member of a chapter who retires from medical practice regardless of membership class and changes his/her state of residence may retain membership in a chapter of prior professional practice/residence.

A member of a chapter who changes residential or professional location may remain a member of that chapter if there is no chapter at the new location.

Section 4 — Component Branches

A chapter may, under provisions in its bylaws approved by the Board of Directors, charter branches in counties or districts within its area. Upon the approval of the Board of Directors of the College, such component branches may include adjacent counties or districts.

Section 5 — Charter Suspension – Revocation

The charter of any chapter may be suspended or revoked by the Board of Directors when the actions of the chapter are deemed to be in conflict with the Bylaws, or if the chapter fails to comply with all the requirements of these Bylaws or with any lawful requirement of the College.

On revocation of the charter of any chapter by the Board of Directors, the chapter shall take whatever legal steps are necessary to change its name so that it no longer suggests any connection with the American College of Emergency Physicians. After revocation, the former chapter shall no longer make any use of the College name or logo.

Section 6 — Ultimate Authority by College

Where these Bylaws and the respective chapter bylaws are in conflict, the provisions of these Bylaws shall be supreme. When, due to amendment, these Bylaws and the chapter bylaws are in conflict, the chapter shall have two years from written notice of such conflict to resolve it through amendment of chapter bylaws.

ARTICLE VII — SECTIONS

The College may have one or more groups of members known as sections to provide for members who have special areas of interest within the field of emergency medicine.

Upon the petition of 100 or more members of the College, the Board of Directors may charter such a section of the College. Minimum dues and procedures to be followed by a section shall be determined by the Board of Directors.

ARTICLE VIII — COUNCIL

The Council is an assembly of members representing ACEP's chartered chapters, sections, the Emergency Medicine Residents' Association (EMRA), the 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.

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.

Section 2 — Powers of the Council

The Council shall have the right and responsibility to advise and instruct the Board of Directors regarding any matter of importance to the College by means of Bylaws and non-Bylaws resolutions and other actions or appropriations enacted by the Council. Notwithstanding any other provision of these Bylaws, the Council shall have the right to amend the College Bylaws and College Manual, amend or restate or repeal the College Articles of Incorporation, and to elect the Council officers, the president-elect, and the members of the Board of Directors.

The Council shall have, in addition, the following powers:

1. To prepare and control its own agenda.
2. To act on any matter brought before it by a councillor or the Board of Directors.
3. To originate and act on resolutions.
4. To form, develop, and utilize committees.
5. To develop, adopt, and amend its rules of procedure (the Council Standing Rules) and other procedures for the conduct of Council business, which do not require action by the Board of Directors.

Notwithstanding any other provision of these Bylaws, voting rights with respect to enactment of resolutions directing the activities of the College, amendment of the Bylaws, amendment of the College Manual, amendment or restatement or repeal of the Articles of Incorporation, and election of the Council officers, the president-elect, and the members of the Board of Directors, are vested exclusively in members currently serving as councillors and are specifically denied to all other members. These rights are not applicable at the chapter level unless specifically permitted in a chapter's bylaws.

Section 3 — Meetings

An annual meeting of the Council shall be held within or outside of the State of Texas at such time and place as determined by the Board of Directors. Notice for the annual meeting is not required. Whenever the term "annual meeting" is used in these Bylaws, it shall mean the annual meeting of the Council.

Special meetings of the Council may be held within or outside of the State of Texas and may be called by an affirmative vote of two-thirds of the entire Board of Directors, by the speaker with concurrence of a two-thirds vote of the entire Steering Committee, or by a petition of councillors comprised of signatures numbering one-third of the number of councillors present at the previous annual meeting, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee, provided that the time and place of such meeting shall be announced not less than 40 nor more than 50 days prior to the meeting.

Voting by proxy shall be allowed only at special meetings of the Council. The proxy of any councillor can be revoked by that councillor at any time. The results of any vote that includes proxy ballots will have the same force as any other vote of the Council.

Councillors eligible to vote at a special meeting of the Council are those who were credentialed by the Tellers, Credentials, & Elections Committee at the previous annual meeting of the Council.

All members of the College shall be notified of all Council meetings by mail or official publication.

Section 4 — Quorum

A majority of the number of councillors credentialed by the Tellers, Credentials, and Elections Committee during each session of the Council meeting shall constitute a quorum for that session. The vote of a majority of councillors voting in person or represented by proxy (if applicable) shall decide any question brought before such meeting, unless the question is one upon which a different vote is required by law, the Articles of Incorporation, or these Bylaws.

Section 5 — Voting Rights

Each sponsoring body shall deposit with the secretary of the Council a certificate certifying its councillor(s) and alternate(s). The certificate must be signed the president, secretary, or chairperson of the sponsoring body. No

councillor or alternate shall be seated who is not a member of the College. College members not specified in the sponsoring body's certificate may be certified and credentialed at the annual meeting in accordance with the Council Standing Rules.

ACEP Past Presidents, Past Speakers, and Past Chairs of the Board, if not certified as councillors or alternate councillors by a sponsoring body, may participate in the Council in a non-voting capacity. Members of the Board of Directors may address the Council on any matter under discussion but shall not have voting privileges in Council sessions."

Whenever the term "present" is used in these Bylaws with respect to councillor voting, it shall mean credentialed as certified by the chair of the Tellers, Credentials, & Elections Committee.

Section 6 — Resolutions

Resolutions pertinent to the objectives of the College or in relation to any report by an officer or committee of the College shall be submitted in writing at least 90 days in advance of the Council meeting at which they are to be considered. Resolutions submitted within 90 days of the Council meeting shall be considered only as provided in the Council Standing Rules**.** Each resolution must be signed by at least two members of the College.

In the case of a resolution submitted by a component body of the Council or by a committee of the College, such resolution must be accompanied by a letter of endorsement from the president or chairperson representing the submitting body. Upon approval by the Council, and except for changes to the Council Standing Rules, resolutions shall be forwarded immediately to the Board of Directors for its consideration.

Section 7 — Nominating Committee

A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members and the president shall appoint the president-elect plus two additional Board members. A member of the College cannot concurrently accept nomination to the Board of Directors and Council Office. Nominations will also be accepted from the floor.

Section 8 — Board of Directors Action on Resolutions

The Board of Directors shall act on all resolutions adopted by the Council, unless otherwise specified in these Bylaws, no later than the second Board meeting following the annual meeting and shall address all other matters referred to the Board within such time and manner as the Council may determine.

The Board of Directors shall take one of the following actions regarding a non-Bylaws resolution adopted by the Council:

1. Implement the resolution as adopted by the Council.
2. Overrule the resolution by a three-fourths vote. The vote and position of each Board member shall be reported at the next meetings of the Steering Committee and the Council.
3. Amend the resolution in a way that does not change the basic intent of the Council. At its next meeting, the Steering Committee must either accept or reject the amendment. If accepted, the amended resolution shall be implemented without further action by the Council. If the Steering Committee rejects the amendment, the Board at its next meeting shall implement the resolution as adopted by the Council, propose a mutually acceptable amendment, or overrule the resolution.

Bylaws amendment resolutions are governed by Article XIII of these Bylaws.

ARTICLE IX — BOARD OF DIRECTORS

Section 1 — Authority

The management and control of the College shall be vested in the Board of Directors, subject to the restrictions imposed by these Bylaws.

Section 2 — Composition and Election

Election of Directors shall be by majority vote of the Councillors present and voting at the annual meeting of the Council.

The Board shall consist of 12 elected directors, plus the president, president-elect, immediate past president, and chair if any of these officers is serving following the conclusion of his or her elected term as director. The outgoing past president shall also remain a member of the Board of Directors until the conclusion of the Board meeting immediately following the annual meeting of the Council. In no instance may a member of the Board of Directors sit as a member of the Council.

The term of office of directors shall be three years and shall begin at the conclusion of the Board meeting following the annual meeting at which their elections occur and shall end at the conclusion of the Board meeting following the third succeeding annual meeting. No director may serve more than two consecutive three-year terms unless specified elsewhere in these Bylaws.

Section 3 — Meetings

The Board of Directors shall meet at least three times annually. One of these meetings shall take place not later than 30 days following the annual meeting of the College. The other meetings shall take place at such other times and places as the Board may determine. Meetings may take place within or outside of the State of Texas. A majority of the Board shall constitute a quorum.

Subject to the provisions of these Bylaws with respect to notice of meetings of the Board of Directors, members of the Board of Directors may participate in and hold additional meetings of such Board by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and participation in a meeting pursuant to this section shall constitute presence in person at such meeting, except where a director participates in such meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened.

Any action required or permitted to be taken at a meeting of the Board of Directors may be taken without a meeting if a consent in writing, setting forth the action to be taken, shall be signed by all of the members of the Board of Directors and Council officers, and such a consent shall have the same force and effect as a unanimous vote of the members of the Board of Directors at a meeting of the Board of Directors.

Special meetings of the Board of Directors may be called by the president with not less than 10 nor more than 50 days notice to each director, either personally or by other appropriate means of communication. Special meetings also may be called by one-third of the current members of the Board in like manner and on like notice. Such notice of a special meeting of the Board of Directors shall specify the business to be transacted at, and the purpose of, such special meeting.

Section 4 — Removal

Any member of the Board of Directors may be removed from office at any meeting of the Council by a three-quarters vote of the councillors present, as certified by the chair of the Tellers, Credentials, & Elections Committee. A removal must be initiated by a petition signed by councillors present at that meeting. The number of signatures on the removal petition shall be not less than one-third of the number of councillors present at the meeting at which the member of the Board of Directors was elected, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee.

Section 5 — Vacancy

Any vacancy filled shall be for the remainder of the unexpired term.

A vacancy created by removal shall be filled by a majority vote of the councillors present and voting at the Council meeting at which the removal occurs. Nominations for such vacancy shall be accepted from the floor of the Council.

Vacancies created other than by removal may be filled by a majority vote of the remaining Board if more than 90 days remain before the annual Council meeting. If there are more than three concurrent vacancies, the Council shall elect directors to fill all vacancies via special election. If fewer than 90 days remain before the annual Council meeting, then the vacancies will not be filled until the annual Council meeting.

ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

Section 1 – Officers

The officers of the Board of Directors shall be president, president-elect, chair, immediate past president, vice president, and secretary-treasurer. The officers of the Council shall be the speaker and vice speaker. The Board of Directors may appoint other officers as described in these Bylaws.

Section 2 — Election of Officers

The chair, vice-president, and secretary-treasurer shall be elected by a majority vote at the Board meeting immediately following the annual meeting. The president-elect shall be elected each year and the speaker and vice speaker elected every other year by a majority vote of the Councillors present and voting at the annual meeting.

Section 3 — Removal

Any officer of the Council, the president, and the president-elect may be removed from office at any meeting of the Council by a three-quarters vote of the councillors present, as certified by the chair of the Tellers, Credentials, & Elections Committee. A removal must be initiated by a petition signed by councillors present at that meeting. The number of signatures on the removal petition shall be not less than one-third of the number of councillors present at the meeting at which the Council officer was elected, as certified in the final report of the chair of the Tellers, Credentials, & Elections Committee.

Removal of an individual from the position of chair, vice president, or secretary-treasurer without removal as a member of the Board of Directors shall be carried out by the Board of Directors. Removal as chair shall also remove that individual from the Board of Directors if the chair is serving only by virtue of that office. Removal shall require a three-quarters vote of the full Board excluding the officer under consideration. Replacement shall be by the same process as for regular elections of these Board officers.

Section 4 — Vacancy

Vacancies in the offices of the Board of Directors and the Council occurring for reasons other than removal shall be filled in accordance with sections 4.1 through 4.4 of this Article X. Vacancies occurring by removal shall be filled in accordance with sections 4.5 and 4.6 of this Article X. Succession or election to fill any vacated office shall not count toward the term limit for that office.

Section 4.1 — President

In the event of a vacancy in the office of the president, the president-elect shall immediately succeed to the office of the president for the remainder of the unexpired term, after which their regular term as president shall be served.

Section 4.2 — President-Elect

In the event of a vacancy in the office of the president-elect, the Board of Directors, speaker, and vice speaker may fill the vacancy by majority vote for the remainder of the unexpired term from among the members of the Board. If the vacancy in the office of president-elect is filled in such a manner, at the next annual Council meeting, the Council shall, by majority vote of the credentialed councillors, either ratify the elected replacement, or failing such ratification, the Council shall elect a new replacement from among the members of the Board. The Council shall, in the normal course of Council elections, elect a new president-elect to succeed the just-ratified or just-elected president-elect only when the latter is succeeding to the office of president at the same annual meeting.

Section 4.3 — Chair, Vice President, & Secretary-Treasurer

In the event of a vacancy in the office of chair, vice president, or secretary-treasurer, election to the vacant office shall occur as the first item of business, after approval of the minutes, at the next meeting of the Board of Directors.

Section 4.4 — Council Officers

In the event of a vacancy in the office of vice speaker, the Steering Committee shall nominate and elect an individual who meets the eligibility requirements of these Bylaws to serve as vice speaker. This election shall occur as the first item of business, following approval of the minutes, at the next meeting of the Steering Committee, by majority vote of the entire Steering Committee. If the vacancy occurs during the first year of a two-year term, the vice speaker will serve until the next meeting of the Council when the Council shall elect a vice speaker to serve the remainder of the unexpired term.

In the event of a vacancy in the office of speaker, the vice speaker shall succeed to the office of speaker for the remainder of the unexpired term, and an interim vice speaker shall then be elected as described above.

In the event that the offices of both speaker and vice speaker become vacant, the Steering Committee shall elect a speaker to serve until the election of a new speaker and vice speaker at the next meeting of the Council.

Section 4.5 — Vacancy by Removal of a Board Officer

In the event of removal of an officer of the Board of Directors, excluding the president, replacement shall be conducted by the same process as for regular elections of those officers. If the president is removed, the vacancy shall be filled by the president-elect for the remainder of the unexpired term, after which their regular term as president shall be served.

Section 4.6 — Vacancy by Removal of a Council Officer

In the event of removal of a Council officer, nominations for replacement shall be accepted from the floor of the Council, and election shall be by majority vote of the councillors present and voting at the Council meeting at which the removal occurs. In the event that the speaker is removed and the vice speaker is elected to the office of speaker, the office of vice speaker shall then be filled by majority vote at that same meeting, from nominees from the floor of the Council.

Section 5 — President

The president shall be a member of the Board of Directors, and shall additionally hold ex-officio membership in all committees. The president’s term of office shall begin at the conclusion of the first ensuing annual meeting of the Council following the meeting at which the election as president-elect occurred and shall end at the conclusion of the next annual meeting of the Council, or when a successor is seated.

Section 6 — Chair

The chair shall be a member of and shall chair the Board of Directors. Any director shall be eligible for election to the position of chair and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The chair’s term of office shall begin at the conclusion of the meeting at which the election as chair occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected. No director may serve more than one term as chair.

Section 7 — Vice President

The vice president shall be a member of the Board of Directors. A director shall be eligible for election to the position of vice president if he or she has at least one year remaining as an elected director on the Board and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The vice president's term of office shall begin at the conclusion of the meeting at which the election as vice president occurs and shall end at the

conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected.

Section 8 — President-Elect

Any member of the Board of Directors excluding the president, president-elect, and immediate past president shall be eligible for election to the position of president-elect by the Council. The president-elect shall be a member of the Board of Directors. The president-elect's term of office shall begin at the conclusion of the meeting at which the election as president-elect occurs and shall end with succession to the office of president. The president-elect shall be elected by a majority vote of the councillors present and voting at the annual meeting of the Council. The president-elect shall succeed to the office of president at the conclusion of the first ensuing annual meeting of the Council following the meeting at which the election as president-elect occurred and shall end at the conclusion of the next annual meeting of the Council, or when a successor is seated.

Section 9 — Secretary-Treasurer

The secretary-treasurer shall be a member of the Board of Directors. The secretary-treasurer shall cause to be kept adequate and proper accounts of the properties, funds, and records of the College and shall perform such other duties as prescribed by the Board.

A director shall be eligible for election to the position of secretary-treasurer if he or she has at least one year remaining on the Board as an elected director and shall be elected at the first Board of Directors meeting following the annual meeting of the Council. The secretary-treasurer's term of office shall begin at the conclusion of the meeting at which the election as secretary-treasurer occurs and shall end at the conclusion of the first Board of Directors meeting following the next annual meeting of the Council or when a successor is elected. No secretary-treasurer may serve more than two consecutive terms.

The secretary-treasurer shall deposit or cause to be deposited all monies and other valuables in the name and to the credit of the College with such depositories as may be designated by the Board of Directors. The secretary-treasurer shall disburse the funds of the College as may be ordered by the Board of Directors; shall render to the Board of Directors, whenever it may request it, an account of all transactions as treasurer, and of the financial condition of the College; and shall have such powers and perform such other duties as may be prescribed by the Board of Directors or these Bylaws. Any of the duties of the secretary-treasurer may, by action of the Board of Directors, be assigned to the executive director.

Section 10 — Immediate Past President

The immediate past president shall remain a member of the Board of Directors for a period of one year following the term as president, or until such time as the regular term as a Board member shall expire, whichever is longer. The term of the immediate past president shall commence at the conclusion of the second annual meeting of the Council following the meeting at which the election of president-elect occurred and shall end at the conclusion of the third annual meeting following the election. The outgoing past president shall also remain a member of the Board of Directors until the conclusion of the Board meeting immediately following the annual meeting of the Council.

Section 11 — Speaker

The term of office of the speaker of the Council shall be two years. The speaker shall attend meetings of the Board of Directors and may address any matter under discussion. The speaker shall preside at all meetings of the Council, except that the vice speaker may preside at the discretion of the speaker. The speaker shall prepare, or cause to be prepared, the agendas for the Council. The speaker may appoint committees of the Council and shall inform the councillors of the activities of the College. The speaker’s term of office shall begin immediately following the conclusion of the annual meeting at which the election occurred and shall conclude at such time as a successor takes office. The speaker shall not have the right to vote in the Council except in the event of a tie vote of the councillors. During the term of office, the speaker is ineligible to accept nomination to the Board of Directors of the College. No speaker may serve consecutive terms.

Section 12 — Vice Speaker

The term of office of the vice speaker of the Council shall be two years. The vice speaker shall attend meetings of the Board of Directors and may address any matter under discussion. The vice speaker shall assume the duties and responsibilities of the speaker if the speaker so requests or if the speaker is unable to perform such duties. The term of the office of the vice speaker shall begin immediately following the conclusion of the annual meeting at which the election occurred and shall conclude at such time as a successor takes office. During the term of office, the vice speaker is ineligible to accept nomination to the Board of Directors of the College. No vice speaker may serve consecutive terms.

Section 13 — Executive Director

An executive director shall be appointed for a term and at a stipend to be fixed by the Board of Directors. The executive director shall, under the direction of the Board of Directors, perform such duties as may be assigned by the Board of Directors. The executive director shall keep or cause to be kept an accurate record of the minutes and transactions of the Council and of the Board of Directors and shall serve as secretary to these bodies. The executive director shall supervise all other employees and agents of the College and have such other powers and duties as may be prescribed by the Board of Directors or these Bylaws. The executive director shall not be entitled to vote.

Section 14 — Assistant Secretary-Treasurer

Annually, the ACEP Board of Directors shall appoint an individual to serve as assistant secretary-treasurer. The assistant secretary-treasurer shall serve as an officer of the corporation without authority to act on behalf of the corporation, except (i) to execute and file required corporate and financial administrative and franchise type reports to state, local, and federal authorities, or (ii) pursuant to any authority granted in writing by the secretary-treasurer. All other duties of the secretary-treasurer are specifically omitted from this authority and are reserved for the duly elected secretary-treasurer. The assistant secretary-treasurer shall not be a member of the Board of Directors.

ARTICLE XI — COMMITTEES

Section 1 — General Committees

The president shall annually appoint committees and task forces to address issues pertinent to the College as deemed advisable. The members thereof need not consist of members of the Board, nor shall it be necessary that the chair of a committee be a member of the Board.

The president shall appoint annually committees on Compensation, Bylaws, and Finance.

Section 2 — Executive Committee

The Board of Directors shall have an Executive Committee, consisting of the president, president-elect, vice president, secretary-treasurer, immediate past president, and chair. The speaker shall attend meetings of the Executive Committee. The Executive Committee shall have the authority to act on behalf of the Board**,** subject to ratification by the Board at its next meeting.

Meetings of the Executive Committee shall be held at the call of the chair or president. A report of its actions shall be given by the Executive Committee to the Board of Directors in writing within two weeks of the adjournment of the meeting.

Section 3 — Steering Committee

A Steering Committee of the Council shall be appointed by the speaker of the Council. The committee shall consist of at least 15 members, each appointed annually for a one-year term. It shall be the function of the committee to represent the Council between Council meetings. The committee shall be required to meet at least two times annually, and all action taken by the committee shall be subject to final approval by the Council at the next regularly scheduled session. The speaker of the Council shall be the chair of the Steering Committee.

The Steering Committee cannot overrule resolutions, actions, or appropriations enacted by the Council. The Steering Committee may amend such instructions of the Council, or approve amendments proposed by the Board of Directors, provided that such amendment shall not change the intent or basic content of the instructions. Such actions to amend, or approve amendment, can only be by a three-quarters vote of all the members of the Steering Committee and must include the position and vote of each member of the Steering Committee. Notice by mail or official publication shall be given to the membership regarding such amendment, or approval of amendment, of the Council's instructions. Such notice shall contain the position and vote of each member of the Steering Committee regarding amendment of or approval of amendment.

Section 4 — Bylaws Interpretation Committee

In addition to the College Bylaws Committee, there shall also be a Bylaws Interpretation Committee, appointed annually and consisting of five ACEP members. The president shall appoint two of the members and the Council speaker shall appoint three members. The chair of this committee shall be chosen by a vote of its members. When petitioned to do so, the Bylaws Interpretation Committee shall be charged with the definitive interpretation of Articles VIII – Council, IX – Board of Directors, X – Officers/Executive Director, XI – Committees, and XIII – Amendments, of these Bylaws. Interpretation of other articles of these Bylaws shall be by the Board of Directors.

Any member shall have the right to petition the Bylaws Interpretation Committee for an opinion on any issue within its purview. If the petition alleges an occurrence of improper action, inaction, or omission, such petition must be received by the executive director no more than 60 days after the occurrence. In the event of a question regarding whether the subject of the petition is addressed by a portion of the Bylaws which falls within the committee's jurisdiction, or a question of whether the time limit has been met, such question shall be resolved jointly by the president and the speaker. The committee shall then respond with an interpretation within 30 days of receipt of the petition. An urgent interpretation can be requested by the president, the Board of Directors, the speaker, or the Council in which case the interpretation of the committee shall be provided within 14 days. The Board shall provide the necessary funds, if requested by the committee, to assist the committee in the gathering of appropriate data and opinions for development of any interpretation. The Bylaws Interpretation Committee shall render its response to the petitioner as a written interpretation of that portion of the Bylaws in question. That response shall be forwarded to the petitioner, the officers of the Council, and the Board of Directors.

Section 5 — Finance Committee

The Finance Committee shall be appointed by the president. The committee shall be composed of the president-elect, secretary-treasurer, speaker of the Council or his/her designee, and at least eight members at large. The chair shall be one of the members at large. The Finance Committee is charged with an audit oversight function and a policy advisory function and may be assigned additional objectives by the president. As audit overseers, the committee performs detailed analysis of the College budget and other financial reports ensuring due diligence and proper accounting principles are followed. In addition, expenses incurred in attending official meetings of the Board, shall be reimbursed consistent with amounts fixed by the Finance Committee and with the policies approved by the Board.

Section 6 — Bylaws Committee

The Bylaws Committee shall be appointed by the president. The Bylaws Committee is charged with the ongoing review of the College Bylaws for areas that may be in need of revision and also charged with the review of chapter bylaws. The Bylaws Committee may be assigned additional objectives by the president or Board of Directors.

Section 7 — Compensation Committee

College officers and members of the Board of Directors may be compensated, the amount and manner of which shall be determined annually by the Compensation Committee. This committee shall be composed of the chair of the Finance Committee plus four members of the College who are currently neither officers nor members of the Board of Directors. The Compensation Committee chair, the Finance Committee chair, plus one other member shall be presidential appointments and two members shall be appointed by the speaker. Members of this committee shall be appointed to staggered terms of not less than two years.

The recommendations of this committee shall be submitted annually for review by the Board of Directors and, if accepted, shall be reported to the Council at the next annual meeting. The recommendations may be rejected by a three-quarters vote of the entire Board of Directors, in which event the Board must determine the compensation or request that the committee reconsider. In the event the Board of Directors chooses to reject the recommendations of the Compensation Committee and determine the compensation, the proposed change shall not take effect unless ratified by a majority of councillors voting at the next annual meeting. If the Council does not ratify the Board's proposed compensation, the Compensation Committee's recommendation will then take effect.

ARTICLE XII — ETHICS

The "Code of Ethics for Emergency Physicians" shall be the ethical foundation of the College. Charges of violations of ethical principles or policies contained in the "Code of Ethics for Emergency Physicians" may be brought in accordance with procedures described in the College Manual.

ARTICLE XIII — AMENDMENTS

Section 1 — Submission

Any member of the College may submit proposed amendments to these Bylaws. Each amendment proposal must be signed by at least two members of the College. In the case of an amendment proposed by a component body of the Council or by a committee of the College, each amendment proposal must be accompanied by a letter of endorsement from the president or chairperson representing the submitting body. Such submissions must be presented to the Council secretary of the College at least 90 days prior to the Council meeting at which the proposed amendments are to be considered. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the submitters, may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

If a proposed Bylaws amendment is a Contested Amendment, as hereinafter defined, then such Contested Amendment shall be considered already to have fulfilled the submission obligation.

Section 2 — Notice

For any proposed Bylaws amendment, including a Contested Amendment as hereinafter defined, the executive director of the College shall give notice to the members of the College, by mail or official publication, at least 30 days prior to the Council meeting at which any such proposed Bylaws amendment is to be considered for adoption.

Section 3 — Amendment Under Initial Consideration

A proposed Bylaws amendment which, at any meeting of the Council, has received an affirmative vote of at least two-thirds of the councillors present, as certified by the chair of the Tellers, Credentials, & Elections Committee, shall be deemed an Amendment Under Initial Consideration. The Board of Directors must vote upon an Amendment Under Initial Consideration no later than the conclusion of the Board's second meeting following said Council meeting. If the Amendment Under Initial Consideration receives the affirmative vote of at least two-thirds of the members of the Board of Directors, then it shall be adopted and these Bylaws shall be so amended immediately.

Section 4 — Contested Amendment

If an Amendment Under Initial Consideration fails to receive an affirmative vote of at least two-thirds of the members of the Board of Directors, then such proposed Bylaws amendment shall be deemed a Contested Amendment. The positions and vote of each member of the Board regarding such Contested Amendment shall be presented to the Council's Steering Committee at the Steering Committee's first meeting following said vote of the Board of Directors. The Council's component bodies and councillors shall be notified within 30 days of the Board action. The Steering Committee shall not have the authority to amend or adopt a Contested Amendment. The speaker may call a special meeting of the Council to consider a Contested Amendment. The time and place of such meeting shall be announced no less than 40 and no more than 50 days prior to the meeting.

The Contested Amendment, identical in every way to its parent Amendment Under Initial Consideration, and the positions and vote of each member of the Board of Directors regarding such Contested Amendment, shall be presented to the Council at the Council's first meeting following said vote of the Board of Directors.

If the unmodified Contested Amendment receives the affirmative vote of at least two-thirds of the councillors present at that Council meeting, as certified by the chair of the Tellers, Credentials, & Elections Committee, then such proposed Bylaws amendment shall be adopted, and these Bylaws shall be so amended immediately.

If a Contested Amendment is modified in any way, and then receives the affirmative vote of at least two-thirds of the councillors present at that Council meeting, as certified by the Tellers, Credentials, & Elections Committee, such Contested Amendment shall then be deemed an Amendment Under Initial Consideration and be subject to the process for adoption defined herein.

ARTICLE XIV — MISCELLANEOUS

Section 1 — Inspection of Records

The minutes of the proceedings of the Board of Directors and of the Council, the membership books, and books of account shall be open to inspection upon the written demand of any member at any reasonable time, for any purpose reasonably related to the member's interest as a member, and shall be produced at any time when requested by the demand of 10 percent of the members at any meeting of the Council. Such inspection may be made by the member, agent, or attorney, and shall include the right to make extracts thereof. Demand of inspection, other than at a meeting of the members, shall be in writing to the president or the secretary-treasurer of the College.

Section 2 — Annual Report

The Board of Directors shall make available to the members as soon as practical after the close of the fiscal year, audited financial statements, certified by an independent certified public accountant.

Section 3 — Parliamentary Authority

The parliamentary authority for meetings of the College shall be *The Standard Code of Parliamentary Procedure (Sturgis)*, except when in conflict with the Bylaws of the College or the Council Standing Rules.

Section 4 — College Manual

The College shall have a College Manual to address such matters as may be deemed suitable by the Board of Directors and the Council.

Amendments to the College Manual may be made by majority vote of both the Council and the Board of Directors.

ARTICLE XV — MANDATORY INDEMNIFICATION

Section 1 — Policy of Indemnification and Advancement of Expenses

To the full extent permitted by the Texas Business Organizations Code, as amended from time to time, the College shall indemnify all Directors, Officers, and all Employees of the College against judgments, penalties (including excise and similar taxes), fines, settlements and reasonable expenses (including court costs and attorneys' fees) actually incurred by any such person who was, is or is threatened to be made a named defendant or respondent in a proceeding because the person is or was a Director, Officer, or Employee of the College and the College shall advance to such person(s) such reasonable expenses as are incurred by such person in connection therewith.

Section 2 — Definitions

For purposes of this Article XV:

1. “Director” means any person who is or was a director of the College and any person who, while a director of the College, is or was serving at the request of the College as a director, officer, partner, venturer, proprietor, trustee, employee, agent, or similar functionary of the College or of another foreign or domestic corporation, partnership, joint venture, sole proprietorship, trust, employee benefit plan or other enterprise.
2. “Officer” means any person who is or was an officer of the College and any person who, while an officer of the College, is or was serving at the request of the College as a director, officer, partner, venturer, proprietor, trustee, employee, agent, or similar functionary of the College or of another foreign or domestic corporation, partnership, joint venture, sole proprietorship, trust, employee benefit plan or other enterprise.
3. “Employee” means an individual:
    a. Selected and engaged by ACEP;
    b. To Whom wages are paid by ACEP;
    c. Whom ACEP has the power to dismiss; and
    d. Whose work conduct ACEP has the power or right to control.
4. “Proceeding” means any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, arbitrative, or investigative, any appeal in such action, suit, or proceeding, and any inquiry or investigation that could lead to such an action, suit, or proceeding.

Section 3 — Non-Exclusive; Continuation

The indemnification provided by this Article XV shall not be deemed exclusive of any other rights to which the person claiming indemnification may be entitled under any agreement or otherwise both as to any action in his or her official capacity and as to any action in another capacity while holding such office, and shall continue as to a person who shall have ceased to be a Director, Officer, or Employee of the College engaged in any other enterprise at the request of the College and shall inure to the benefit of the heirs, executors and administrators of such person.

Section 4 — Insurance or Other Arrangement

The College shall have the power to purchase and maintain insurance or another arrangement on behalf of any person who is or was a Director, Officer, or Employee of the College, or who is or was not a Director, Officer, or Employee of the College but is or was serving at the request of the College as a Director, Officer, or Employee or any other capacity in another corporation, or a partnership, joint venture, trust or other enterprise, against any liability asserted against such person and incurred by such person in such capacity, arising out of such person’s status as such, whether or not such person is indemnified against such liability by the provisions of this Article XV.

Section 5 — Exclusion of Certain Acts from Indemnification

Notwithstanding any other provision of this Article XV, no Director, Officer, or Employee of the College shall be indemnified for any dishonest or fraudulent acts, willful violation of applicable law, or actions taken by such person when acting outside of the scope of such person's office, position, or authority with or granted by the College or the Board of Directors.

COLLEGE MANUAL

Revised October 2014

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

College Manual

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

College Manual

Revised October 2014

I. Applications for Membership

All applications for membership will be in writing on an application form approved by the Board of Directors. Each member will receive a certificate of membership in such form as may be determined by the Board of Directors. The title to such a certificate shall remain, at all times, with the College.

II. Procedures for Addressing Charges of Ethical Violations and Other Misconduct

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

A. Complaint Received

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

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

B. Executive Director

1. Sends a written acknowledgement to the complainant confirming the complainant's intent to file a complaint and identifying the elements that must be addressed in an ethics complaint.
2. Confirms receipt of an acknowledgement signed by the complainant specifying intent to file an ethics complaint and to be bound by the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct ("Procedures")."
3. Notifies the ACEP President and the chair of the Ethics Committee or the Bylaws Committee, as appropriate, that a complaint has been filed and forwards to each of them a copy of the complaint.
4. a. Determines, in consultation with the ACEP President and the chair of the Ethics and/or Bylaws Committee, that the complaint is frivolous, inconsequential, or does not allege an actionable violation of a policy or principle included in the *Code of Ethics for Emergency Physicians* or of ACEP Bylaws, or other conduct warranting censure, suspension, or expulsion. If so, the Executive Director dismisses the complaint and will notify the complainant of this determination, or

b. Determines, in consultation with the Ethics Committee chair, that the complaint alleges conduct that may constitute a violation of a policy or principle included in the *Code of Ethics for Emergency Physicians*, and if so, forwards the complaint and the response together, as soon as both are received, to each member of the Ethics Committee, or, at the discretion of the chair of the Ethics Committee, to members of a subcommittee of the Ethics Committee appointed for that purpose, or
c. Determines, in consultation with the Bylaws Committee chair, that the complaint alleges conduct that may constitute a violation of ACEP Bylaws or other conduct justifying censure, suspension, or expulsion, and forwards the complaint and response together, as soon as both are received, to each member of the Bylaws Committee, or at the discretion of the chair of the Bylaws Committee, to members of a subcommittee of the Bylaws Committee appointed for that purpose, or
d. Determines that the complaint is more appropriately addressed through judicial or administrative avenues, such as in the case of pending litigation or action by state licensing boards, and ACEP should defer actions pursuant to such other avenues. If so, the Executive Director will refer the matter to the ACEP President for review. If the President also determines that the complaint is more appropriately addressed through judicial or administrative avenues, the complaint will not be considered. The Board of Directors will review the President's action at the next regularly scheduled Board meeting. The President's action can be overturned by a majority vote of the Board, or
e. Determines that the alleged violation is not the subject of a pending ACEP Standard of Care Review. If the alleged violation is the subject of a pending Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.

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

C. Bylaws Committee [within sixty (60) days of the forwarding of the complaint/response specified in Section B.4.c. above]

1. Reviews the written record of any complaint that alleges a violation of the ACEP Bylaws and the accompanying response.
2. Discusses the complaint and response by telephone conference call.
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
   a. Current ACEP Bylaws apply.
   b. Alleged behavior constitutes a violation of current ACEP Bylaws.
   c. Alleged conduct warrants censure, suspension, or expulsion.
5. Proceeds to develop its recommendation based solely on the written record.
6. Develops a report regarding the complaint and recommendation for action; minority reports may also be presented.

7. The Bylaws Committee will deliver its report and minority reports, if any to the Board of Directors. In its report, the Bylaws Committee shall recommend that the Board of Directors:
    a. Dismiss the complaint; or
    b. Take disciplinary action, the specifics of which shall be included in the committee's report.
8. At the discretion of the chair of the Bylaws Committee, these functions may be carried out by a subcommittee of five or more members of the Bylaws Committee. The Bylaws Committee chair shall appoint this subcommittee and designate one of its members to chair the-subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.

D. Ethics Committee [within sixty (60) days of the forwarding of the complaint/response specified in Section B.4.b. above]

1. Reviews the written record of any complaint that alleges a violation of current ACEP "Principles of Ethics for Emergency Physicians" or other current ACEP ethics policies.
2. Discusses the complaint and response by telephone conference call;
3. Determines the need to solicit in writing additional information or documentation from the parties, third parties, or experts regarding the complaint.
4. Considers whether:
    a. Current ACEP "Principles of Ethics for Emergency Physicians" or other current ACEP ethics policies apply.
    b. Alleged behavior constitutes a violation of current ACEP "Principles of Ethics for Emergency Physicians" or other current ACEP ethics policies.
    c. Alleged conduct warrants censure, suspension, or expulsion.
5. Proceeds to develop its recommendation based solely on the written record.
6. Develops a report regarding the complaint and recommendation for action. Minority reports may also be presented.
7. The Ethics Committee will deliver its report and minority reports, if any, to the Board of Directors. In its report, the Ethics Committee shall recommend that the Board of Directors:
    a. Dismiss the complaint; or
    b. Take disciplinary action, the specifics of which shall be included in the committee's report.
8. At the discretion of the chair of the Ethics Committee, these functions may be carried out by a subcommittee of five or more members of the Ethics Committee. The Ethics Committee chair shall appoint this subcommittee and designate one of its members to chair the subcommittee. The subcommittee may seek counsel from other consultants with particular expertise relevant to the matter under consideration. In the event that a subcommittee is appointed, it shall deliver its report and recommendations to the Board of Directors.

E. Board of Directors

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

6. If the respondent chooses the option described in Section E.4.b., that is, a Board decision based solely on the written record, the Board will implement its decision to impose disciplinary action based on the written record.

F. Ad Hoc Committee

1. If a majority of Board members have recused themselves from consideration of a complaint, the Board shall delegate the decisions regarding disciplinary action to an Ad Hoc Committee composed of nine (9) members.
2. This Ad Hoc Committee shall be composed of all those Board members who have not recused themselves, if any, plus independent third parties who are ACEP members. Should the chair of the Board receive notification of recusal from consideration of an ethics complaint from a majority of Board members, the chair shall request those Board members who have not recused themselves to submit nominations of independent third parties who are ACEP members to serve on an Ad Hoc Committee to act on that ethics complaint. At the next meeting of the Board, the Board members who have not recused themselves shall elect from those nominees, by majority vote, the required number of independent third party members of the Ad Hoc Committee. Should all Board members recuse themselves, the chair shall appoint a committee of seven (7) independent third parties who are ACEP members without conflicts in this matter who will select the nine (9) members of the ad hoc committee.
3. The Ad Hoc Committee:
    a. Receives the report of the Ethics Committee or Bylaws Committee, including minority reports, if any, and the complaint and response.
    b. May request further information in writing from the complainant and/or respondent.
    c. Decides to:
        i. Dismiss the complaint; or
        ii. Render a decision to impose disciplinary action based on written record.
    d. If the Ad Hoc Committee determines to impose disciplinary pursuant to Section F.3.c.ii., the respondent will be provided with notification of the Ad Hoc Committee's determination and the option of:
        i. A hearing conducted by the Ad Hoc Committee; or
        ii. The imposition of the Ad Hoc Committee decision based solely on the written record.
    e. If the respondent requests a hearing, the Ad Hoc Committee shall follow the hearing procedures described in Section H below. An affirmative vote of two-thirds of the Ad Hoc Committee shall be required to take disciplinary action against the respondent. If the Ad Hoc Committee does not achieve a two-thirds vote of its members, the respondent shall be exonerated. If the respondent does not request a hearing, the Ad Hoc Committee will report to the Board its decision to impose disciplinary action based on the written record. This decision will be final and will be implemented by the Board.

G. Right of Respondent to Request a Hearing

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

H. Hearing Procedures

1. If the respondent requests a hearing , the complainant and respondent will be notified in writing by certified U.S. mail by the Executive Director within ten (10) business days of such request. Such notice will include a list of witnesses, if any, that the Board, its subcommittee pursuant to Section H.6. below, or an Ad Hoc Committee pursuant to Section F., intends to call in the hearing.
2. The Executive Director will send a notification of the date, time, and place of the hearing and will provide the parties with information regarding the hearing process and the conduct of the hearing by certified U.S. mail.

3. The time set for the hearing will not be less than thirty (30) days nor more than nine (9) months after the date on which notice of hearing was received by the respondent.
4. The complainant and respondent each may be represented by counsel or any other person of their choice. Each party will bear the expense of his or her own counsel.
5. The parties have the right to have a record made of the proceedings by transcript, audiotape, or videotape at the expense of the requesting party.
6. The hearing may be conducted by the entire Board, by a subcommittee of three to five members of the Board of Directors, at the discretion of and as appointed by the chair of the Board of Directors or, if required pursuant to Section F., by an Ad Hoc Committee described in Section F. If the hearing is conducted by a subcommittee or by an Ad Hoc Committee that includes one or more Board members as described in Section F., the presiding officer of the hearing will be a Board member designated by the chair of the Board. The chair of the Board of Directors will act as the presiding officer throughout the hearing conducted by the full Board unless the chair is unable to serve or is disqualified from serving, in which case the ACEP President will designate a member of the Board of Directors to chair the hearing. If all Board members have recused themselves, the Ad Hoc Committee members shall choose an individual from among themselves to chair the hearing. If a subcommittee of the Board or an Ad Hoc Committee conducts the hearing, such hearing must take place with all of the parties and all the members of the subcommittee or ad hoc committee present in person. If the full Board conducts the hearing, all of the parties, and a quorum of the Board, must be present in person. Hearings may not take place by telephone conference call.
7. The parties to the complaint have the right to call, examine, and cross-examine witnesses and to present evidence that is determined to be relevant by the presiding officer, even if the evidence would not be admissible in a court of law. Respondent may submit a written statement at the close of the hearing. All witness expenses will be borne by the party who calls the witness.
8. The Board, its appointed subcommittee, or an Ad Hoc Committee will, after having given the complainant and the respondent an opportunity to be heard, including oral arguments and the filing of any written briefs, conclude the hearing.
9. In the event that the hearing is conducted by a subcommittee of the Board or an Ad Hoc Committee, such subcommittee or Ad Hoc Committee will, within one hundred twenty (120) days after the hearing concludes, submit the written record of the hearing, along with the subcommittee's recommendation or the Ad Hoc Committee's decision, to the Board of Directors. If the hearing is conducted by a subcommittee of the Board, within thirty (30) days after receiving a subcommittee report and recommendation, or, if the full Board conducts the hearing, within thirty (30) days after the hearing concludes, the Board shall render a decision. The affirmative vote of two-thirds of the Directors entitled to vote pursuant to this Section, with a quorum of Directors present pursuant to ACEP Bylaws, shall be required to take disciplinary action against the respondent. If the Board does not achieve a two-thirds vote of entitled Directors with a quorum present, the respondent shall be exonerated. Directors shall be entitled to vote if they have not recused themselves or been recused, and, in the case of a hearing conducted by the full Board, if they have attended the entire hearing. If the hearing is conducted by an Ad Hoc Committee pursuant to Section F., the decision of such Ad Hoc Committee will be final and will be implemented by the Board.
10. The decision of the Board or Ad Hoc Committee will be expressed in a resolution that will be included in the minutes of the meeting at which the decision occurs. Written notice of the Board's or Ad Hoc Committee's decision will be sent by certified U.S. mail to the respondent and complainant within sixty (60) days of the decision. This written notice will include the Board's or Ad Hoc Committee's decision and a statement of the basis for that decision.

I. Disciplinary Action: Censure, Suspension, or Expulsion

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

b. Public Censure: a public letter of censure shall detail the manner in which the censured member has been found to violate the College's ethical standards set forth in Section A.2. above.

2. Suspension from ACEP membership shall be for a period of twelve months; the dates of commencement and completion of the suspension shall be determined by the Board of Directors. At the end of the twelve-month period of suspension, the suspended member shall be offered reinstatement. Request for reinstatement shall be processed in the same manner as that of any member whose membership has lapsed (i.e., has been cancelled for non-payment of dues).
3. Expulsion from ACEP membership shall be for a period of five years, after which the expelled member may petition the Board of Directors for readmission to membership. The decision regarding such a petition shall be entirely at the discretion of the Board of Directors.

J. Disclosure

1. Nature of Disciplinary Action
   a. Private censure: the content of a private letter of censure shall not be disclosed, but the fact that such a letter has been issued shall be disclosed. The name of the respondent shall be disclosed, but the conduct that resulted in censure shall not be disclosed.
   b. Public censure: both the fact of issuance, and the content, of a public letter of censure shall be disclosed.
   c. Suspension: the dates of suspension, including whether or not the member was reinstated at the end of the period of suspension, along with a statement of the basis for the suspension, shall be disclosed. ACEP is also required to report the suspension of membership and a description of the conduct that led to suspension to the Boards of Medical Examiners in the states in which the physician is licensed, which may result in a report of such action to the National Practitioner Data Bank.
   d. Expulsion: the date of expulsion, along with a statement of the basis for the expulsion, shall be disclosed. If the five-year period has elapsed, the disclosure shall indicate whether the former member petitioned for reinstatement and, if so, the Board's decision on such petition. ACEP is also required to report the expulsion from membership and a description of the conduct that led to expulsion to the Boards of Medical Examiners in the states in which the physician is licensed which may result in a report of such action to the National Practitioner Data Bank.
2. Scope and Manner of Disclosure
   a. Disclosure to ACEP members: Any ACEP member may transmit to the Executive Director a request for information regarding disciplinary actions taken by the College. Such letter shall specify the name of the member or former member who is the subject of the request. The Executive Director shall disclose, in writing, the relevant information as described in Section J.1.
   b. Public Disclosure: The Board of Directors shall publicize in an appropriate ACEP publication the names of members receiving public censure, suspension, or expulsion. This published announcement shall also state which ACEP bylaw or policy was violated by the member and shall inform ACEP members that they may request further information about the disciplinary action. If any person makes a request for information about disciplinary actions against a member who has received public censure, suspension, or expulsion, the Executive Director shall refer that person to the published announcement of that disciplinary action in an ACEP publication.

K. Ground Rules

1. All proceedings are confidential until a final decision on the complaint is rendered by the Board of Directors or an Ad Hoc Committee pursuant to Section F., at which time the decision will be available upon request by ACEP members, to the extent specified in Section J. Files of these proceedings, including written submissions and hearing record will be kept confidential.
2. Timetable guidelines are counted by calendar days unless otherwise specified.
3. The Ethics Committee, the Bylaws Committee, the Board of Directors, their appointed subcommittees, as appropriate, or an Ad Hoc Committee, may request further written documentation from either party to the complaint; a time to satisfy any request will be specified in the notice of such request, and these times will not count against the committee’s, Board’s,

subcommittee's, or Ad Hoc Committee's overall time to complete its task. However, such requests and the responses thereto shall not extend the time to deliver a recommendation or a decision to the Board beyond ninety (90) days from the date the complaint is forwarded to the appropriate committee, subcommittee, or Ad Hoc Committee.

4. All parties to the complaint are responsible for their own costs; ACEP will pay its own administrative and committee costs.
5. If a participant in this process (such as a member of the Ethics Committee, the Bylaws Committee, or Board of Directors) is a party to the complaint, has a material reason for bias, subjectivity, or conflicts of interest in the matter, or is in direct economic competition with the respondent, that person shall recuse himself or herself from the process except as a complaining party or respondent. Any committee member who recuses himself or herself shall report this recusal promptly to the committee chair, and any Board member who recuses himself or herself shall report this recusal promptly to the chair of the Board.
6. Once the Board has made a decision or implemented a decision of an Ad Hoc Committee pursuant to Section F. on a complaint, it will not consider additional allegations against the same respondent based on the same or similar facts.
7. The Board's decision or the decision of an Ad Hoc Committee pursuant to Section F. to impose an adverse action must be based on a reasonable belief that the action is warranted by the facts presented or discovered in the course of the disciplinary process.
8. If a respondent fails to respond to a complaint, to notice of the right to request a hearing, or to a request for information, the Board or an Ad Hoc Committee pursuant to Section F. may make a decision on the complaint solely on the basis of the information it has received.
9. If a complaint alleges a violation that is the subject of a pending ACEP Standard of Care Review, the Standard of Care Review will be suspended pending the resolution of the complaint brought pursuant to these Procedures.
10. If a respondent seeks to voluntarily resign his/her ACEP membership after ACEP has received a complaint against that respondent, that request for resignation will not be accepted by ACEP until the complaint has been resolved. For the purposes of this provision, non-payment of ACEP member dues will be interpreted as a request for resignation.

III. Chartering Chapters

Upon petition of any five members of the College or one third of the members within the petitioning jurisdiction, whichever number is greater, the Board may issue a charter for a chapter of the College. No more than one chapter will be chartered in any one state, territory, or commonwealth. The Board of Directors may issue a charter for a government services chapter without geographic restrictions upon petition of five or more active members of the College serving in government medical assignments.

Chapters will be in such form as will be approved by the Board of Directors. Each chapter in a state, territory, or commonwealth in which incorporation is possible will incorporate within one year of receiving its charter.

Each chapter will have power to acquire, lease, own, and convey property; to invest in financial instruments sanctioned by its Board of Directors; to fund and carry on research; to issue publications and distribute information by various electronic means; to establish, conduct, and maintain schools, courses, museums, libraries, and other institutions for study in and teaching of emergency patient care and emergency services; to retain professional legislative analysts; to retain legal counsel; and to use any reasonable means for attainment of objectives to fulfill the mission of the College.

IV. Charter Suspension-Revocation

Any member of the College may file written charges against any chapter with the executive director of the College. Such charges must be signed, and must specify the acts of conduct for which the complaint is made. The executive director of the College must present the charges to the Board of Directors at its next meeting. The Board of Directors will then act upon the charges and will either dismiss them or proceed as hereinafter set forth.

If the Board fails to dismiss the charges it will within 10 days thereafter cause a copy of the charges to be served upon the accused chapter by sending it by registered United States mail to the secretary or other officer of the chapter. The Board will notify the accuser at the same time and in the same manner.

A hearing will be convened not less than 15 days nor more than 90 days after service of charges. The Board will, after having given the accused and the accuser reasonable opportunity to be heard in person or by counsel and to present all evidence and proofs, conclude the hearing and within 30 days render a decision. The affirmative vote of a majority of the members of the Board present and voting will constitute the decision of the Board, which may either dismiss the charges or take such actions as it deems appropriate. In either event the Board will make known its decision in a written resolution signed by the secretary and president. In the former event the Board will furnish the accused and the accuser with a copy of the resolution. In the latter event its resolution will be read at the next regular meeting of the Board or at a special meeting duly called for that purpose, provided that a copy of the decision will be delivered to the accused in the same manner provided for the service of charges at least 15 days before such meeting. The accused and the accusers will be given reasonable opportunity to be heard at the meeting of the Board of Directors where the decision is read. A two-thirds majority vote of the entire Board of Directors will be required to suspend or to revoke the charter.

On revocation of the charter of any chapter by the Board of Directors, the chapter will take whatever legal steps are necessary to change its name so that it no longer suggests any connection with the American College of Emergency Physicians. After revocation, the former chapter will no longer make any use of the College name or logo.

V. Filling Board Vacancies Created by Other Than Removal

General Provisions

Nominations: A slate of one or more nominees for each vacant position will be developed by the Nominating Committee.

Eligibility*:* Eligibility for a vacancy election nomination shall be in accordance with Article IX, Section 2 of the Bylaws.

Order of Elections: If there are multiple vacancies with varying lengths of unexpired terms, the longest term will be elected first, then followed in succession to the shortest term.

Term of Office: When elected by the Council, the replacement director's term will begin at the conclusion of the Board meeting following the annual meeting at which their election occurs or immediately upon election if elected at any other Council meeting. If elected by the Board, the term shall begin at the conclusion of the Board meeting at which their election occurs. In all instances the term shall be for the remainder of the unexpired term to which they have been elected.

Election by the Board of Directors (when applicable in accordance with the Bylaws):

When selecting nominees for election by the Board of Directors, the Nominating Committee will give special consideration to unelected nominees from the most recent Board and Council Officer elections. The election may occur at any Board meeting more than 90 days before the annual meeting and shall be by a majority vote of the remaining directors (i.e. total number of directors). The Board shall consider each vacant position separately. Board members may choose to abstain from voting for any particular nominee. If a nominee fails to achieve a majority vote after being considered for all vacant positions, the nominee shall be removed from consideration and additional nominees from the Nominating Committee considered until all vacant positions have been filled. No floor nominations are allowed.

Election by the Council (when applicable in accordance with the Bylaws):

The election will comply with the usual Council election process as closely as possible except as noted. A special meeting of the Council may be held in accordance with the Bylaws to elect replacement directors. If the election is at the annual Council meeting, the Council will hold the vacancy election following the regular elections and elect the replacement director from the remaining slate of nominees (including Speaker and Vice-Speaker nominees when applicable).

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.

VII. Amendments

The method of amending the College Manual shall be specified in the College Bylaws.

Council Meeting
October 14-15, 2016
Mandalay Bay Resort and Convention Center
Las Vegas, NV

Minutes

The 45th annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:00 am, Friday, October 14, 2016, by Speaker James M. Cusick, MD, FACEP.

Seated at the head table were: James M. Cusick , MD, FACEP, speaker; John G. McManus, Jr., MD, MBA, FACEP, vice speaker; Dean Wilkerson, JD, MBA, CAE, Council secretary and executive director; and Jim Slaughter, JD, parliamentarian.

Dr. Cusick provided a meeting dedication and then led the Council in reciting the Pledge of Allegiance.

Victoria Coan sang the National Anthem.

Scot Shepherd, MD, FACEP, president of the Nevada Chapter, welcomed councillors and other meeting attendees.

Melissa Costello, MD, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 325 councillors of the 394 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

Mr. Eric Joy provided an overview of the Council meeting Web site and other technology enhancements.

David Wilcox, MD, FACEP, addressed the Council regarding the Emergency Medicine Foundation (EMF) Challenge.

Peter Jacoby, MD, FACEP, addressed the Council regarding the National Emergency Medicine Political Action Committee (NEMPAC) Challenge.

The following members were credentialed by the Tellers, Credentials, & Elections Committee for seating at the 2016 Council meeting:

Alabama	Lisa M Bundy, MD, FACEP Muhammad N Husainy, DO, FACEP Annalise Sorrentino, MD, FACEP
Alaska	Anne Zink, MD, FACEP
Arizona	Patricia A Bayless, MD, FACEP Paul Andrew Kozak, MD, FACEP Donald J Lauer, MD, MPH, FACEP J Scott Lowry, MD, FACEP Wendy Ann Lucid, MD, FACEP Craig Norquist, MD, FACEP Dale P Woolridge, MD, PhD, FACEP
Arkansas	Darren E Flamik, MD, FACEP Paul A Veach, MD, FACEP

Assoc of Academic Chairs of EM	Gabor David Kelen, MD, FACEP
California	John D Bibb, MD, FACEP Rodney W Borger, MD, FACEP John Dirk Coburn, MD Fred Dennis, MD, MBA, FACEP Carrieann E Drenten, MD Irv E Edwards, MD, FACEP Andrew N Fenton, MD, FACEP Marc Allan Futernick, MD, FACEP Vikant Gulati, MD, FACEP Ramon W Johnson, MD, FACEP Kevin M Jones, DO Roneet Lev, MD, FACEP Stephen J Liu, MD, FACEP John Thomas Ludlow, MD William K Mallon, MD Cameron J McClure, MD, FACEP Aimee K Moulin, MD, FACEP Leslie Mukau, MD, FACEP Chi Lee Perlroth, MD, FACEP Maria Raven, MD, MPH, FACEP Vivian Reyes, MD, FACEP Nicolas Sawyer, MD Eric W Snyder, MD, FACEP Peter Erik Sokolove, MD, FACEP Lawrence M Stock, MD, FACEP Thomas Jerome Sugarman, MD, FACEP Gary William Tamkin, MD, FACEP Lori D Winston, MD, FACEP
Colorado	Nathaniel T Hibbs, DO, FACEP Douglas M Hill, DO, FACEP Kevin W McGarvey, MD Carla Elizabeth Murphy, DO, FACEP Eric B Olsen, MD, FACEP Lee Wilton Shockley, MD, FACEP Donald E Stader, MD, FACEP
Connecticut	Hynes M Birmingham, MD, FACEP Mark R Dziedzic, MD, FACEP Daniel Freess, MD, FACEP Elizabeth Schiller, MD, FACEP Gregory L Shangold, MD, FACEP David E Wilcox, MD, FACEP
Council of EM Residency Directors)	Saadia Akhtar, MD
Delaware	Kathryn Groner, MD John T Powell, MD, MHCDS, FACEP
District of Columbia	Ethan A Booker, MD, FACEP Natalie L Kirilichin, MD Aisha T Liferidge, MD, FACEP
Emergency Medicine Residents' Association	Christian J Dameff, MD Nida F Degesys, MD

	Jasmeet Singh Dhaliwal, MD, MPH
	Ramnik S Dhaliwal, MD, JD
	Tiffany Jackson, MD
	Alicia Mikolaycik Kurtz, MD
	Matthew Rudy, MD
	Alison L Smith, MD, MPH
Florida	Andrew I Bern, MD, FACEP
	Jordan GR Celeste, MD
	Amy Ruben Conley, MD, FACEP
	Jay L Falk, MD, FACEP
	Kelly Gray-Eurom, MD, MMM, FACEP
	Larry Allen Hobbs, MD, FACEP
	Saundra A Jackson, MD, FACEP
	Steven B Kailes, MD, FACEP
	Michael Lozano, MD, FACEP
	Kristin McCabe-Kline, MD, FACEP
	Raymond Merritt, DO
	Ernest Page, II, MD, FACEP
	Sanjay Pattani, MD, FACEP
	Danyelle Redden, MD, FACEP
	Todd L Slesinger, MD, FACEP
	Kristine Staff, MD
	Joel B Stern, MD, FACEP
Georgia	Matthew R Astin, MD, FACEP
	James Joseph Dugal, MD, FACEP(E)
	Matthew Taylor Keadey, MD, FACEP
	Jeffrey F Linzer, Sr, MD, FACEP
	Matthew Lyon, MD, FACEP
	DW “Chip” Pettigrew, III, MD, FACEP
	Johnny L Sy, DO, FACEP
	Matthew J Watson, MD, FACEP
Government Services	James David Barry, MD, FACEP
	Marco Coppola, DO, FACEP
	Melissa L Givens, MD, FACEP
	Joshua Jacobson, DO
	Chad Kessler, MD, MHPE, FACEP
	Julio Rafael Lairet, DO, FACEP
	Linda L Lawrence, MD, FACEP
	Brett A Matzek, MD, FACEP
	David S McClellan, MD, FACEP
	Torree M McGowan, MD, FACEP
	Nadia M Pearson, DO, FACEP
	Christopher G Scharenbrock, MD, FACEP
	Gillian Schmitz, MD, FACEP
Hawaii	Jason K Fleming, MD, FACEP
	Richard M McDowell, MD, FACEP
Idaho	Nathan R Andrew, MD, FACEP
	Ken John Gramyk, MD, FACEP
Illinois	Christine Babcock, MD, FACEP
	E Bradshaw Bunney, MD, FACEP
	Shu Boung Chan, MD, FACEP

	Cai Glushak, MD, FACEP David L Griffen, MD, PhD, FACEP John W Hafner, MD, FACEP George Z Hevesy, MD, FACEP Janet Lin, MD, FACEP Valerie Jean Phillips, MD, FACEP Henry Pitzele, MD, FACEP Yanina Purim-Shem-Tov, MD, FACEP William P Sullivan, DO, FACEP Nathan Seth Trueger, MD, MPH
Indiana	Sara Ann Brown, MD, FACEP John T Finnell, II, MD, FACEP John Thomas Rice, MD, FACEP James L Shoemaker, Jr, MD, FACEP Christopher S Weaver, MD, FACEP Lindsay M Weaver, MD, FACEP
Iowa	Ryan M Dowden, MD, FACEP Andrew Sean Nugent, MD, FACEP Rachael Sokol, DO, FACEP Michael E Takacs, MD, FACEP
Kansas	Chad Michael Cannon, MD, FACEP John M Gallagher, MD, FACEP Jeffrey G Norvell, MD, FACEP
Kentucky	David Wesley Brewer, MD, FACEP Royce Duane Coleman, MD, FACEP Melissa Platt, MD, FACEP Ryan Stanton, MD, FACEP
Louisiana	James B Aiken, MD, MHA, FACEP Jon Michael Cuba, MD, FACEP Phillip Luke LeBas, MD, FACEP Mark Rice, MD, FACEP Michael D Smith, MD, MBA, CPE, FACEP
Maine	Garreth C Debiegun, MD, FACEP James B Mullen, III, MD, FACEP Charles F Pattavina, MD, FACEP
Maryland	Jason D Adler, MD, FACEP Richard J Ferraro, MD, FACEP Kerry Forrestal, MD, FACEP Hugh F Hill, III, MD, JD, FACEP Kathleen D Keeffe, MD, FACEP Orlee Israeli Panitch, MD, FACEP Esteban Schabelman, MD, FACEP
Massachusetts	Brien Alfred Barnewolt, MD, FACEP Kate Burke, MD, FACEP Stephen K Epstein, MD, MPP, FACEP Jeffrey Hopkins, MD, FACEP Kathleen Kerrigan, MD, FACEP Matthew B Mostofi, DO, FACEP Mark D Pearlmutter, MD, FACEP

	Jesse Michael Schafer, MD
	Peter B Smulowitz, MD, FACEP
	Brian Sutton, MD, FACEP
Michigan	Michael J Baker, MD, FACEP
	Keenan M Bora, MD, FACEP
	Kathleen Cowling, DO, FACEP
	Nicholas Dyc, MD, FACEP
	Gregory Gafni-Pappas, DO, FACEP
	Rami R Khoury, MD, FACEP
	Robert T Malinowski, MD, FACEP
	Jacob Manteuffel, MD, FACEP
	James C Mitchiner, MD, MPH, FACEP
	Kevin Monfette, MD, FACEP
	David T Overton, MD, FACEP
	Paul R Pomeroy, Jr, MD, FACEP
	Luke Chris Saski, MD, FACEP
	Larisa May Traill, MD, FACEP
	Bradley J Uren, MD, FACEP
	Bradford L Walters, MD, FACEP
	Mildred J Willy, MD, FACEP
	James Michael Ziadeh, MD, FACEP
Minnesota	William G Heegaard, MD, FACEP
	David M Larson, MD, FACEP
	David A Milbrandt, MD, FACEP
	David Nestler, MD, MS, FACEP
	Gary C Starr, MD, FACEP
	Thomas E Wyatt, MD, FACEP
	Andrew R Zinkel, MD, FACEP
Mississippi	Melissa Wysong Costello, MD, FACEP
	Lawrence Albert Leake, MD, FACEP
Missouri	Douglas Mark Char, MD, FACEP
	Jonathan Heidt, MD, MHA, FACEP
	Thomas B Pinson, MD, FACEP
	Robert Francis Poirier, Jr., MD, MBA, FACEP
	Sebastian A Rueckert, MD, MBA, FACEP
	Christine Sullivan, MD, FACEP
Montana	Harry Eugene Sibold, MD, FACEP
Nebraska	Renee Engler, MD, FACEP
	Laura R Millemon, MD, FACEP
Nevada	Eric John Anderson, MD, FACEP
	Gregory Alan Juhl, MD, FACEP
	Scott Franklin Shepherd, MD, FACEP
New Hampshire	Reed Brozen, MD, FACEP
	Matthew Alexander Roginski, MD
New Jersey	Victor M Almeida, DO, FACEP
	Robert M Eisenstein, MD, FACEP
	William Basil Felegi, DO, FACEP
	Jenice Forde-Baker, MD, FACEP

	Anthony William Hartmann, MD, FACEP Steven M Hochman, MD, FACEP Marjory E Langer, MD, FACEP Alexis M LaPietra, DO J Mark Meredith, MD, FACEP
New Mexico	Eric Michael Ketcham, MD, FACEP Tony B Salazar, MD, FACEP
New York	Brahim Ardolic, MD, FACEP Samuel Francis Bosco, MD, FACEP Jay Miller Brenner, MD, FACEP Jeremy T Cushman, MD, FACEP Jason Zemmel D'Amore, MD, FACEP Mathew Foley, MD, FACEP Theodore J Gaeta, DO, FACEP Sanjey Gupta, MD, FACEP Michael Gary Guttenberg, DO, FACEP Abbas Husain, MD, FACEP Stuart Gary Kessler, MD, FACEP Penelope Chun Lema, MD, FACEP Joshua B Moskovitz, MD, MPH, FACEP Nestor B Nestor, MD, FACEP Salvatore R Pardo, MD, FACEP Jennifer Pugh, MD, FACEP Jeffrey S Rabrich, DO, FACEP Christopher C Raio, MD, FACEP Gary S Rudolph, MD, FACEP James Gerard Ryan, MD, FACEP Frederick M Schiavone, MD, FACEP Trent T She, MD Virgil W Smaltz, MD, MPA, FACEP Jeffrey J Thompson, MD, FACEP Asa “Peter” Viccellio, MD, FACEP
North Carolina	Gregory J Cannon, MD, FACEP Jennifer Casaletto, MD, FACEP Charles W Henrichs, III, MD, FACEP Jeffrey Allen Klein, MD, FACEP Thomas Lee Mason, MD, FACEP Abhishek Mehrotra, MD, FACEP Bret Nicks, MD, FACEP Jennifer L Raley, MD, FACEP Stephen A Small, MD, FACEP Michael J Utecht, MD, FACEP
North Dakota	K J Temple, MD, FACEP
Ohio	Eileen F Baker, MD, FACEP Saurin P Bhatt, MD Dan Charles Breece, DO, FACEP Laura Michelle Espy-Bell, MD Purva Grover, MD, FACEP Gary R Katz, MD, MBA, FACEP Erika Charlotte Kube, MD, FACEP Thomas W Lukens, MD, PhD, FACEP John L Lyman, MD, FACEP

	Catherine Anna Marco, MD, FACEP Daniel R Martin, MD, FACEP Michael McCrea, MD, FACEP Matthew J Sanders, DO, FACEP Ryan Squier, MD, FACEP Nicole Ann Veitinger, DO, FACEP
Oklahoma	Jeffrey Michael Goodloe, MD, FACEP Jeffrey Johnson, MD James Raymond Kennedye, MD, MPH, FACEP
Oregon	Robert D Barriatua, MD, FACEP David P Lehrfeld, MD John C Moorhead, MD, FACEP Hans T Notenboom, MD, FACEP Erin Schneider, MD
Pennsylvania	Kirby Black, MD Erik Blutinger, MD Deborah Brooks, MD Merle Andrea Carter, MD, FACEP Ankur A Doshi, MD, FACEP Joshua Enyart, DO Todd Fijewski, MD, FACEP Maria Koenig Guyette, MD, FACEP Marilyn Joan Heine, MD, FACEP Scott Jason Korvek, MD, FACEP Vishnu M Patel, MD Ericka Powell, MD, FACEP Shawn M Quinn, DO, FACEP Anna Schwartz, MD, FACEP Michael A Turturro, MD, FACEP Arvind Venkat, MD, FACEP Gary David Zimmer, MD, FACEP
Puerto Rico	Luis A Serrano, MD, FACEP Ivonne Velez-Acevedo, MD, FACEP
Rhode Island	Achyut B Kamat, MD, FACEP Melanie J Lippmann, MD, FACEP Jessica Smith, MD, FACEP
Society of Academic Emergency Medicine	Kathleen J Clem, MD, FACEP
South Carolina	Thomas H Coleman, MD, FACEP Allison Leigh Harvey, MD, FACEP Dietrich Jehle, MD, FACEP L Wade Manaker, MD, FACEP Frank C Smeeks, MD, FACEP
South Dakota	Scott Gregory Vankeulen, MD
Tennessee	Sanford H Herman, MD, FACEP Kenneth L Holbert, MD, FACEP Sarah Hoper, MD, JD, FACEP Thomas R Mitchell, MD, FACEP Karolyn K Moody, DO, MPH

Texas	Sara Andrabi, MD Carrie de Moor, MD, FACEP Justin W Fairless, DO, FACEP Angela Siler Fisher, MD, FACEP Diana L Fite, MD, FACEP Andrea L Green, MD, FACEP Robert D Greenberg, MD, FACEP Alison Haddock, MD, FACEP Justin P Hensley, MD, FACEP Heidi C Knowles, MD, FACEP John Bruce Moskow, MD, FACEP Heather S Owen, MD, FACEP Daniel Eugene Peckenpaugh, MD, FACEP R Lynn Rea, MD, FACEP Richard Dean Robinson, MD, FACEP Chet D Schrader, MD, FACEP Nicholas P Steinour, MD, FACEP Gerad A Troutman, MD, FACEP Hemant H Vankawala, MD, FACEP James M Williams, DO, FACEP Sandra Williams, DO, FACEP
Utah	James V Antinori, MD, FACEP Bennion D Buchanan, MD, FACEP John R Dayton, MD, FACEP Stephen Carl Hartsell, MD, FACEP
Vermont	Joshua Harris, MD
Virginia	Brian C Dawson, MD, FACEP Bruce M Lo, MD, MBA, RDMS, FACEP Cameron K Olderog, MD, FACEP Jeremiah O'Shea, MD, FACEP Joran Sequeira, MD Mark Robert Sochor, MD, FACEP Sara F Sutherland, MD, MBA, FACEP Stephen J Wolf, MD, FACEP
Washington	Cameron Ross Buck, MD, FACEP Enrique R Enguidanos, MD, FACEP John Matheson, MD, FACEP Nathaniel R Schlicher, MD, JD, FACEP Patrick Solari, MD, FACEP Jennifer L'Hommedieu Stankus, MD, JD, FACEP Liam Yore, MD, FACEP
West Virginia	Frederick C Blum, MD, FACEP Thomas Marshall, MD, FACEP
Wisconsin	Howard Jeffery Croft, MD, FACEP William D Falco, MD, MS, FACEP William C Haselow, MD, FACEP Michael Dean Repplinger, MD, PhD, FACEP
Wyoming	Waseem A Khawaja, MD, FACEP

Sections of Membership

Air Medical Transport	Gaston Ariel Costa, MD
Amer Assoc of Women Emergency Physicians	E Lea Walters, MD, FACEP
Careers in Emergency Medicine	Sullivan K Smith, MD, FACEP
Critical Care Medicine	Ayan Sen, MD, FACEP
Cruise Ship Medicine	Sydney W Schneidman, MD, FACEP
Democratic Group Practice	David F Tulsiak, MD, FACEP
Disaster Medicine	Roy L Alson, MD, PhD, FACEP
Dual Training	Michael C Bond, MD, FACEP
Emergency Medical Informatics	Jeffrey A Nielson, MD, FACEP
Emergency Medical Services-Prehospital Care	Gina Piazza, DO, FACEP
EM Practice Management & Health Policy	Jonathan F Thomas, MD
Emergency Medicine Research	Nidhi Garg, MD, FACEP
Emergency Medicine Workforce	Guy Nuki, MD
Emergency Ultrasound	Robert M Bramante, MD, FACEP
Forensic Medicine	Lawrence J R Goldhahn, MD, FACEP
Freestanding Emegency Centers	Michael Joseph Sarabia, MD, FACEP
Geriatric Emergency Medicine	Marianna Karounos, DO, FACEP
International Emergency Medicine	Elizabeth L DeVos, MD, FACEP
Medical Humanities	David P Sklar, MD, FACEP
Observation Services	Carol L Clark, MD, MBA, FACEP
Palliative Medicine	Kate Aberger, MD, FACEP
Pediatric Emergency Medicine	Madeline Matar Joseph, MD, FACEP
Quality Improvement & Patient Safety	Jeffrey J Pothof, MD, FACEP
Rural Emergency Medicine	Darrell L Carter, MD, FACEP
Sports Medicine	Christopher Aaron Gee, MD, MPH, FACEP
Tactical Emergency Medicine	Howard K Mell, MD, MPH, CPE, FACEP
Telemedicine	Hartmut Gross, MD, FACEP
Toxicology	Jennifer Hannum, MD, FACEP

Trauma & Injury Prevention	Gregory Luke Larkin, MD, MPH, FACEP
Undersea & Hyperbaric Medicine	Richard Walker, III, MD, FACEP
Wellness	Susan Theresa Haney, MD, FACEP
Wilderness Medicine	Susanne J Spano, MD, FACEP
Young Physicians	Leisa Rossello Deutsch, MD, MPH, FACEP

In addition to the credentialed councillors, the following past leaders attended all or part of the Council meeting and were not serving as councillors:

Past Presidents

Nancy J. Auer, MD, FACEP (WA)
Larry A. Bedard, MD, FACEP (CA)
Brooks F. Bock, MD, FACEP (CO)
Michael L. Carius, MD, FACEP (CT)
Angela F. Gardner, MD, FACEP (TX)
Gregory L. Henry, MD, FACEP (MI)
J. Brian Hancock, MD, FACEP (MI)
John C. Johnson, MD, FACEP (IN)
Nicholas J. Jouriles, MD, FACEP (OH)
Brian F. Keaton, MD, FACEP (OH)
Linda L. Lawrence, MD, FACEP (GS)
Alex M. Rosenau, DO, FACEP (PA)
Robert W. Schafermeyer MD, FACEP (NC)
Sandra M. Schneider, MD, FACEP (TX)
David C. Seaberg, MD, CPE, FACEP (TN)
Richard L. Stennes, MD, MBA, FACEP (CA)
Robert E. Suter, DO, MPH, FACEP (TX)

Past Speakers

Michael J. Bresler, MD, FACEP (CA)
Marco Coppola, DO, FACEP (GS)
Mark L. DeBard, MD, FACEP (OH)
Peter J. Jacoby, MD, FACEP (CT)
Kevin M. Klauer, DO, FACEP (OH)
Todd B. Taylor, MD, FACEP (TN)
Arlo F. Weltge, MD, MPH, FACEP (TX)
Dennis C. Whitehead, MD, FACEP (MI)

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The Council Standing Rules were distributed to the councillors prior to the meeting and were not read aloud. The rules are listed as distributed.

Council Standing Rules

Preamble

These Council Standing Rules serve as an operational guide and description for how the Council conducts its business at the annual meeting and throughout the year in accordance with the College Bylaws, the College Manual, and standing tradition.

Alternate Councillors

A properly credentialed alternate councillor may substitute for a designated councillor not seated on the Council meeting floor. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed.

If the number of alternate councillors is insufficient to fill all councillor positions for a particular chapter, section, or EMRA, then a member of that sponsoring body may be seated as a councillor pro-tem by either the concurrence of an officer of the sponsoring body or upon written request to the Council secretary with a majority vote of the Council. Disputes regarding the assignment of councillor pro-tem positions will be decided by the speaker.

Amendments to Council Standing Rules

These rules shall be amended by a majority vote using the formal Council resolution process outlined herein and become effective immediately upon adoption. Suspension of these Council Standing Rules requires a two-thirds vote.

Announcements

Proposed announcements to the Council must be submitted by the author to the Council secretary, or to the

speaker. The speaker will have sole discretion as to the propriety of announcements. Announcements of general interest to members of the Council, at the discretion of the speaker, may be made from the podium. Only announcements germane to the business of the Council or the College will be permitted.

Appeals of Decisions from the Chair

A two-thirds vote is required to override a ruling by the chair.

Board of Directors Seating

Members of the Board of Directors will be seated on the floor of the Council and are granted full floor privileges except the right to vote.

Campaign Rules

Rules governing campaigns for election of the president-elect, Board of Directors, and Council officers shall be developed by the Steering Committee and reviewed on an annual basis. Candidates, councillors, chapters, and sections, etc. are responsible for abiding by the campaign rules.

Cellular Phones, Pagers, and Computers

Cellular phones, pagers, and computers must be kept in "quiet" mode during the Council meeting. Talking on cellular phones is prohibited in Council meeting rooms. Use of computers for Council business during the meeting is encouraged, but not appropriate for other unrelated activities.

Councillor Allocation for Sections of Membership

To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

Councillor Seating

Councillor seating will be grouped by chapter and the location rotated year to year in an equitable manner.

Credentialing and Proper Identification

To facilitate identification and seating, councillors are required to wear a name badge with a ribbon indicating councillor or alternate status. Individuals without such identification will be denied admission to the Council floor. Voting status will be designated by possession of a councillor voting card issued at the time of credentialing by the Tellers, Credentials and Elections Committee. College members and guests must also wear proper identification for admission to the Council meeting room and reference committees.

The Tellers, Credentials and Elections Committee, at a minimum, will report the number of credentialed councillors at the beginning of each Council session. This number is used as the denominator in determining a two-thirds vote necessary to adopt a Bylaws amendment.

Debate

Councillors, members of the Board of Directors, past presidents, and past speakers wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, etc.), and whether they are speaking "for" or "against" the motion.

Debate should not exceed two minutes for each recognized individual unless special permission has been granted. Participants should refrain from speaking again on the same issue until all others wishing to speak have had the opportunity to do so.

In accordance with parliamentary procedure, the individual speaking may only be interrupted for the following reasons: 1) point of personal privilege; 2) motion to reconsider; 3) appeal; 4) point of order; 5) parliamentary inquiry; 6) withdraw a motion; or 7) division of assembly. All other motions must wait their turn and be recognized by the chair.

Seated councillors or alternate councillors have full privileges of the floor. Upon written request and at the discretion of the chair, alternate councillors not currently seated, and other individuals may be recognized and address the Council. Such requests must be made in writing prior to debate on that issue and should include the individual's name, organization affiliation, issue to be addressed, and the rationale for speaking to the Council.

Distribution of Printed or Other Material During the Annual Meeting

The speaker will have sole discretion to authorize the distribution of printed or other material on the Council floor during the annual meeting. Such authorization must be obtained in advance.

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot. There shall be no write-in voting.
When voting electronically, the names of all candidates for a particular office will be projected at the same time. Thirty (30) seconds will be allowed for each ballot. Councillors may change votes only during the allotted time. The computer will accept the last vote or group of votes selected before voting is closed. When voting with paper ballots, the chair of the Tellers, Credentials, and Elections Committee will determine the best procedure for the election process.

Councillors must vote for the number of candidates equal to the number of available positions for each ballot. A councillor's individual ballot shall be considered invalid if there are greater or fewer votes on the ballot than is required. The total number of valid and invalid individual ballots will be used for purposes of determining the denominator for a majority of those voting.

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast shall be elected. If more candidates receive a majority vote than the number of positions available, the candidates with the highest number of votes will be elected. When one or more vacancies still exist, elected candidates and their respective positions are removed and all non-elected candidates remain on the ballot for the subsequent vote. If no candidate is elected on any ballot, the candidate with the lowest number of valid votes is removed from subsequent ballots. In the event of a tire for the lowest number of valid votes on a ballot in which no candidate is elected, a run-off will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote* for each open position.

*NOTE: If at any time, the total number of invalid individual ballots added to any candidate's total valid votes would change which candidate is elected or removed, then only those candidates not affected by this discrepancy will be elected. If open positions remain, a subsequent vote will be held to include all remaining candidates from that round of voting.

The chair of the Tellers, Credentials, and Elections Committee will make the final determination as to the validity of each ballot. Upon completion of the voting and verification of votes for all candidates, the Tellers, Credentials, and Elections Committee chair will report the results to the speaker.

Within 24 hours after the close of the annual Council meeting, the Chair of the Tellers, Credentials, and Elections Committee shall present to the Council Secretary a written report of the results of all elections. This report shall include the number of credentialed councillors, the slate of candidates, and the number of open positions for each round of voting, the number of valid and invalid ballots cast in each round of voting, the number needed to elect and the number of valid votes cast per candidate in each round of voting, and verification of the final results of the elections. This written report shall be considered a privileged and confidential document of the College. However, when there is a serious concern that the results of the election are not accurate, the Speaker has discretion to disclose the results to provide the Council an assurance that the elections are valid. Individual candidates may request and receive their own total number of votes and the vote totals of the other candidates without attribution.

Limiting Debate

A motion to limit debate on any item of business before the Council may be made by any councillor who has been granted the floor and who has not debated the issue just prior to making that motion. This motion requires a second, is not debatable, and must be adopted by a two-thirds vote. ***See also Debate and Voting Immediately.***

Nominating Committee

The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committees shall consider activity and involvement in the College, the Council, and chapter or sections when considering the slate of candidates.

Nominations

A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, or past speaker, after which nominations will be closed and shall not be reopened.

A prospective floor candidate or an individual who intends to nominate a candidate from the floor may make this intent known in advance by notifying the Council secretary in writing. Upon receipt of this notification, the

candidate becomes a "declared floor candidate" and has all the rights and responsibilities of committee nominated candidates. ***See also Election Procedures.***

Parliamentary Procedure

The current edition of *Sturgis, Standard Code of Parliamentary Procedure* will govern the Council, except where superseded by these Council Standing Rules, the College Manual, and/or the Bylaws. ***See also Personal Privilege and Voting Immediately.***

Past Presidents and Past Speakers Seating

Past presidents and past speakers of the College are invited to sit with their respective chapter delegations, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

Personal Privilege

Any councillor may call for a "point of personal privilege" at any time even if it interrupts the current person speaking. This procedure is intended for uses such as asking a question for clarification, asking the person speaking to talk louder, or to make a request for personal comfort. Use of "personal privilege" to interject debate is out of order.

Policy Review

The Council Steering Committee will report annually to the Council the results of a periodic review of non-Bylaws resolutions adopted by the Council and approved by the Board of Directors.

Reference Committees

Resolutions meeting the filing and transmittal requirements in these Standing Rules will be assigned by the speaker to a Reference Committee for deliberation and recommendation to the Council. Reference Committee meetings are open to all members of the College, its committees, and invited guests.

Reference Committees will hear as much testimony for its assigned resolutions as is necessary or practical and then adjourn to executive session to prepare recommendations for each resolution in a written Reference Committee Report.

A Reference Committee may recommend that a resolution:

A) **Be Adopted or Not Be Adopted:** In this case, the speaker shall state the resolution, which is then the subject for debate and action by the Council.

B) **Be Amended or Substituted:** In this case, the speaker shall state the resolution as amended or substituted, which is then the subject for debate and action by the Council.

C) **Be Referred:** In this case, the speaker shall state the motion to refer. Debate on a Reference Committee's motion to refer may go fully into the merits of the resolution. If the motion to refer is defeated, the speaker shall state the original resolution.

Other information regarding the conduct of Reference Committees is contained in the Councillor Handbook.

Reports

Committee and officer reports to be included in the Council minutes must be submitted in writing to the Council secretary. Authors of reports who petition or are requested to address the Council should note that the purpose of these presentations are to elaborate on the facts and findings of the written report and to allow for questions. Debate on relevant issues may occur subsequent to the report presentation.

Resolutions

"Resolutions" are considered formal motions that if adopted by a majority vote of the Council and ratified by the Board of Directors become official College policy. Resolutions pertaining only to the Council Standing Rules do not require Board ratification and become effective immediately upon adoption. Resolutions pertaining to the College Bylaws (Bylaws resolutions) require adoption by a two-thirds vote of credentialed councillors and subsequently a two-thirds vote of the Board of Directors.

Resolutions must be submitted in writing by at least two members or by chapters, sections, committees, or the Board of Directors. A letter of endorsement from the sponsoring body is required if submitted by a chapter, section, or committee.

All motions for substantive amendments to resolutions must be submitted in writing through the electronic means provided to the Council during the annual meeting, with the exception of technical difficulties preventing such electronic submission, signed by the author, and presented to the Council prior to being considered. When

appropriate, amendments will be distributed or projected for viewing.

Background information, including financial analysis, will be prepared by staff on all resolutions submitted on or before 90 days prior to the annual meeting.

• Regular Non-Bylaws Resolutions

Non-Bylaws resolutions submitted on or before 90 days prior to the annual meeting are known as "regular resolutions" and will be referred to an appropriate Reference Committee for consideration at the annual meeting.

Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90 to 45 day window that appear to alter the original intent of a regular resolution or that would render the background information meaningless will be considered as "Late Resolutions."

• Bylaws Resolutions

Bylaws resolutions must be submitted on or before 90 days prior to the annual meeting and will be referred to an appropriate Reference Committee for consideration at the annual meeting. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the author(s), may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

Bylaws resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, revisions during the 90 to 45 day window that appear to alter the original intent of a Bylaws resolution, or are otherwise considered to be out of order under parliamentary authority, will not be permitted.

• Late Resolutions

Resolutions submitted after the 90-day submission deadline, but at least 24 hours prior to the beginning of the annual meeting are known as "late resolutions." These late resolutions are considered by the Steering Committee at its meeting on the evening prior to the opening of the annual meeting. The Steering Committee is empowered to decide whether a late submission is justified due to events that occurred after the filing deadline. An author of the late resolution shall be given an opportunity to inform the Steering Committee why the late submission was justified. If a majority of the Steering Committee votes to accept a late resolution, it will be presented to the Council at its opening session and assigned to a Reference Committee. If the Steering Committee votes unfavorably and rejects a late resolution, the reason for such action shall be reported to the Council at its opening session. The Council does not consider rejected late resolutions. The Steering Committee's decision to reject a late resolution may be appealed to the Council. When a rejected late resolution is appealed, the Speaker will state the reason(s) for the ruling on the late resolution and without debate, the ruling may be overridden by a two-thirds vote.

• Emergency Resolutions

Emergency resolutions are resolutions that do not qualify as "regular" or "late" resolutions. They are limited to substantive issues that because of their acute nature could not have been anticipated prior to the annual meeting or resolutions of commendation that become appropriate during the course of the Council meeting. Resolutions not meeting these criteria may be ruled out of order by the speaker. Should this ruling be appealed, the speaker will state the reason(s) for ruling the emergency resolution out of order and without debate, the ruling may only be overridden by a two-thirds vote. ***See also Appeals of Decisions from the Chair.***

Emergency resolutions must be submitted in writing, signed by at least two members, and presented to the Council secretary. The author of the resolution, when recognized by the chair, may give a one-minute summary of the emergency resolution to enable the Council to determine its merits. Without debate, a simple majority vote of the councillors present and voting is required to accept the emergency resolution for floor debate and action. If an emergency resolution is introduced prior to the beginning of the Reference Committee hearings, it shall upon acceptance by the Council be referred to the appropriate Reference Committee. If an emergency resolution is introduced and accepted after the Reference Committee hearings, the resolution shall be debated on the floor of the Council at a time chosen by the speaker.

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

A "Unanimous Consent Agenda" is a list of resolutions with a waiver of debate and may include items that meet one of the following criteria as determined by the Reference Committee:

1. Non-controversial in nature
2. Generated little or no debate during the Reference Committee
3. Clear consensus of opinion (either pro or con) was expressed at Reference Committee

Bylaws resolutions and resolutions that require substantive amendments shall not be placed on a Unanimous Consent Agenda.

A Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, or defeat for each resolution listed. A request for extraction of any resolution from a Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

Voting Immediately

A motion to "vote immediately" may be made by any councillor who has been granted the floor. This motion requires a second, is not debatable, and must be adopted by two-thirds of the councillors voting.
Councillors are out of order who move to "vote immediately" during or immediately following their presentation of testimony on that motion. The motion to "vote immediately" applies only to the immediately pending matter, therefore, motions to "vote immediately on all pending matters" is out of order.

The opportunity for testimony on both sides of the issue, for and against, must be presented before the motion to "vote immediately" will be considered in order. ***See also Debate and Limiting Debate.***

Voting on Resolutions and Motions

Voting may be accomplished by an electronic voting system, voting cards, standing or voice vote at the discretion of the speaker. Numerical results of electronic votes and standing votes on resolutions and motions will be presented before proceeding to the next issue.

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The councillors reviewed and accepted the minutes of the October 24-25, 2015, Council meeting and approved the actions of the Steering Committee taken at their January 26, 2016, and May 15, 2016, meetings.

Dr. Cusick called for submission of emergency resolutions. None were submitted.

Dr. Cusick reported that two late resolutions were received and reviewed by the Steering Committee. One late resolution was withdrawn and the other late resolution was accepted and assigned to Reference Committee C.

Dr. Cusick presented the Nominating Committee report. Four members were nominated for President-Elect: Hans R. House MD, MACM, FACEP; Paul D. Kivela, MD, MBA, FACEP; Robert E. O'Connor, MD, MPH, FACEP; and John J. Rogers, MD, CPE, FACEP. Dr. Cusick called for floor nominations. There were no floor nominees. The nominations were then closed.

Seven members were nominated for four positions on the Board of Directors: James J. Augustine, MD, FACEP; John T. Finnell, MD, FACEP; Kevin M. Klauer, DO, EJD, FACEP; Debra G. Perina, MD, FACEP; Gillian R. Schmitz, MD, FACEP; Matthew J. Watson, MD, FACEP; and James M. Williams, DO, MS, FACEP. Dr. Cusick called for floor nominations. There were no floor nominees. The nominations were then closed.

Dr. McManus explained the Candidate Forum procedures. The candidates then made their opening statements to the Council.

2016 Council Resolutions

The Council recessed at 9:15 am for the Reference Committee hearings. The resolutions considered by the 2016 Council appear below as submitted.

RESOLUTION 1

RESOLVED, That the American College of Emergency Physicians commends Michael J. Gerardi, MD,

FACEP, for his exemplary service, leadership, and commitment to the College, the specialty of emergency medicine, and to the patients we serve.

RESOLUTION 2

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Kenneth L. DeHart, 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 Kenneth L. DeHart, 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 South Carolina and the United States.

RESOLUTION 3

RESOLVED, That the "Unanimous Consent" section of the Council Standing Rules be amended to read:

Unanimous Consent Agenda

A "Unanimous Consent Agenda" is a list of resolutions with a waiver of debate and may include items that meet one of the following criteria as determined by the Reference Committee:

1. Non-controversial in nature
2. Generated little or no debate during the Reference Committee
3. Clear consensus of opinion (either pro or con) was expressed at Reference Committee

Bylaws resolutions and resolutions that require substantive amendments shall not be placed on a Unanimous Consent Agenda.

A Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, or defeat for each resolution listed. A request for extraction of any resolution from a Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. **The requestor, when recognized by the chair, may give a one-minute summary of the reason for extraction to enable the Council to determine the "merits of extraction." The Reference Committee chair will then read the summary of the testimony from the Reference Committee Report. Without debate, a one-third affirmative vote of the councillors present and voting is required to remove the item from the Unanimous Consent Agenda. This process will be repeated for each item requested to be removed from the Unanimous Consent Agenda.** Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

RESOLUTION 4

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 2 – Fellow Status, be amended to read:

"Fellows shall be authorized to use the letters FACEP in conjunction with professional activities. **Members previously designated as ACEP Fellows under any prior criteria shall retain Fellow status.** Maintenance of Fellow status requires continued membership in the College. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

RESOLUTION 5

RESOLVED, That the 2016 ACEP Council supports the establishment of a full voting designated young physician position on the ACEP Board of Directors.

RESOLUTION 6

RESOLVED, That the ACEP Board of Directors pursue an appropriate avenue to study and determine if any specific issues posed to Senior/Late Career Emergency Physicians exist, and that if there is a need to address issues related to Senior/Late Career Emergency Physicians, to address those issues in an appropriate manner to be determined by the ACEP Board and that a report on this matter shall be delivered to the 2017 ACEP Council.

RESOLUTION 7

RESOLVED, That the ACEP Board of Directors develop strategies to increase diversity within the ACEP Council and its leadership and report back to the Council on effective means of implementation.

RESOLUTION 8

RESOLVED, That ACEP oppose mandatory, required, high stakes secured examination for Maintenance of Certification (MOC) in Emergency Medicine; and be it further

RESOLVED, That ACEP work with members, other interested organizations, and interested certifying bodies to develop reasonable, evidence based, cost-effective, and time sensitive methods to allow individual practitioners options to demonstrate or verify their content knowledge for continued practice in Emergency Medicine.

RESOLUTION 9

RESOLVED, That ACEP explore the possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers; and be it further

RESOLVED, That ACEP explore the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where they are allowed by state law.

RESOLUTION 10

RESOLVED, That ACEP adopt and support a national policy that the possession of small amounts of marijuana for personal use be decriminalized; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association for national action on decriminalization of possession of small amounts of marijuana for personal use.

RESOLUTION 11

RESOLVED, That ACEP lobby to MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided; and be it further

RESOLVED, That ACEP suggest the AMA lobby MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided.

RESOLUTION 12

RESOLVED, That the American College of Emergency Physicians, in order to promote high quality, safe, and efficient emergency medical care, clinical and non-clinical, reach out and build coalitions with non-medical organizations involved in developing quality standards to achieve objective and meaningful advances in quality in the eyes of our patients, institutions, and payers; and be it further

RESOLVED, That the American College of Emergency Physicians, in conjunction with non-medical organizations involved in developing quality standards, define the costs of providing the highest levels of quality care, to quality/safety reflects reimbursement and reimbursement reflects quality/safety.

RESOLUITON 13

RESOLVED, That ACEP request that the Secretary of the Department of Health and Human Services (HHS) under section 319 of the Public Health Service (PHS) Act determines that emergency department boarding and hallway care is an immediate threat to the public health and public safety; and be it further

RESOLVED, That ACEP work with the United States Department of Health and Human Services, the United States Public Health Service, The Joint Commission, and other appropriate stakeholders to determine the next action steps to be taken to reduce emergency department crowding and boarding with a report back to the ACEP Council at the Council's next scheduled meeting; and be it further

RESOLVED, That ACEP reaffirms its support of:

1. Smoothing of elective admissions as a mechanism for sustained improvement in hospital capacity.
2. Early discharge (before 11 am) as a mechanism for sustained improvement in hospital capacity.
3. Enhanced weekend discharges as a mechanism for sustained improvement in hospital capacity.
4. The requirement for a genuine institutional solution to boarding when there is no hospital capacity, which must include both providing additional staff as needed AND redistributing the majority of ED boarders to other areas of the hospital.
5. The concept of a true 24/7 hospital

RESOLUTION 14

RESOLVED, That the ACEP promote the development and application of throughput quality data measures and dashboard reporting for behavioral health patients boarded in EDs; and be it further

RESOLVED, That ACEP endorse integration of a dashboard for reporting and tracking of behavioral health patients boarding in EDs in electronic health record systems as a means for linking to broader priority systems, for communicating the impact of boarded behavioral health patients, and to further collaborate with all appropriate health care and government stakeholders.

RESOLUTION 15

RESOLVED, That ACEP shall create a study of the impact of narrow networks laws and potential solutions that address balance billing issues without increasing the burden on the patient; and be it further

RESOLVED, That ACEP dedicate resources and support to ensure any proposed legislation regarding narrow networks does not affect a physician's ability to receive fair reimbursement for providing medical care.

RESOLUTION 16

RESOLVED, That ACEP develop a report or information paper supporting the use of Freestanding Emergency Centers as an alternative care model for the replacement of Emergency Departments in Critical Access and Rural Hospitals that have closed, or are in imminent risk of closure, to maintain access to emergency care in the underserved and rural regions of the United States.

RESOLUTION 17

RESOLVED, That ACEP add to its legislative agenda as a priority to advocate for health care insurance companies to be required to collect patient's deductibles after the insurance company pays the physician the full negotiated rate; and be it further

RESOLVED, 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 the full negotiated rate.

RESOLUTION 18

RESOLVED, That ACEP oppose the overstep of CMS mandated reporting standards that require potential harm to patients without the recognition of appropriate physician assessment and evidence based goal directed care of individual patients; and be it further

RESOLVED, That ACEP actively communicate to members and the public the dangers of CMS overstep of physician responsibility to patients for quality indicators and actively work to communicate to hospitals the need and options to recognize appropriate physician treatment while avoiding unnecessary harm to patients.

RESOLUTION 19

RESOLVED, That ACEP create a Health Care Financing Task Force as originally intended to study alternative health care financing models, including single-payer, that foster competition and preserve patient choice and that the task force report to the 2017 ACEP Council regarding its investigation.

RESOLUTION 20

RESOLVED, That the American College of Emergency Physicians work with the Undersea & Hyperbaric Medical Society (UHMS) and the Divers Alert Network (DAN) to support and advocate for improved 24/7 emergency hyperbaric medicine availability across the United States to provide timely and appropriate treatment to patients in need.

RESOLUTION 21

RESOLVED, That ACEP develop guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning Substance Use Disorder patients to sustainable long-term treatment programs from the ED; and be it further

RESOLVED, That ACEP provide educational resources to ED providers for improving direct referral of Substance Use Disorder patients to treatment.

RESOLUTION 22

RESOLVED, That ACEP study the moral and ethical responsibilities of emergency physicians within the context of court ordered forensic collection of evidence in the context of patient refusal of consent, and if appropriate,

develop policy to support emergency physician's professional responsibilities when in conflict with court ordered forensic collection of evidence and or medical treatment.

RESOLUTION 23

RESOLVED, That ACEP review the evidence on ED-initiated treatment of patients with substance use disorders to provide emergency physician education; and be it further

RESOLVED, That ACEP support, through reimbursement and practice regulation advocacy, the availability and access of novel induction and maintenance programs (including methadone, buprenorphine) from the Emergency Department.

RESOLUTION 24

RESOLVED, That ACEP partner with stakeholders including the American Psychiatric Association, the Substance Abuse and Mental Health Services Administration, National Alliance of Mental Illness, and other interested parties, to develop model practices focused on building bed capacity, enhancing alternatives, and reducing the length of stay for mental health patients in EDs; and be it further

RESOLVED, That ACEP develop and share these ED mental health best practices designed to reduce ED mental health visits, reduce ED mental health boarding, and improve the overall care of patients who board in our EDs; and be it further

RESOLVED, That ACEP work with the Agency for Healthcare Research and Quality and the National Academy of Medicine to develop community and hospital based benchmark performance metrics for ED mental health flow and linking inpatient psychiatric facilities acceptance of patients to licensure.

RESOLUTION 25

RESOLVED, That the American College of Emergency Physicians, in order to promote high quality, safe, and efficient emergency medicine care, support current state and federal initiatives for accelerated training and assessment for national registry testing and certification in recognition of the current level of training and experience of military medical specialist providers in our nation's service.

RESOLUTION 26

RESOLVED, That ACEP supports users of clinical ultrasound with a statement declaring opposition to the use of exclusive imaging contracts to limit the use of clinical ultrasound by non-radiology specialists and the billing for such services; and be it further

RESOLVED, That ACEP continue to support emergency physicians working to develop and implement clinical ultrasound programs who face opposition in hospitals where radiologists or others hold exclusive imaging contracts.

RESOLUTION 27

RESOLVED, That ACEP dispute the current Pediatric Surgery Center Guidelines and work with appropriate stakeholders to amend the guidelines; and be it further

RESOLVED, That ACEP reaffirm the Guidelines for the Care of Children in the Emergency Department as the standard for pediatric emergency care.

RESOLUTION 28

RESOLVED, That ACEP develop a strategy to seek reimbursement for counseling on safe opiate use, reversal agent instruction, and drug abuse counseling for our patients; and be it further

RESOLVED, ACEP develop a toolkit and education for implementing safe opioid use, reversal agent instruction, and drug abuse counseling in our Emergency Departments.

RESOLUTION 29

RESOLVED, That ACEP advocates and supports the training and equipping of all first responders, including police, fire, and EMS personnel to use injectable and nasal spray Naloxone; and be it further

RESOLVED, That ACEP advocates and supports that appropriately trained pharmacists be able to dispense Naloxone without prescription; and be it further

RESOLVED, That ACEP develop a comprehensive policy on the prevention and treatment of the opioid use disorder epidemic including such innovative treatments as allowing school nurses and other trained school personnel to administer Naloxone, "safe injection sites," and needle exchange programs.

RESOLUTION 30

RESOLVED, That ACEP investigate the scope of treatment of marijuana intoxication in the ED that has legal implications; and be it further

RESOLVED, That ACEP determines if there are state or federal laws that provide guidance to emergency physicians in the treatment of marijuana intoxication in the ED; and be it further

RESOLVED, That the Board of Directors assign an appropriate committee or task force to answer clinically relevant questions that address the need to care for ED patients with possible marijuana (or other drug) intoxication; and be it further

RESOLVED, That ACEP investigate how other medical specialties address the treatment of marijuana intoxication in other clinical settings; and be it further

RESOLVED, That ACEP provide the resources necessary to coordinate the treatment of marijuana intoxication in the ED.

RESOLUTION 31 (This late resolution was accepted by the Council for submission.)

RESOLVED, That ACEP actively oppose the FDA approval of sublingual formulations of synthetic fentanyl analogs, including sufentanil, via direct testimony or other means that the Board may find suitable; and be it further

RESOLVED**,** That ACEP create a report detailing the risks, benefits, and alternatives to the use of narcotic analgesics that, by their specific route of administration or formulation, carry a higher risk of misuse or abuse than other similarly classified drugs, in EMS and Emergency Medicine.

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Commendation and memorial resolutions were not assigned to reference committees.

Resolutions 3-8 were referred to Reference Committee A. Chad Kessler, MD, FACEP, chaired Reference Committee A and other members were: James R. Kennedye, MD, MPH, FACEP; Heidi C. Knowles, MD, FACEP; Paul R. Pomeroy, Jr., MD, FACEP; Anne Zink, MD, FACEP; Leslie Moore, JD; and Dan Sullivan.

Resolutions 9-20 were assigned to Reference Committee B. Nathaniel R. Schlicher, MD, JD, FACEP, chaired Reference Committee B and other members were: Jordan GR Celeste, MD, FACEP; William B. Felegi, DO, FACEP; Heather A. Heaton, MD; Donald L. Lum, MD, FACEP; Tony B. Salazar, MD, FACEP; Harry Monroe; and Barbara Tomar, MHA.

Resolutions 21-31 were referred to Reference Committee C. Kelly Gray-Eurom, MD, MMM, FACEP, chaired Reference Committee C and other members were: Sabina A. Braithwaite, MD, FACEP; Gregory Cannon, MD, FACEP; Nathaniel T. Hibbs, DO, FACEP; Ramon W. Johnson, MD, FACEP; Harry E. Sibold, MD, FACEP; Margaret Montgomery, RN, MSN; and Sandy Schneider, MD, FACEP.

At 1:00 pm a Town Hall Meeting was held. The topic was "Alternate Delivery Models and Their Impact on Emergency Medicine." Marco Coppola, DO, FACEP, served as the moderator and the discussants were Paolo Coppola, MD, FACEP; Hartmut Gross, MD, FACEP; Howard Mell, MD, FACEP; and Gerad Troutman, MD, FACEP.

The Candidate Forum began at 2:30 pm with candidates rotating through each of the Reference Committee meeting rooms.

At 4:15 pm the Council reconvened in the main Council meeting room to hear reports and the reading and presentation of the memorial resolutions.

Dr. Cusick introduced the Board of Directors and honored guests and then addressed the Council.

Dr. Cusick reviewed the procedure for the adoption of the 2016 memorial resolution. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. McManus then presented the memorial resolution to the colleagues of Kenneth L. DeHart, MD, FACEP. The Council honored the memory of those who passed away since the last Council meeting 2016 and adopted the memorial resolution by observing a moment of silence.

Dr. Cusick announced that the commendation resolution would be presented during the Council luncheon on

Saturday, October 15, 2016.

Michael L Carius, MD, FACEP, reported on activities of the American Board of Emergency Medicine.

William P. Jaquis, MD, FACEP, presented the secretary-treasurer's report.

Ramnik Dhaliwal, MD, JD, addressed the Council regarding the activities of the Emergency Medicine Residents' Association.

Brooks Bock, MD, FACEP, addressed the Council regarding the activities of the Emergency Medicine Foundation.

Peter Jacoby, MD, FACEP, addressed the Council regarding the activities of NEMPAC and the 911 Network.

Jay A. Kaplan, MD, FACEP, president, addressed the Council. He reflected on his past year as ACEP president and highlighted the successes of the College.

The Council recessed at 5:30 pm for the candidate reception and reconvened at 8:00 am on Saturday, October 15, 2016.

Dr. Costello reported that 386 councillors of the 394 eligible for seating had been credentialed. She then introduced the members of the Tellers, Credentials, & Elections Committee, reviewed the electronic voting procedures, and conducted a test of the keypads using demographic and survey questions.

Mr. Wilkerson addressed the Council and then showed a video of the new ACEP headquarters building.

REFERENCE COMMITTEE A

Dr. Kessler presented the report of Reference Committee A. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Amended Resolution 6 and Amended Resolution 7

The Council adopted the resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 6

RESOLVED, THAT THE ACEP BOARD OF DIRECTORS ~~PURSUE AN APPROPRIATE AVENUE~~ **CREATE A TASK FORCE** TO STUDY ~~AND DETERMINE IF ANY~~ **ISSUES** SPECIfiC ~~ISSUES POSED~~ TO SENIOR/LATE CAREER EMERGENCY PHYSICIANS. ~~EXIST, AND THAT IF THERE IS A NEED TO ADDRESS ISSUES RELATED TO SENIOR/LATE CAREER EMERGENCY PHYSICIANS, TO ADDRESS THOSE ISSUES IN AN APPROPRIATE MANNER TO BE DETERMINED BY THE ACEP BOARD AND THAT A REPORT ON THIS MATTER SHALL BE DELIVERED~~ **THE TASK FORCE SHALL MAKE RECOMMENDATIONS REGARDING IDENTIFIED ISSUES TO THE BOARD, WHICH SHALL DELIVER AN UPDATE ON THIS MATTER** TO THE 2017 ACEP COUNCIL.

AMENDED RESOLUTION 7

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 ~~ACEP~~ COUNCIL AND ITS LEADERSHIP AND REPORT BACK TO THE COUNCIL ON EFFECTIVE MEANS OF IMPLEMENTATION.

The committee recommended that Resolution 3 not be adopted.

It was moved THAT RESOLUTION 3 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 4 be adopted.

It was moved THAT RESOLUTION 4 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 5 not be adopted.

It was moved THAT RESOLUTION 5 BE ADOPTED.

It was moved THAT THE WORDS "FULL VOTING" BE DELETED. The motion was not adopted.

The main motion was then voted on and was not adopted

The committee recommended that Resolution 8 not be adopted.

It was moved THAT RESOLUTION 8 BE ADOPTED.

It was moved THAT RESOLUTION 8 BE DIVIDED. The motion was adopted.

It was moved THAT THE FIRST RESOLVED BE AMENDED TO READ:

RESOLVED, THAT ACEP ~~OPPOSE MANDATORY, REQUIRED, HIGH STAKES SECURED EXAMINATION~~ **WORK WITH THE AMERICAN BOARD OF EMERGENCY MEDICINE (ABEM TO FURTHER DEVELOP ALTERNATIVE WAYS TO ASSESS MEDICAL KNOWLEDGE OTHER THAN BY A HIGH-STAKES STANDARDIZED TEST** FOR MAINTENANCE OF CERTIFICATION (MOC) IN EMERGENCY MEDICINE. The motion was adopted.

The amended main motion was then voted on and was not adopted.

It was moved THAT THE SECOND RESOLVED OF RESOLUTION 8 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

REFERENCE COMMITTEE C

Dr. Gray-Eurom presented the report of Reference Committee C. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 21, Resolution 22, Amended Resolution 25, Amended Resolution 26, Resolution 27, and Resolution 28.

Resolution 21 was extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 25

RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, IN ORDER TO PROMOTE HIGH QUALITY, SAFE, AND EFFICIENT EMERGENCY MEDICINE CARE, SUPPORT CURRENT STATE AND FEDERAL INITIATIVES FOR ACCELERATED TRAINING ~~AND ASSESSMENT FOR NATIONAL REGISTRY TESTING AND CERTIFICATION IN RECOGNITION OF THE~~ **TO ALLOW TRANSITION OF CURRENT MILITARY PRE-HOSPITAL PERSONNEL TO THE CIVILIAN SECTOR AND WHICH RECOGNIZE THE** CURRENT LEVEL OF TRAINING AND EXPERIENCE OF MILITARY MEDICAL SPECIALIST PROVIDERS IN OUR NATION'S SERVICE.

AMENDED RESOLUTION 26

RESOLVED, THAT ACEP SUPPORTS USERS OF ~~CLINICAL~~ **EMERGENCY** ULTRASOUND WITH A STATEMENT DECLARING OPPOSITION TO THE USE OF EXCLUSIVE IMAGING CONTRACTS TO LIMIT THE USE OF ~~CLINICAL~~ **EMERGENCY** ULTRASOUND BY NON-RADIOLOGY SPECIALISTS AND THE BILLING FOR SUCH SERVICES; AND BE IT FURTHER

RESOLVED, THAT ACEP CONTINUE TO SUPPORT EMERGENCY PHYSICIANS WORKING TO DEVELOP AND IMPLEMENT ~~CLINICAL~~ **EMERGENCY** ULTRASOUND PROGRAMS WHO FACE OPPOSITION IN HOSPITALS WHERE RADIOLOGISTS OR OTHERS HOLD EXCLUSIVE IMAGING CONTRACTS.

The committee recommended that RESOLUTION 21 BE ADOPTED.

It was moved THAT 21 BE ADOPTED.

Without objection, the title of the resolution was amended by deleting the words "including warm handoffs."

The main motion was then voted on and adopted.

The committee recommended that Amended Resolution 23 be adopted.

It was moved THAT AMENDED RESOLUTION 23 BE ADOPTED:

RESOLVED, THAT ACEP REVIEW THE EVIDENCE ON ED-INITIATED TREATMENT OF PATIENTS WITH SUBSTANCE USE DISORDERS TO PROVIDE EMERGENCY PHYSICIAN EDUCATION; AND BE IT FURTHER

RESOLVED, THAT ACEP SUPPORT, THROUGH REIMBURSEMENT AND PRACTICE REGULATION ADVOCACY, THE AVAILABILITY AND ACCESS OF NOVEL INDUCTION ~~AND MAINTENANCE~~ PROGRAMS **SUCH AS** ~~(INCLUDING METHADONE~~, BUPRENORPHINE~~)~~ ~~,~~FROM THE EMERGENCY DEPARTMENT.

Without objection, the title was amended by replacing the word "medical" with the word "medication."

It was moved THAT THE WORDS "SUCH AS" AND THE WORD "BUPRENORPHINE" BE DELETED. The motion was adopted.

It was moved THAT THE SECOND RESOLVED BE AMENDED TO READ:

RESOLVED, THAT ACEP SUPPORT, THROUGH REIMBURSEMENT AND PRACTICE REGULATION ADVOCACY, THE AVAILABILITY AND ACCESS OF NOVEL INDUCTION PROGRAMS AND THE DEVELOPMENT OF CLINICAL POLICY GUIDELINES REGARDING OPIOUD WITHDRAWAL MANAGEMENTIN THE EMERGENCY DEPARTMENT. The motion was not adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 24 be adopted.

It was moved THAT AMENDED RESOLUTION 24 BE ADOPTED:

RESOLVED, THAT ACEP PARTNER WITH STAKEHOLDERS INCLUDING THE AMERICAN PSYCHIATRIC ASSOCIATION, THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, **THE** NATIONAL ALLIANCE OF MENTAL ILLNESS, AND OTHER INTERESTED PARTIES, TO DEVELOP MODEL PRACTICES FOCUSED ON BUILDING BED CAPACITY, ENHANCING ALTERNATIVES, AND REDUCING THE LENGTH OF STAY FOR MENTAL HEALTH PATIENTS IN EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP AND SHARE THESE ED MENTAL HEALTH BEST PRACTICES DESIGNED TO REDUCE ED MENTAL HEALTH VISITS, REDUCE ED MENTAL HEALTH BOARDING, AND IMPROVE THE OVERALL CARE OF PATIENTS WHO BOARD IN OUR EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH ~~THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY AND THE NATIONAL ACADEMY OF MEDICINE~~ **APPROPRIATE STAKEHOLDERS** TO DEVELOP COMMUNITY AND HOSPITAL BASED BENCHMARK PERFORMANCE METRICS FOR ED MENTAL HEALTH FLOW AND ~~LINKING~~ INPATIENT

PSYCHIATRIC FACILITIES ACCEPTANCE OF PATIENTS ~~TO LICENSURE~~.

It was moved THAT THE THIRD RESOLVED BE AMENDED TO READ:

RESOLVED, THAT ACEP WORK WITH **THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY AND OTHER APPROPRIATE STAKEHOLDERS** TO DEVELOP COMMUNITY AND HOSPITAL BASED BENCHMARK PERFORMANCE METRICS FOR ED MENTAL HEALTH FLOW AND ~~LINKING INPATIENT~~ PSYCHIATRIC FACILITIES ACCEPTANCE OF PATIENTS ~~TO LICENSURE~~. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 35 be adopted.

It was moved THAT AMENDED RESOLUTION 29 BE ADOPTED:

RESOLVED, THAT ACEP ADVOCATES AND SUPPORTS THE TRAINING AND EQUIPPING OF ALL FIRST RESPONDERS, INCLUDING POLICE, FIRE, AND EMS PERSONNEL TO USE INJECTABLE AND NASAL SPRAY NALOXONE; AND BE IT FURTHER

RESOLVED, THAT ACEP ADVOCATES AND SUPPORTS THAT APPROPRIATELY TRAINED PHARMACISTS BE ABLE TO DISPENSE NALOXONE WITHOUT PRESCRIPTION; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP A COMPREHENSIVE POLICY ON THE PREVENTION AND TREATMENT OF THE OPIOID USE DISORDER EPIDEMIC INCLUDING ~~SUCH~~ INNOVATIVE TREATMENTS. ~~AS ALLOWING SCHOOL NURSES AND OTHER TRAINED SCHOOL PERSONNEL TO ADMINISTER NALOXONE, "SAFE INJECTION SITES," AND NEEDLE EXCHANGE PROGRAMS.~~ The motion was adopted.

The committee recommended that Resolution 30 not be adopted.

It was moved THAT THE RESOLUTION BE AMENDED TO READ:

RESOLVED, THAT ACEP INVESTIGATE THE SCOPE OF TREATMENT OF ~~MARIJUANA INTOXICATION~~ **POSSIBLE COMPLICATIONS OF CANNABINOID USE**IN THE ED THAT ~~HAS~~ **HAVE** LEGAL IMPLICATIONS; AND BE IT FURTHER

~~RESOLVED, THAT ACEP DETERMINES IF THERE ARE STATE OR FEDERAL LAWS THAT PROVIDE GUIDANCE TO EMERGENCY PHYSICIANS IN THE TREATMENT OF MARIJUANA INTOXICATION IN THE ED; AND BE IT FURTHER~~

RESOLVED, THAT THE BOARD OF DIRECTORS ASSIGN AN APPROPRIATE COMMITTEE OR TASK FORCE TO ANSWER CLINICALLY RELEVANT QUESTIONS THAT ADDRESS THE NEED TO CARE FOR ED PATIENTS WITH POSSIBLE ~~MARIJUANA (OR OTHER DRUG) INTOXICATION~~ **COMPLICATIONS OF CANNABINOID USE**; AND BE IT FURTHER

RESOLVED, THAT ACEP INVESTIGATE HOW OTHER MEDICAL SPECIALTIES ADDRESS THE TREATMENT OF ~~MARIJUANA INTOXICATION~~ **COMPLICATIONS OF CANNABINOID USE** IN OTHER CLINICAL SETTINGS; AND BE IT FURTHER

RESOLVED, THAT ACEP PROVIDE THE RESOURCES NECESSARY TO COORDINATE THE TREATMENT OF ~~MARIJUANA INTOXICATION~~ **COMPLICATIONS OF CANNABINOID USE** IN THE ED.

It was moved THAT THE RESOLUTION 30 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 31 be adopted.

It was moved THAT AMENDED RESOLUTION 31 BE ADOPTED:

RESOLVED, THAT ACEP ACTIVELY OPPOSE THE FDA APPROVAL OF SUBLINGUAL FORMULATIONS OF SYNTHETIC FENTANYL ANALOGS, INCLUDING SUFENTANIL, VIA DIRECT TESTIMONY OR OTHER MEANS THAT THE BOARD MAY FIND SUITABLE.~~; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP CREATE A REPORT DETAILING THE RISKS, BENEFITS, AND ALTERNATIVES TO THE USE OF NARCOTIC ANALGESICS THAT, BY THEIR SPECIFIC ROUTE OF ADMINISTRATION OR FORMULATION, CARRY A HIGHER RISK OF MISUSE OR ABUSE THAN OTHER SIMILARLY CLASSIFIED DRUGS, IN EMS AND EMERGENCY MEDICINE.~~ The motion was adopted.

The Council recessed at 11:30 am for the awards luncheon and reconvened at 1:00 pm on Saturday, October 15, 2016.

REFERENCE COMMITTEE B

Dr. Schlicher presented the report of Reference Committee B. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 9, Resolution 11, Amended Resolution 12, Amended Resolution 13, Amended Resolution 14, Amended Resolution 15, Amended Resolution 16, Amended Resolution 17, Resolution 19 and Resolution 20.

For referral: Resolution 10.

Amended Resolution 12, Resolution 13, and Amended Resolution 17 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 14

RESOLVED, THAT THE ACEP PROMOTE THE DEVELOPMENT AND APPLICATION OF THROUGHPUT QUALITY DATA MEASURES AND DASHBOARD REPORTING FOR BEHAVIORAL HEALTH PATIENTS ~~BOARDED~~ IN EDS; AND BE IT FURTHER

RESOLVED, THAT ACEP ENDORSE INTEGRATION OF A DASHBOARD FOR REPORTING AND TRACKING OF BEHAVIORAL HEALTH PATIENTS BOARDING IN EDS IN ELECTRONIC HEALTH RECORD SYSTEMS AS A MEANS FOR LINKING TO BROADER PRIORITY SYSTEMS, FOR COMMUNICATING THE IMPACT OF BOARDED BEHAVIORAL HEALTH PATIENTS, AND TO FURTHER COLLABORATE WITH ALL APPROPRIATE HEALTH CARE AND GOVERNMENT STAKEHOLDERS.

AMENDED RESOLUTION 15

RESOLVED, THAT ACEP SHALL CREATE A STUDY OF THE IMPACT OF NARROW NETWORKS LAWS AND POTENTIAL SOLUTIONS THAT ADDRESS BALANCE BILLING ISSUES WITHOUT INCREASING THE BURDEN ON THE PATIENT; AND BE IT FURTHER

RESOLVED, THAT ACEP DEDICATE RESOURCES AND SUPPORT TO ENSURE ANY PROPOSED LEGISLATION REGARDING NARROW NETWORKS ~~DOES NOT AFFECT~~ **PROTECTS** ~~A PHYSICIAN'S ABILITY TO RECEIVE~~ **FAIR PAYMENT** FOR ~~PROVIDING~~ **EMERGENCY** MEDICAL CARE.

AMENDED RESOLUTION 16

RESOLVED, THAT ACEP DEVELOP A REPORT OR INFORMATION PAPER ~~SUPPORTING~~ **ANALYZING** THE USE OF FREESTANDING EMERGENCY CENTERS AS AN ALTERNATIVE CARE MODEL ~~FOR THE REPLACEMENT OF~~ **TO MAINTAIN ACCESS TO EMERGENCY CARE IN AREAS WHERE** EMERGENCY DEPARTMENTS IN CRITICAL ACCESS AND RURAL HOSPITALS THAT HAVE CLOSED, OR ARE IN ~~IMMINENT RISK OF CLOSURE, TO MAINTAIN ACCESS TO EMERGENCY CARE IN THE UNDERSERVED AND RURAL REGIONS OF THE UNITED STATES~~ **THE PROCESS OF CLOSING**.

The committee recommended that Amended Resolution 13 be adopted.

It was moved THAT AMENDED RESOLUTION 12 BE ADOPTED:

RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, ~~IN ORDER TO PROMOTE HIGH QUALITY, SAFE, AND EFFICIENT EMERGENCY MEDICAL CARE, CLINICAL AND NON-CLINICAL,~~ REACH OUT AND BUILD COALITIONS WITH NON-MEDICAL ORGANIZATIONS INVOLVED IN DEVELOPING **NON-CLINICAL** QUALITY STANDARDS ~~TO ACHIEVE OBJECTIVE AND MEANINGFUL ADVANCES IN QUALITY IN THE EYES OF OUR PATIENTS, INSTITUTIONS, AND PAYERS; AND BE IT FURTHER~~ **THAT INCLUDE AN EVALUATION OF THE COST OF PROVIDING THE HIGHEST LEVEL QUALITY OF CARE.**

~~RESOLVED, THAT THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, IN CONJUNCTION WITH NON-MEDICAL ORGANIZATIONS INVOLVED IN DEVELOPING QUALITY STANDARDS, DEFINE THE COSTS OF PROVIDING THE HIGHEST LEVELS OF QUALITY CARE, TO QUALITY/SAFETY REFLECTS REIMBURSEMENT AND REIMBURSEMENT REFLECTS QUALITY/SAFETY.~~

It was moved THAT RESOLUTION 12 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 13 be adopted.

It was moved THAT AMENDED RESOLUTION 13 BE ADOPTED.

RESOLVED, THAT ACEP REQUEST THAT THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) UNDER SECTION 319 OF THE PUBLIC HEALTH SERVICE (PHS) ACT DETERMINES THAT EMERGENCY DEPARTMENT BOARDING AND HALLWAY CARE IS AN IMMEDIATE THREAT TO THE PUBLIC HEALTH AND PUBLIC SAFETY; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE UNITED STATES PUBLIC HEALTH SERVICE, THE JOINT COMMISSION, AND OTHER APPROPRIATE STAKEHOLDERS TO DETERMINE THE NEXT ACTION STEPS TO BE TAKEN TO REDUCE EMERGENCY DEPARTMENT CROWDING AND BOARDING WITH A REPORT BACK TO THE ACEP COUNCIL AT THE COUNCIL'S NEXT SCHEDULED MEETING; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~REAFFIRMS ITS SUPPORT OF~~ **PUBLICLY PROMOTE THE FOLLOWING AS SUSTAINABLE SOLUTIONS TO HOSPITAL CROWDING WHICH HAVE THE HIGHEST IMPACT ON PATIENT SAFETY, HOSPITAL CAPACITY, ICU AVAILABILITY, AND COSTS**:

1. SMOOTHING OF ELECTIVE ADMISSIONS AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY.
2. EARLY DISCHARGE (BEFORE 11 AM) AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY.
3. ENHANCED WEEKEND DISCHARGES AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY.
4. THE REQUIREMENT FOR A GENUINE INSTITUTIONAL SOLUTION TO BOARDING WHEN THERE IS NO HOSPITAL CAPACITY, WHICH MUST INCLUDE BOTH PROVIDING ADDITIONAL STAFF AS NEEDED AND REDISTRIBUTING THE MAJORITY OF ED BOARDERS TO OTHER AREAS OF THE HOSPITAL.
5. THE CONCEPT OF A TRUE 24/7 HOSPITAL.

Without objection, the title of the resolution was amended to read: "Emergency Department Boarding and Crowding is a Public Health Emergency."

Without objection, item 2. was amended to read: "EARLY DISCHARGE **STRATEGIES** (~~BEFORE~~ **E.G.,** 11 AM **DISCHARGES, SCHEDULED DISCHARGES, STAGGERED DISCHARGES**) AS A MECHANISM FOR SUSTAINED IMPROVEMENT IN HOSPITAL CAPACITY."

The amended main motion was then voted on and was adopted.

The committee recommended that Amended Resolution 17 be adopted.

It was moved THAT AMENDED RESOLUTION 17 BE ADOPTED:

RESOLVED, 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 ~~THE FULL NEGOTIATED RATE~~; AND BE IT FURTHER

RESOLVED, 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 ~~THE FULL NEGOTIATED RATE~~ **EMTALA RELATED CARE**.

It was moved THAT AMENDED RESOLUTION 17 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 18 be adopted.

It was moved THAT AMENDED RESOLUTION 18 BE ADOPTED.

RESOLVED, THAT ACEP ~~OPPOSE THE OVERSTEP OF~~ **WORK WITH** CMS **REGARDING** MANDATED REPORTING STANDARDS THAT ~~REQUIRE~~ **MAY RESULT IN** ~~POTENTIAL~~ HARM TO PATIENTS WITHOUT THE RECOGNITION OF ~~APPROPRIATE PHYSICIAN ASSESSMENT~~ ~~AND~~ EVIDENCE BASED~~, GOAL DIRECTED~~ CARE OF INDIVIDUAL PATIENTS; AND BE IT FURTHER

RESOLVED, THAT ACEP ACTIVELY COMMUNICATE TO MEMBERS AND ~~THE PUBLIC~~ **HOSPITALS** THE DANGERS ~~OF CMS OVERSTEP OF PHYSICIAN RESPONSIBILITY TO PATIENTS FOR~~ **THAT** QUALITY INDICATORS **COULD PRESENT HARM TO POTENTIAL PATIENTS,** AND ~~ACTIVELY WORK TO COMMUNICATE TO HOSPITALS THE NEED AND OPTIONS TO RECOGNIZE APPROPRIATE PHYSICIAN TREATMENT WHILE AVOIDING UNNECESSARY HARM TO PATIENTS.~~ **THE IMPORTANCE OF PHYSICIAN AUTONOMY IN TREATMENT**. The motion was adopted.

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Dr. Parker, president-elect, addressed the Council.

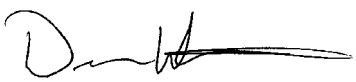
Dr. Costello reported that 392 of the 394 councillors eligible for seating had been credentialed.

The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Klauer and Dr. Schmitz were elected to a three-year term. Dr. Augustine and Dr. Perina were re-elected to a three-year term.

The Tellers, Credentials, & Elections Committee conducted the president-elect election. Dr. Kivela was elected.

There being no further business, Dr. Cusick adjourned the 2016 Council meeting at 3:00 pm on Saturday, October 15, 2016. The next meeting of the ACEP Council is scheduled for October 27-28, 2017, at the Marriott Marquis Hotel in Washington, DC.

Respectfully submitted,



Dean Wilkerson, JD, MBA, CAE
Council Secretary

Approved by,

James M. Cusick, MD FACEP
Council Speaker

Council Meeting
October 27-28, 2017
Marriott Marquis Hotel
Washington, DC

Minutes

The 46th annual meeting of the Council of the American College of Emergency Physicians was called to order at 8:00 am, Friday, October 27, 2017, by Speaker James M. Cusick, MD, FACEP.

Seated at the head table were: James M. Cusick, MD, FACEP, speaker; John G. McManus, Jr., MD, MBA, FACEP, vice speaker; Dean Wilkerson, JD, MBA, CAE, Council secretary and executive director; and Jim Slaughter, JD, parliamentarian.

Dr. Cusick provided a meeting dedication and then led the Council in reciting the Pledge of Allegiance.

The Arlington County Combined Public Safety Honor Guard presented colors and Officer Jennifer Levy with the Arlington County Policy Department sang the National Anthem.

Guenevere Burke, MD, FACEP, president of the District of Columbia Chapter, welcomed councillors and other meeting attendees.

Melissa Costello, MD, FACEP, chair of the Tellers, Credentials, & Elections Committee, reported that 322 councillors of the 410 eligible for seating had been credentialed. A roll call was not conducted because limited access to the Council floor was monitored by the committee.

Mr. Eric Joy provided an overview of the Council meeting Web site and other technology enhancements.

David Wilcox, MD, FACEP, addressed the Council regarding the Emergency Medicine Foundation (EMF) Challenge.

Peter Jacoby, MD, FACEP, addressed the Council regarding the National Emergency Medicine Political Action Committee (NEMPAC) Challenge.

The following members were credentialed by the Tellers, Credentials, & Elections Committee for seating at the 2017 Council meeting:

ALABAMA CHAPTER	Lisa M Bundy, MD, FACEP Melissa Wysong Costello, MD, FACEP Muhammad N Husainy, DO, FACEP
ALASKA CHAPTER	Anne Zink, MD, FACEP
ARIZONA CHAPTER	Patricia A Bayless, MD, FACEP Bradley A Dreifuss, MD, FACEP Paul Andrew Kozak, MD, FACEP Michael E Sheehy, DO, FACEP Todd Brian Taylor, MD, FACEP Nicholas F Vasquez, MD, FACEP Dale P Woolridge, MD, PhD, FACEP
ARKANSAS CHAPTER	J Shane Hardin, MD, PhD Charles Scott, MD, FACEP

AACEM	Gabor David Kelen, MD, FACEP
CALIFORNIA CHAPTER	John O Anis, MD, FACEP John D Bibb, MD, FACEP Rodney W Borger, MD, FACEP John Dirk Coburn, MD Fred Dennis, MD, MBA, FACEP Adam P Dougherty, MD Carrieann E Drenten, MD, FACEP Irv E Edwards, MD, FACEP Marc Allan Futernick, MD, FACEP Douglas Everett Gibson, MD, FACEP Vikant Gulati, MD, FACEP Ramon W Johnson, MD, FACEP Kevin M Jones, DO, FACEP John Thomas Ludlow, MD, FACEP William K Mallon, MD, FACEP Aimee K Moulin, MD, FACEP Leslie Mukau, MD, FACEP Karen Murrell, MD, MBA, FACEP Luke J Palmisano, MD, MBA, FACEP Chi Lee Perlroth, MD, FACEP Maria Raven, MD, MPH, FACEP Vivian Reyes, MD, FACEP Nicolas Sawyer, MD Peter Erik Sokolove, MD, FACEP Lawrence M Stock, MD, FACEP Thomas Jerome Sugarman, MD, FACEP Gary William Tamkin, MD, FACEP Andrea M Wagner, MD, FACEP Lori D Winston, MD, FACEP
COLORADO CHAPTER	Andrew J French, MD, FACEP Nathaniel T Hibbs, DO, FACEP Douglas M Hill, DO, FACEP Christopher David Johnston, MD Carla Elizabeth Murphy, DO, FACEP Mark Notash, MD, FACEP Eric B Olsen, MD, FACEP Donald E Stader, MD, FACEP
CONNECTICUT CHAPTER	Ije E Akunyili, MD, MPA, FACEP Thomas A Brunell, MD, FACEP Daniel Freess, MD, FACEP Elizabeth Schiller, MD, FACEP Gregory L Shangold, MD, FACEP David E Wilcox, MD, FACEP
CORD	Saadia Akhtar, MD, FACEP
DELAWARE CHAPTER	Kathryn Groner, MD, FACEP John T Powell, MD, MHCDS, FACEP
DISTRICT OF COLUMBIA CHAPTER	Natalie L Kirilichin, MD Aisha T Liferidge, MD, MPH, FACEP Jordan M Warchol, MD

EMRA	Nida F Degesys, MD Ramnik S Dhaliwal, MD, JD Tiffany Jackson, MD Zachary Joseph Jarou, MD Alicia Mikolaycik Kurtz, MD Eric McDonald, MD Scott H Pasichow, MD, MPH Rachel Solnick, MD
FLORIDA CHAPTER	Andrew I Bern, MD, FACEP Jordan GR Celeste, MD, FACEP Amy Ruben Conley, MD, FACEP Jay L Falk, MD, FACEP Kelly Gray-Eurom, MD, MMM, FACEP Larry Allen Hobbs, MD, FACEP Steven B Kailes, MD, FACEP Michael Lozano, MD, FACEP Kristin McCabe-Kline, MD, FACEP Ashley Booth Norse, MD, FACEP Ernest Page, II, MD, FACEP Sanjay Pattani, MD, FACEP Danyelle Redden, MD, MPH, FACEP Todd L Slesinger, MD, FACEP Kristine Staff, MD, FACEP Joel B Stern, MD, FACEP Joseph Adrian Tyndall, MD, FACEP L Kendall Webb, MD, FACEP
GEORGIA CHAPTER	Matthew R Astin, MD, FACEP James Joseph Dugal, MD, FACEP(E) Matthew Taylor Keadey, MD, FACEP Jeffrey F Linzer, Sr, MD, FACEP Matthew Lyon, MD, FACEP Matthew Rudy, MD, FACEP Stephen A Shiver, MD, FACEP James L Smith, Jr, MD, FACEP Johnny L Sy, DO, FACEP
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IDAHO CHAPTER	Nathan R Andrew, MD, FACEP Ken John Gramyk, MD, FACEP

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INDIANA CHAPTER	Michael D Bishop, MD, FACEP(E) Sara Ann Brown, MD, FACEP Timothy A Burrell, MD, MBA, FACEP John T Finnell, II, MD, FACEP Gina Teresa Huhnke, MD, FACEP James L Shoemaker, Jr, MD, FACEP
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KANSAS CHAPTER	Dennis Michael Allin, MD, FACEP John F McMaster, MD, FACEP Jeffrey G Norvell, MD MBA, FACEP
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LOUISIANA CHAPTER	James B Aiken, MD, MHA, FACEP Jon Michael Cuba, MD, FACEP Phillip Luke LeBas, MD, FACEP Mark Rice, MD, FACEP Michael D Smith, MD, MBA, CPE, FACEP
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	Ira R Nemeth, MD, FACEP
	Mark D Pearlmutter, MD, FACEP
	Kathryn W Weibrecht, MD, FACEP
	Scott G Weiner, MD, FACEP
MICHIGAN CHAPTER	Michael J Baker, MD, FACEP
	Kathleen Cowling, DO, FACEP
	Nicholas Dyc, MD, FACEP
	Gregory Gafni-Pappas, DO, FACEP
	Rami R Khoury, MD, FACEP
	Robert T Malinowski, MD, FACEP
	Jacob Manteuffel, MD, FACEP
	Emily M Mills, MD, FACEP
	James C Mitchiner, MD, MPH, FACEP
	Kevin Monfette, MD, FACEP
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	Laura R Millemon, MD, FACEP
NEVADA CHAPTER	John Dietrich Anderson, MD, FACEP
	Gregory Alan Juhl, MD, FACEP
	John McCourt, MD, FACEP
NEW HAMPSHIRE CHAPTER	Reed Brozen, MD, FACEP
	Sarah Garlan Johansen, MD, FACEP

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	Todd Fijewski, MD, FACEP
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	Maria Koenig Guyette, MD, FACEP
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	F Richard Heath, MD, FACEP
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	Dhimitri Nikolla, DO
	Shawn M Quinn, DO, FACEP
	Edward A Ramoska, MD, MPH, FACEP
	Anna Schwartz, MD, FACEP
	Robert J Strony, DO, FACEP
	Arvind Venkat, MD, FACEP
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	Jesus M Perez, MD
RHODE ISLAND CHAPTER	Nadine T Himelfarb, MD, FACEP
	Achyut B Kamat, MD, FACEP
	Jessica Smith, MD, FACEP
SAEM	Kathleen J Clem, MD, FACEP
SOUTH CAROLINA CHAPTER	Thomas H Coleman, MD, FACEP
	Stephen A D Grant, MD, FACEP
	Allison Leigh Harvey, MD, FACEP
	L Wade Manaker, MD, FACEP
	Frank C Smeeks, MD, FACEP
SOUTH DAKOTA CHAPTER	Scott Gregory VanKeulen, MD, FACEP

TENNESSEE CHAPTER	Sanford H Herman, MD, FACEP Thomas R Mitchell, MD, FACEP Karolyn K Moody, DO, MPH, FACEP Matthew Neal, MD John H Proctor, MD, MBA, FACEP
TEXAS CHAPTER	Sara Andrabi, MD Carrie de Moor, MD, FACEP Justin W Fairless, DO, FACEP Angela Siler Fisher, MD, FACEP Diana L Fite, MD, FACEP Juan Francisco Fitz, MD, FACEP Andrea L Green, MD, FACEP Robert D Greenberg, MD, FACEP Alison J Haddock, MD, FACEP Robert Hancock, Jr, DO, FACEP Justin P Hensley, MD, FACEP Doug Jeffrey, MD, FACEP Heidi C Knowles, MD, FACEP Thomas J McLaughlin, DO, FACEP Laura N Medford-Davis, MD Craig Meek, MD, FACEP Daniel Eugene Peckenpaugh, MD, FACEP R Lynn Rea, MD, FACEP Gerad A Troutman, MD, FACEP Hemant H Vankawala, MD, FACEP James M Williams, DO, FACEP Sandra Williams, DO, FACEP
UTAH CHAPTER	Jim V Antinori, MD, FACEP Bennion D Buchanan, MD, FACEP John R Dayton, MD, FACEP Stephen Carl Hartsell, MD, FACEP
VERMONT CHAPTER	Nicholas A Aunchman, MD, FACEP
VIRGINIA CHAPTER	Trisha Danielle Anest, MD Kenneth Hickey, MD, FACEP Aida A Kalley, MD, FACEP David Matthew Kruse, MD, FACEP Robert E O'Connor, MD, MPH, FACEP Cameron K Olderog, MD, FACEP Mark Robert Sochor, MD, FACEP Sara F Sutherland, MD, MBA, FACEP Stephen J Wolf, MD, FACEP
WASHINGTON CHAPTER	Cameron Ross Buck, MD, FACEP Carlton E Heine, MD, PhD, FACEP Catharine R Keay, MD, FACEP John Matheson, MD, FACEP Nathaniel R Schlicher, MD, JD, FACEP Patrick Solari, MD, FACEP Jennifer L Stankus, MD, JD, FACEP Liam Yore, MD, FACEP
WEST VIRGINIA CHAPTER	Frederick C Blum, MD, FACEP Adam Thomas Crawford, DO Christopher S Goode, MD, FACEP

WISCONSIN CHAPTER	Howard Jeffery Croft, MD, FACEP William D Falco, MD, MS, FACEP William C Haselow, MD, FACEP Lisa J Maurer, MD, FACEP Jeffrey J Pothof, MD, FACEP Robert Sands Redwood, MD, FACEP
WYOMING CHAPTER	Jessica Kisicki, MD, FACEP

Sections of Membership

AIR MEDICAL TRANSPORT	Henderson D McGinnis, MD, FACEP
AMER ASSOC OF WOMEN EMER PHYSICIANS	E Lea Walters, MD, FACEP
CAREERS IN EMERGENCY MEDICINE	Sullivan K Smith, MD, FACEP
CRITICAL CARE MEDICINE	Ayan Sen, MD, FACEP
CRUISE SHIP MEDICINE	Sydney W Schneidman, MD, FACEP
DEMOCRATIC GROUP PRACTICE	David F Tulsiak, MD, FACEP
DISASTER MEDICINE	Roy L Alson, MD, PhD, FACEP
DUAL TRAINING	Carissa J Tyo, MD, FACEP
EMERGENCY MEDICAL INFORMATICS	R Carter Clements, MD, FACEP
EMS-PREHOSPITAL CARE	Gina Piazza, DO, FACEP
EMER MED PRAC MGMT & HEALTH POLICY	Heather Ann Heaton, MD, FACEP
EMERGENCY MEDICINE RESEARCH	Aaron Brody, MD
EMERGENCY MEDICINE WORKFORCE	Guy Nuki, MD
EMERGENCY ULTRASOUND	Robert M Bramante, MD, FACEP
EVENT MEDICINE	John Carlton Maino, II, MD, FACEP
FORENSIC MEDICINE	Lawrence J R Goldhahn, MD, FACEP
FREESTANDING EMEGENCY CENTERS	David C Ernst, MD, FACEP
GERIATRIC EMERGENCY MEDICINE	Teresita M Hogan, MD, FACEP
INTERNATIONAL EMERGENCY MEDICINE	Elizabeth L DeVos, MD, FACEP
MEDICAL HUMANITIES	Seth Collings Hawkins, MD, FACEP
OBSERVATION SERVICES	Sharon E Mace, MD, FACEP
PAIN MANAGEMENT	Alexis M LaPietra, DO, FACEP
PALLIATIVE MEDICINE	Sangeeta Lamba, MD, FACEP
PEDIATRIC EMERGENCY MEDICINE	Wendy Ann Lucid, MD, FACEP

QUALITY IMPROVEMENT & PATIENT SAFETY	Brian Sharp, MD, FACEP
RURAL EMERGENCY MEDICINE	William Ken Milne, MD
SPORTS MEDICINE	Jolie C Holschen, MD, FACEP
TACTICAL EMERGENCY MEDICINE	James Phillips, MD
TELEMEDICINE	Hartmut Gross, MD, FACEP
TOXICOLOGY	Jennifer Hannum, MD, FACEP
TRAUMA & INJURY PREVENTION	Gregory Luke Larkin, MD, MPH, FACEP
UNDERSEA & HYPERBARIC MEDICINE	Richard Walker, III, MD, FACEP
WELLNESS	Laura H McPeake, MD, FACEP
WILDERNESS MEDICINE	Susanne J Spano, MD, FACEP
YOUNG PHYSICIANS	Chadd K Kraus, DO, DrPH, MPH, FACEP

In addition to the credentialed councillors, the following past leaders attended all or part of the Council meeting and were not serving as councillors:

Past Presidents

Nancy J. Auer, MD, FACEP (WA)	Brian F. Keaton, MD, FACEP (OH)
Larry A. Bedard, MD, FACEP (CA)	Linda L. Lawrence, MD, FACEP (GS)
Brooks F. Bock, MD, FACEP (CO)	Alex M. Rosenau, DO, FACEP (PA)
Michael L. Carius, MD, FACEP (CT)	Robert W. Schafermeyer MD, FACEP (NC)
Angela F. Gardner, MD, FACEP (TX)	Andrew Sama, MD, FACEP
Michael J. Gerardi, MD, FACEP (NJ)	Sandra M. Schneider, MD, FACEP (TX)
Gregory L. Henry, MD, FACEP (MI)	David C. Seaberg, MD, CPE, FACEP (TN)
J. Brian Hancock, MD, FACEP (MI)	Richard L. Stennes, MD, MBA, FACEP (CA)
Nicholas J. Jouriles, MD, FACEP (OH)	Robert E. Suter, DO, MPH, FACEP (TX)

Past Speakers

Michael J. Bresler, MD, FACEP (CA)	Kevin M. Klauer, DO, FACEP (OH)
Marco Coppola, DO, FACEP (GS)	Todd B. Taylor, MD, FACEP (TN)
Mark L. DeBard, MD, FACEP (OH)	Arlo F. Weltge, MD, MPH, FACEP (TX)
Peter J. Jacoby, MD, FACEP (CT)	Dennis C. Whitehead, MD, FACEP (MI)

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The Council Standing Rules were distributed to the councillors prior to the meeting and were not read aloud. The rules are listed as distributed.

Council Standing Rules

Preamble

These Council Standing Rules serve as an operational guide and description for how the Council conducts its business at the annual meeting and throughout the year in accordance with the College Bylaws, the College Manual, and standing tradition.

Alternate Councillors

A properly credentialed alternate councillor may substitute for a designated councillor not seated on the Council meeting floor. Substitutions between designated councillors and alternates may only take place once debate and voting on the current motion under consideration has been completed.

If the number of alternate councillors is insufficient to fill all councillor positions for a particular chapter, section, or EMRA, then a member of that sponsoring body may be seated as a councillor pro-tem by either the concurrence of an officer of the sponsoring body or upon written request to the Council secretary with a majority vote of the Council. Disputes regarding the assignment of councillor pro-tem positions will be decided by the speaker.

Amendments to Council Standing Rules

These rules shall be amended by a majority vote using the formal Council resolution process outlined herein and become effective immediately upon adoption. Suspension of these Council Standing Rules requires a two-thirds vote.

Announcements

Proposed announcements to the Council must be submitted by the author to the Council secretary, or to the speaker. The speaker will have sole discretion as to the propriety of announcements. Announcements of general interest to members of the Council, at the discretion of the speaker, may be made from the podium. Only announcements germane to the business of the Council or the College will be permitted.

Appeals of Decisions from the Chair

A two-thirds vote is required to override a ruling by the chair.

Board of Directors Seating

Members of the Board of Directors will be seated on the floor of the Council and are granted full floor privileges except the right to vote.

Campaign Rules

Rules governing campaigns for election of the president-elect, Board of Directors, and Council officers shall be developed by the Steering Committee and reviewed on an annual basis. Candidates, councillors, chapters, and sections, etc. are responsible for abiding by the campaign rules.

Cellular Phones, Pagers, and Computers

Cellular phones, pagers, and computers must be kept in "quiet" mode during the Council meeting. Talking on cellular phones is prohibited in Council meeting rooms. Use of computers for Council business during the meeting is encouraged, but not appropriate for other unrelated activities.

Councillor Allocation for Sections of Membership

To be eligible to seat a credentialed councillor, a section must have 100 dues-paying members, or the minimum number established by the Board of Directors, on December 31 preceding the annual meeting. Section councillors must be certified by the section by notifying the Council secretary at least 60 days before the annual meeting.

Councillor Seating

Councillor seating will be grouped by chapter and the location rotated year to year in an equitable manner.

Credentialing and Proper Identification

To facilitate identification and seating, councillors are required to wear a name badge with a ribbon indicating councillor or alternate status. Individuals without such identification will be denied admission to the Council floor. Voting status will be designated by possession of a councillor voting card issued at the time of credentialing by the Tellers, Credentials and Elections Committee. College members and guests must also wear proper identification for admission to the Council meeting room and reference committees.

The Tellers, Credentials and Elections Committee, at a minimum, will report the number of credentialed councillors at the beginning of each Council session. This number is used as the denominator in determining a two-thirds vote necessary to adopt a Bylaws amendment.

Debate

Councillors, members of the Board of Directors, past presidents, and past speakers wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, etc.), and whether they are speaking "for" or "against" the motion.

Debate should not exceed two minutes for each recognized individual unless special permission has been

granted. Participants should refrain from speaking again on the same issue until all others wishing to speak have had the opportunity to do so.

In accordance with parliamentary procedure, the individual speaking may only be interrupted for the following reasons: 1) point of personal privilege; 2) motion to reconsider; 3) appeal; 4) point of order; 5) parliamentary inquiry; 6) withdraw a motion; or 7) division of assembly. All other motions must wait their turn and be recognized by the chair.

Seated councillors or alternate councillors have full privileges of the floor. Upon written request and at the discretion of the chair, alternate councillors not currently seated, and other individuals may be recognized and address the Council. Such requests must be made in writing prior to debate on that issue and should include the individual's name, organization affiliation, issue to be addressed, and the rationale for speaking to the Council.

Distribution of Printed or Other Material During the Annual Meeting

The speaker will have sole discretion to authorize the distribution of printed or other material on the Council floor during the annual meeting. Such authorization must be obtained in advance.

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot. There shall be no write-in voting.
When voting electronically, the names of all candidates for a particular office will be projected at the same time. Thirty (30) seconds will be allowed for each ballot. Councillors may change votes only during the allotted time. The computer will accept the last vote or group of votes selected before voting is closed. When voting with paper ballots, the chair of the Tellers, Credentials, and Elections Committee will determine the best procedure for the election process.

Councillors must vote for the number of candidates equal to the number of available positions for each ballot. A councillor's individual ballot shall be considered invalid if there are greater or fewer votes on the ballot than is required. The total number of valid and invalid individual ballots will be used for purposes of determining the denominator for a majority of those voting.

The total valid votes for each candidate will be tallied and candidates who receive a majority of votes cast shall be elected. If more candidates receive a majority vote than the number of positions available, the candidates with the highest number of votes will be elected. When one or more vacancies still exist, elected candidates and their respective positions are removed and all non-elected candidates remain on the ballot for the subsequent vote. If no candidate is elected on any ballot, the candidate with the lowest number of valid votes is removed from subsequent ballots. In the event of a tire for the lowest number of valid votes on a ballot in which no candidate is elected, a run-off will be held to determine which candidate is removed from subsequent ballots. This procedure will be repeated until a candidate receives the required majority vote* for each open position.

*NOTE: If at any time, the total number of invalid individual ballots added to any candidate's total valid votes would change which candidate is elected or removed, then only those candidates not affected by this discrepancy will be elected. If open positions remain, a subsequent vote will be held to include all remaining candidates from that round of voting.

The chair of the Tellers, Credentials, and Elections Committee will make the final determination as to the validity of each ballot. Upon completion of the voting and verification of votes for all candidates, the Tellers, Credentials, and Elections Committee chair will report the results to the speaker.

Within 24 hours after the close of the annual Council meeting, the Chair of the Tellers, Credentials, and Elections Committee shall present to the Council Secretary a written report of the results of all elections. This report shall include the number of credentialed councillors, the slate of candidates, and the number of open positions for each round of voting, the number of valid and invalid ballots cast in each round of voting, the number needed to elect and the number of valid votes cast per candidate in each round of voting, and verification of the final results of the elections. This written report shall be considered a privileged and confidential document of the College. However, when there is a serious concern that the results of the election are not accurate, the Speaker has discretion to disclose the results to provide the Council an assurance that the elections are valid. Individual candidates may request and receive their own total number of votes and the vote totals of the other candidates without attribution.

Limiting Debate

A motion to limit debate on any item of business before the Council may be made by any councillor who has been granted the floor and who has not debated the issue just prior to making that motion. This motion requires a second, is not debatable, and must be adopted by a two-thirds vote. ***See also Debate and Voting Immediately.***

Nominating Committee

The Nominating Committee shall be charged with developing a slate of candidates for all offices elected by the Council. Among other factors, the committees shall consider activity and involvement in the College, the Council, and chapter or sections when considering the slate of candidates.

Nominations

A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, or past speaker, after which nominations will be closed and shall not be reopened.

A prospective floor candidate or an individual who intends to nominate a candidate from the floor may make this intent known in advance by notifying the Council secretary in writing. Upon receipt of this notification, the candidate becomes a "declared floor candidate" and has all the rights and responsibilities of committee nominated candidates. ***See also Election Procedures.***

Parliamentary Procedure

The current edition of *Sturgis, Standard Code of Parliamentary Procedure* will govern the Council, except where superseded by these Council Standing Rules, the College Manual, and/or the Bylaws. ***See also Personal Privilege and Voting Immediately.***

Past Presidents and Past Speakers Seating

Past presidents and past speakers of the College are invited to sit with their respective chapter delegations, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor.

Personal Privilege

Any councillor may call for a "point of personal privilege" at any time even if it interrupts the current person speaking. This procedure is intended for uses such as asking a question for clarification, asking the person speaking to talk louder, or to make a request for personal comfort. Use of "personal privilege" to interject debate is out of order.

Policy Review

The Council Steering Committee will report annually to the Council the results of a periodic review of non-Bylaws resolutions adopted by the Council and approved by the Board of Directors.

Reference Committees

Resolutions meeting the filing and transmittal requirements in these Standing Rules will be assigned by the speaker to a Reference Committee for deliberation and recommendation to the Council. Reference Committee meetings are open to all members of the College, its committees, and invited guests.

Reference Committees will hear as much testimony for its assigned resolutions as is necessary or practical and then adjourn to executive session to prepare recommendations for each resolution in a written Reference Committee Report.

A Reference Committee may recommend that a resolution:

A) **Be Adopted or Not Be Adopted:** In this case, the speaker shall state the resolution, which is then the subject for debate and action by the Council.

B) **Be Amended or Substituted:** In this case, the speaker shall state the resolution as amended or substituted, which is then the subject for debate and action by the Council.

C) **Be Referred:** In this case, the speaker shall state the motion to refer. Debate on a Reference Committee's motion to refer may go fully into the merits of the resolution. If the motion to refer is defeated, the speaker shall state the original resolution.

Other information regarding the conduct of Reference Committees is contained in the Councillor Handbook.

Reports

Committee and officer reports to be included in the Council minutes must be submitted in writing to the Council secretary. Authors of reports who petition or are requested to address the Council should note that the purpose of these presentations are to elaborate on the facts and findings of the written report and to allow for questions. Debate on relevant issues may occur subsequent to the report presentation.

Resolutions

"Resolutions" are considered formal motions that if adopted by a majority vote of the Council and ratified by

the Board of Directors become official College policy. Resolutions pertaining only to the Council Standing Rules do not require Board ratification and become effective immediately upon adoption. Resolutions pertaining to the College Bylaws (Bylaws resolutions) require adoption by a two-thirds vote of credentialed councillors and subsequently a two-thirds vote of the Board of Directors.

Resolutions must be submitted in writing by at least two members or by chapters, sections, committees, or the Board of Directors. A letter of endorsement from the sponsoring body is required if submitted by a chapter, section, or committee.

All motions for substantive amendments to resolutions must be submitted in writing through the electronic means provided to the Council during the annual meeting, with the exception of technical difficulties preventing such electronic submission, signed by the author, and presented to the Council prior to being considered. When appropriate, amendments will be distributed or projected for viewing.

Background information, including financial analysis, will be prepared by staff on all resolutions submitted on or before 90 days prior to the annual meeting.

• Regular Non-Bylaws Resolutions

Non-Bylaws resolutions submitted on or before 90 days prior to the annual meeting are known as "regular resolutions" and will be referred to an appropriate Reference Committee for consideration at the annual meeting.

Regular resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, extensive revisions during the 90 to 45 day window that appear to alter the original intent of a regular resolution or that would render the background information meaningless will be considered as "Late Resolutions."

• Bylaws Resolutions

Bylaws resolutions must be submitted on or before 90 days prior to the annual meeting and will be referred to an appropriate Reference Committee for consideration at the annual meeting. The Bylaws Committee, up to 45 days prior to the Council meeting, with the consent of the author(s), may make changes to Bylaws resolutions insofar as such changes would clarify the intent or circumvent conflicts with other portions of the Bylaws.

Bylaws resolutions may be modified or withdrawn by the author(s) up to 45 days prior to the annual meeting. After such time, revisions will follow the usual amendment process and may be withdrawn only with consent of the Council at the annual meeting. As determined by the speaker, revisions during the 90 to 45 day window that appear to alter the original intent of a Bylaws resolution, or are otherwise considered to be out of order under parliamentary authority, will not be permitted.

• Late Resolutions

Resolutions submitted after the 90-day submission deadline, but at least 24 hours prior to the beginning of the annual meeting are known as "late resolutions." These late resolutions are considered by the Steering Committee at its meeting on the evening prior to the opening of the annual meeting. The Steering Committee is empowered to decide whether a late submission is justified due to events that occurred after the filing deadline. An author of the late resolution shall be given an opportunity to inform the Steering Committee why the late submission was justified. If a majority of the Steering Committee votes to accept a late resolution, it will be presented to the Council at its opening session and assigned to a Reference Committee. If the Steering Committee votes unfavorably and rejects a late resolution, the reason for such action shall be reported to the Council at its opening session. The Council does not consider rejected late resolutions. The Steering Committee's decision to reject a late resolution may be appealed to the Council. When a rejected late resolution is appealed, the Speaker will state the reason(s) for the ruling on the late resolution and without debate, the ruling may be overridden by a two-thirds vote.

• Emergency Resolutions

Emergency resolutions are resolutions that do not qualify as "regular" or "late" resolutions. They are limited to substantive issues that because of their acute nature could not have been anticipated prior to the annual meeting or resolutions of commendation that become appropriate during the course of the Council meeting. Resolutions not meeting these criteria may be ruled out of order by the speaker. Should this ruling be appealed, the speaker will state the reason(s) for ruling the emergency resolution out of order and without debate, the ruling may only be overridden by a two-thirds vote. ***See also Appeals of Decisions from the Chair.***

Emergency resolutions must be submitted in writing, signed by at least two members, and presented to the Council secretary. The author of the resolution, when recognized by the chair, may give a one-minute summary of the emergency resolution to enable the Council to determine its merits. Without debate, a simple majority vote of the councillors present and voting is required to accept the emergency resolution for floor

debate and action. If an emergency resolution is introduced prior to the beginning of the Reference Committee hearings, it shall upon acceptance by the Council be referred to the appropriate Reference Committee. If an emergency resolution is introduced and accepted after the Reference Committee hearings, the resolution shall be debated on the floor of the Council at a time chosen by the speaker.

Smoking Policy

Smoking is not permitted in any College venue.

Unanimous Consent Agenda

A "Unanimous Consent Agenda" is a list of resolutions with a waiver of debate and may include items that meet one of the following criteria as determined by the Reference Committee:

1. Non-controversial in nature
2. Generated little or no debate during the Reference Committee
3. Clear consensus of opinion (either pro or con) was expressed at Reference Committee

Bylaws resolutions and resolutions that require substantive amendments shall not be placed on a Unanimous Consent Agenda.

A Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report along with the committee's recommendation for adoption, referral, or defeat for each resolution listed. A request for extraction of any resolution from a Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report.

Voting Immediately

A motion to "vote immediately" may be made by any councillor who has been granted the floor. This motion requires a second, is not debatable, and must be adopted by two-thirds of the councillors voting.
Councillors are out of order who move to "vote immediately" during or immediately following their presentation of testimony on that motion. The motion to "vote immediately" applies only to the immediately pending matter, therefore, motions to "vote immediately on all pending matters" is out of order.

The opportunity for testimony on both sides of the issue, for and against, must be presented before the motion to "vote immediately" will be considered in order. ***See also Debate and Limiting Debate.***

Voting on Resolutions and Motions

Voting may be accomplished by an electronic voting system, voting cards, standing or voice vote at the discretion of the speaker. Numerical results of electronic votes and standing votes on resolutions and motions will be presented before proceeding to the next issue.

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The councillors reviewed and accepted the minutes of the October 14-15, 2016, Council meeting and approved the actions of the Steering Committee taken at their January 18, 2017, and June 26, 2017, meetings.

Dr. Cusick called for submission of emergency resolutions. None were submitted.

Dr. Cusick reported that seven late resolutions were received and reviewed by the Steering Committee. Six memorial resolutions and one commendation resolution were accepted by the Steering Committee. Memorial and commendation resolutions are not assigned to a Reference Committee for testimony. The other late resolution was not accepted for submission to the Council. Dr. Cusick stated the reason the late resolution was rejected.

It was moved THAT THE STEERING COMMITTEE'S DECISION TO REJECT THE LATE RESOLUTION "FREESTANDING EMERGENCY CENTERS AS A CARE MODEL FO RMAINTAINING ACCESS TO EMERGENCY CARE IN UNDERSERVED, RURAL, AND FEDERALLY DECLARED DISASTER AREAS OF THE UNITED STATES BE APPEALED. The motion was adopted.

The resolution was numbered 62 and assigned to Reference Committee B.

Dr. Cusick presented the Nominating Committee report. Four members were nominated for President-Elect: Vidor E. Friedman, MD, FACEP; Hans R. House MD, MACM, FACEP; William P. Jaquis, MD, FACEP; and John J.

Rogers, MD, CPE, FACEP. Dr. Cusick called for floor nominations. There were no floor nominees. The nominations were then closed.

Dr. McManus was the only nominee for Speaker of the Council. Dr. Cusick called for floor nominations. There were no floor nominees. The nominations were then closed. With no objections, Dr. McManus was declared as the 2017-19 speaker of the Council. He then addressed the Council.

Seven members were nominated for four positions on the Board of Directors: Stephen H. Anderson, MD, FACEP; Kathleen J. Clem, MD, FACEP; John T. Finnell, MD, FACEP; Alison J. Haddock, MD, FACEP; Jon Mark Hirshon, MD, PhD, MPH, FACEP; Aisha T. Liferidge, MD, MPH, FACEP; and Virgil W. Smaltz, MD, FACEP. Dr. Cusick called for floor nominations. Carrie de Moor, MD, FACEP, Freestanding Emergency Centers, was nominated from the floor. The nominations were then closed.

Three members were nominated for Council Vice Speaker: Sabina Braithwaite, MD, FACEP; Andrea L. Green, MD, FACEP; and Gary R. Katz, MD, MBA, FACEP.

Dr. Cusick explained the Candidate Forum procedures. The candidates then made their opening statements to the Council.

Terry L. Kowalenko, MD, FACEP, reported on activities of the American Board of Emergency Medicine, their financial reporting, and changes to the Maintenance of Certification examination.

2017 Council Resolutions

The Council recessed at 9:25 am for the Reference Committee hearings. The resolutions considered by the 2017 Council appear below as submitted.

RESOLUTION 1

RESOLVED, That the American College of Emergency Physicians commends James M. Cusick, MD, FACEP, as a practicing emergency physician rendering excellent care to the patients we serve, for his leadership in the College as Council Vice Speaker and Council Speaker over the past four years, and for his lifetime of service and dedication to the specialty of Emergency Medicine.

RESOLUTION 2

RESOLVED, That the American College of Emergency Physicians commends Robert E. O'Connor, MD, MPH, 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.

RESOLUTION 3

RESOLVED, That the American College of Emergency Physicians commends Gordon B. Wheeler for his service as Associate Executive Director of Public Affairs.

RESOLUTION 4

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Charles R. Bauer, 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 Charles R. Bauer MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of Texas and the United States.

RESOLUTION 5

RESOLVED, That ACEP and the Michigan College of Emergency Physicians hereby acknowledges the many contributions made by Diane Kay Bollman as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That ACEP and the Michigan College of Emergency Physicians extend to the family of Diane Kay Bollman, her friends, and her colleagues, our condolences along with our profound gratitude for her tremendous service to the specialty of emergency medicine, Michigan emergency physicians, and patients, who will never fully know her impact, across the United States and likely beyond.

RESOLUTION 6

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Aaron T. Daggy, MD, FACEP, as one of the leaders in pre-hospital medicine, EMS and fire, and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Aaron T. Daggy, 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 New York and the United States.

RESOLUTION 7

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Geoffrey Edmund Renk, MD, PhD, 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, Lisa Flaggman, 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 South Carolina and the United States.

RESOLUTION 8

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the contributions made by Sal Silvestri, MD, as a leader in emergency medicine and EMS; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Sal Silvestri, MD, our deepest sympathy, our great sense of sadness and loss, and our gratitude for having been able to learn so much from a kind, gentle, caring leader in our emergency medicine world.

RESOLUTION 9

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Robert Wears, MD, FACEP, as one of the leaders in emergency medicine and a true pioneer of the specialty; and be it further

RESOLVED, That national ACEP and the Florida College of Emergency Physicians extends to his wife, Dianne Wears, his children and grandchildren, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine.

RESOLUTION 10

RESOLVED, That the ACEP Bylaws Article VI – Chapters, Section 2 – Chapter Bylaws, paragraph 1, be amended to read:

A petition for the chartering of a chapter shall be accompanied by the proposed bylaws of the chapter. No charter shall be issued until such bylaws are approved by the Board of Directors of the College. Chartered chapters must ensure that their bylaws conform to the College Bylaws and ~~to the "Guidelines for Bylaws and Model Chapter Bylaws for Chapters of the American College of Emergency Physicians."~~**current approved chapter bylaws guidance documents**. Proposed amendments to the bylaws of a chapter shall be submitted in a format and manner designated by the College not later than 30 days following the adoption of such proposed amendments by the chapter, pursuant to its bylaws and procedures. No proposed amendment shall have any force or effect until it has been approved by the Board of Directors of the College. A proposed amendment shall be considered approved if the Board of Directors or its designee fails to give written notice of any objection within 90 days of receipt as documented by the College.

RESOLUTION 11

RESOLVED, That the ACEP Bylaws, Article VIII – Council, Section 1 – Composition of the Council, paragraph one, be amended to read:

"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. **Chapters are strongly encouraged to appoint and mentor councillors and alternate councillors that represent the diversity of their membership, including candidate physician and young physician members.**"

RESOLUTION 12

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 5 – Voting Rights, paragraph two, be amended to read:

"ACEP Past Presidents**,** ~~and ACEP~~ Past Speakers, **and Past Chairs of the Board,** if not certified as councillors or alternate councillors by a sponsoring body, may participate in the Council in a non-voting capacity. Members of the Board of Directors may address the Council on any matter under discussion but shall not have voting privileges in Council sessions."

RESOLUITON 13

RESOLVED, That the "Debate" section, paragraph one, of the Council Standing Rules be amended to read:

"Councillors, members of the Board of Directors, past presidents, ~~and~~ past speakers**, and past chairs of the Board** wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, **past chair,** etc.), and whether they are speaking "for" or "against" the motion;" and be it further

RESOLVED, That the "Nominations" section, paragraph one, of the Council Standing Rules be amended to read:

"A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, ~~or~~ past speaker**, or past chair of the Board**, after which nominations will be closed and shall not be reopened;" and be it further

RESOLVED, That the "Past Presidents and Past Speakers Seating" section of the Council Standing Rules be amended to read:

"Past Presidents**,** ~~and~~ Past Speakers**, and Past Chairs of the Board** Seating

"Past presidents**,** ~~and~~ past speakers**, and past chairs of the Board** of the College are invited to sit with their respective component body, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor."

RESOLUTION 14

RESOLVED, That the "Unanimous Consent" section of the Council Standing Rules be amended to read:

Unanimous Consent Agenda

~~A "Unanimous Consent Agenda" is a list of resolutions with a waiver of debate and may include items that meet one of the following criteria as determined by the Reference Committee:~~

~~1. Non-controversial in nature~~

~~2. Generated little or no debate during the Reference Committee~~

~~3. Clear consensus of opinion (either pro or con) was expressed at Reference Committee~~

~~Bylaws resolutions and resolutions that require substantive amendments shall not be placed on a Unanimous Consent Agenda.~~

A Unanimous Consent Agenda will be listed at the beginning of the Reference Committee report **consisting of the committee's summarization of testimony provided** ~~along with the committee's~~ **and a** recommendation for adoption, **not adoption, or** referral~~, or defeat~~ for each resolution ~~listed~~ **referred to the committee**. **Bylaws resolutions shall not be placed on a Unanimous Consent Agenda.** A request for extraction of any resolution from a Unanimous Consent Agenda by any credentialed councillor is in order at the beginning of the Reference Committee report **and such resolution will be extracted upon a second by another credentialed councillor**. Thereafter, the remaining items on the Unanimous Consent Agenda will be approved unanimously en bloc without discussion. **Extracted resolutions shall then be discussed in the order presented on the Reference Committee report.** The Reference Committee reports will then proceed in the usual manner with any extracted resolution(s) debated at an appropriate time during that report..

RESOLUTION 15 *(This resolution was withdrawn.)*

RESOLVED, That ACEP request a detailed financial audit of the American Board of Emergency Medicine; and be it further

RESOLVED, That the full results of any and all American Board of Emergency Medicine financial audits are to be shared with the ACEP Board of Directors at least every other year; and be it further

RESOLVED, That ACEP encourage the American Board of Emergency Medicine to allow full, legal financial

statements to be available to their diplomates; and be it further

RESOLVED, That ACEP leadership initiate a meeting to discuss methods by which the American Board of Emergency Medicine will be transparent and responsive to its diplomates; and be it further

RESOLVED, That the ACEP Board of Directors develop procedures to ensure that anyone nominated by ACEP to serve on the American Board of Emergency Medicine Board of Directors shall advocate for financial transparency and financial disclosure to its diplomates.

RESOLUTION 16 *(This resolution was withdrawn.)*

RESOLVED, That ACEP encourage the American Board of Emergency Medicine to allow its diplomates to elect directly at least one-third of its Board of Directors; and be it further

RESOLVED, That ACEP encourage the American Board of Emergency Medicine (ABEM) to change its rules to allow the ABEM president to be elected by a vote of the diplomates from among the ABEM Board of Directors; and be it further

RESOLVED, That ACEP initiate a nomination process, including developing criteria to be acknowledged and agreed upon by a member before being nominated, that ensures that those nominated by ACEP to serve on the American Board of Emergency Medicine (ABEM) Board of Directors are in agreement with the need for a more democratic and responsive ABEM; and be it further.

RESOLVED, That ACEP charge the American Board of Emergency Medicine (ABEM) directors nominated by the College to create a sponsoring organization-driven director recall procedure within the ABEM Bylaws

RESOLUTION 17 *(This resolution was withdrawn.)*

RESOLVED, That status in any other organization, to include certification boards, should not be criteria for ACEP membership or fellowship; and be it further

RESOLVED, That no other organization should be referenced by name in the College Bylaws or rules delineating ACEP membership or fellowship status; and be it further

RESOLVED, That ACEP review and revise all categories of membership and fellowship criteria to prohibit the actions of any other organization from unilaterally impacting membership eligibility for the College.

RESOLUTION 18

RESOLVED, That ACEP explore alternative funding opportunities (e.g., use of personal insurance reimbursement and/or sponsorship by third parties) to restore the traditional (and possibly expanded) services available at the Annual Conference Wellness Center; and be it further

RESOLVED, That ACEP explore ways to better promote available resources for the wellness center at the Annual Conference and in general throughout the year.

RESOLUTION 19

RESOLVED, That ACEP work with the Council of Emergency Medicine Residency Directors, the Society for Academic Emergency Medicine, the American College of Osteopathic Emergency Physicians, the American Osteopathic Association, the Emergency Medicine Residents' Association, and the Residency Review Committee for Emergency Medicine to develop a consensus derived, uniform, consistent approach towards scholarly activity for residents to foster the future of Emergency Medicine research.

RESOLUTION 20

RESOLVED, That the Council Steering Committee create expenditure limitations in the Candidate Campaign Rules to allow younger members to consider candidacy for leadership positions without the concern for financial means; and be it further

RESOLVED, That the Candidate Campaign Rules be amended by adding: "Candidates will not attend annual chapter meetings unless officially invited, on the meeting's agenda for a planned educational endeavor, and accept reimbursement of travel expenses in accordance with the chapter's policies.;" and be it further

RESOLVED, That the Council Steering Committee consider changes in the election process such as:

- requiring candidates to disclose financial expenditures on their candidacy;
- capping the monetary amount that can be used on all candidate-related expenditures, including travel, "coaches," videos, etc.;
- prohibit ACEP residency and ACEP chapter visits for each candidate during the period of declared candidacy;
- restricting publication of non-scholarly work in non-peer reviewed journals such as *ACEP Now* and other Emergency Medicine open subscription media; and restricting social media "public service announcements."

RESOLUTION 21

RESOLVED, That the Board of Directors task the appropriate committees to create a year-round forum for councillors to introduce, debate, and vote on resolutions; and be it further

RESOLVED, That the results of the votes in the electronic Council forum be nonbinding resolutions to offer ACEP leadership expeditious guidance on emergent issues; and be it further

RESOLVED, That the electronic Council forum product feature include a user experience that can be used during the annual Council meeting to receive and display proposed amendments in real time during discussion and voting.

RESOLUTION 22

RESOLVED, That ACEP work with the American Board of Emergency Medicine, and possibly the American Board of Medical Specialties, to create a new definition of Initial Residency Period that would permit Graduate Medical Education funding for the duration of residency, including dual training periods.

RESOLUTION 23

RESOLVED, That ACEP make it a primary goal of the upcoming year to work with state chapters to identify, develop, and implement processes that enhance the relationship, optimizing appropriate and timely information sharing; and be it further

RESOLVED, That individual Board members and an appropriate staff member participate in regular contact with state chapters and report back to the Council in 2018; and be it further

RESOLVED, That ACEP explore the concept of developing Regional State Chapter relationships and report back to the Council on the feasibility and usefulness of doing so.

RESOLUTION 24

RESOLVED, That ACEP study the needs, and cost-effective evidence-based requirements that would support practicing board-certified emergency physicians to legitimately demonstrate their ongoing competence and skills necessary for their own practice settings and develop appropriate minimum guidelines for appropriate "maintenance of competence" with minimum and legitimate barriers to continued practice, and present a report for consideration at the 2018 Council meeting.

RESOLUTION 25

RESOLVED, That the Council Steering Committee develop and promote a standardized format for a "co-sponsorship memo" that can be distributed through the Council listserve or other platform so that councillors may collaborate and further refine resolutions prior to submission.

RESOLUTION 26

RESOLVED, That the ACEP Board study the impact and potential membership benefit of a new chapter representing locums physicians and report back to the Council at the 2018 meeting.

RESOLUTION 27

RESOLVED, That ACEP create a policy statement supporting 9-1-1 number access to a Public Safety Answering Points for 100% of the U.S. population at next generation 9-1-1 level; and be it further

RESOLVED, That ACEP create and advocate for broad recognition of a policy statement supporting every Public Safety Answering Point or EMS dispatch point be able to give appropriate medical prearrival instruction for bystander aid, including CPR and hemorrhage control, and include EMS physician involvement in their creation, implementation, and quality improvement activities; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to inventory and summarize models for 9-1-1 and Public Safety Answering Point funding as a resource for areas in need of increased service levels; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to engage in development of model legislation incorporating enduring funding stream for 9-1-1 call centers/Public Safety Answering Points incorporating key elements including: bringing systems to at least the next generation 9-1-1 level, providing medically appropriate prearrival instructions, and incorporating EMS physician involvement in quality oversight, response profiles, and prearrival instructions.

RESOLUTION 28

RESOLVED, That ACEP support the coverage of medications for patients under observation status; and be it further

RESOLVED, That ACEP support a goal that patient out-of-pocket expenses for observation be no greater than the cost to the patient for inpatient services.

RESOLUTION 29

RESOLVED, That ACEP draft model state legislation and assist chapters in advocating for mandatory CPR training in schools; and be it further

RESOLVED, That ACEP work with other stakeholder organizations, including the American Heart Association and the American Red Cross, to draft and advocate for federal legislation and support to mandate CPR training in schools; and be it further

RESOLVED, That ACEP work with other stakeholder organizations, including the American Heart Association and the American Red Cross, to advocate for increased CPR training by laypersons.

RESOLUTION 30

RESOLVED, That ACEP request the Emergency Medicine Foundation and the Emergency Medicine Residents' Association to prioritize funding for emergency medicine faculty and resident research, emergency medicine resident competitions, and emergency medicine resident prizes for focused emergency medicine economic and operational material including studies and reports that can be used to educate policy makers and the general public to demonstrate the value of emergency medicine; and be it further

RESOLVED, That ACEP accelerate the development of a multi-year public relations campaign to educate the public and policy makers regarding the value of emergency medicine; items to emphasize should include (but are not limited to) the cost effectiveness of timely emergency care; the value of high level medical care and medical opinions available 24 x 7 to patients and referring physicians; and the threats posed by overzealous cost cutting by insurers and others who try to discourage or limit patient access to Emergency Departments; and be it further

RESOLVED, That a public relations campaign educating the public and policy makers regarding the value of emergency medicine utilize viral-marketing techniques such as mementos, short video clips, and humor to expand outreach to all appropriate demographic groups including Gen X, Y, and Z as well as Millennials; and be it further

RESOLVED, That a repository of public relations materials demonstrating the value of emergency medicine, including printed, video, and other information including emergency medicine economic research be assembled on the ACEP web site and such materials would be accessible to all members of ACEP who wish to reach specific target markets; and be it further

RESOLVED, That specific public relations materials regarding the value of emergency medicine be developed for legislators, which would include printed material and materials in various electronic formats; and be it further

RESOLVED, That the ACEP Board of Directors provide a report to the 2018 Council on the development and distribution of public relations materials demonstrating the value of emergency medicine to policy makers and the public.

RESOLUTION 31

RESOLVED, That ACEP join their partner organization, the American Medical Association, in supporting the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision and endorse Supervised Injection Facilities as an effective public health intervention in areas and communities heavily impacted by IV drug use.

RESOLUTION 32

RESOLVED, ACEP considers any medication that is used to treat or correct a life-threatening condition for which there is no adequate substitute to be an essential emergency medication, examples of such medications include but are not limited to epinephrine, sodium bicarbonate, and naloxone; and be it further

RESOLVED, That ACEP request a meeting with the FDA requesting adequate amounts of essential emergency medications be in supply at all times; and be it further

RESOLVED, That ACEP 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 be it further

RESOLVED, 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; and be it further

RESOLVED, That ACEP submit a resolution to the AMA House of Delegates regarding essential medicines for consideration.

RESOLUTION 33

RESOLVED, That ACEP develop model hospital policy language similar to the "Delivery of Care to Undocumented Persons" policy that physicians can access and present to their hospital systems for implementation; and be it further

RESOLVED, That ACEP 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 physicians can ensure the policy is communicated in the languages most relevant to their patient populations.

RESOLUTION 34

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

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

RESOLUTION 35

RESOLVED, That ACEP work with the Undersea & Hyperbaric Medical Society and the ACEP Undersea & Hyperbaric Medicine Section to petition and advocate for CMS to require that hyperbaric facilities be accredited to receive federal payment.

RESOLUTION 36

RESOLVED, That ACEP advocate for paid parental leave, including but not limited to supporting the American Medical Association's effort to study the effects of the Family Medical Leave Act expansion including paid parental leave (AMA Policy H-405.954); and be it further

RESOLVED, That ACEP conduct an environmental survey and develop a paper on best practices regarding maternity and paternity leave for emergency physicians; and be it further

RESOLVED, That ACEP develop a policy statement in support of paid parental leave.

RESOLUTION 37 *(This resolution was withdrawn.)*

RESOLVED, That ACEP support the legalization, authorization, and implementation of medically supervised injection facilities in coordination with state and local health departments; and be it further

RESOLVED, That ACEP support the decriminalization of the possession of illegal substances in medically supervised facilities, as well as legal and liability protections for persons working or volunteering in such facilities.

RESOLUTION 38

RESOLVED, That ACEP create a policy statement that:

- recognizes the threat that unaffordable prices of medications used to treat acute and chronic diseases poses to our patients and the challenges this imposes upon the emergency medical system;
- supports the negotiation of drug prices under Medicare Part D;
- supports the importation of prescription drugs; and
- supports value-based pharmaceutical pricing; and be it further

RESOLVED, That ACEP work with the American Medical Association and other stakeholders to support regulatory and legislative efforts to address these issues.

RESOLUTION 39

RESOLVED, That ACEP develop policy that addresses ACEP involvement in state level regulatory and legislative agendas, including direct lobbying efforts, without expressed formal request to ACEP by the state chapter and without formal established explicit ACEP policy conflict; and be it further

RESOLVED, That ACEP present a policy that addresses ACEP involvement in state level regulatory and legislative activities for consideration and comment at the 2018 Council meeting.

RESOLUTION 40

RESOLVED, That the policy of many third party payers including Anthem of denying payment for Emergency Medical Services is in opposition to the prudent layperson definition of an emergency and federal EMTALA laws; and be it further

RESOLVED, That ACEP 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; and be it further

RESOLVED, That ACEP, in order to promote public health and patient safety, continue to uphold federal EMTALA laws by providing a medical screening examination and appropriate medical care to all patients who request emergency services and ACEP will advocate for subsequent reimbursement for such services; and be it further

RESOLVED, That ACEP continue to advocate for our patients to prevent any negative clinical or financial

impact caused by the lack of reimbursement for emergency medical services; and be it further

RESOLVED, That ACEP partner with affected states and the American Medical Association to oppose this harmful policy and the denial of payment for emergency services.

RESOLUTION 41

RESOLVED, That ACEP encourage the adoption of state laws that allow for reimbursement for HCV testing in settings beyond the primary care setting including the Emergency Department.

RESOLUTION 42

RESOLVED, That ACEP has no position on the medical use of marijuana, cannabis, synthetic cannabinoids and similar substances, in light of the fact there is no legitimate medically recognized use of such substances in emergency care; and be it further

RESOLVED, That ACEP does not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

RESOLUTION 43

RESOLVED, That ACEP expand its policy statement "Workforce Diversity in Health Care Settings" to help identify and promote inclusion of qualified individuals with additional diverse characteristics (including racial and ethnic diversity, as per existing policy) and amend it to read:

"The American College of Emergency Physicians believes that:

- Hospitals and emergency physicians should work together to promote staffing of hospitals and their emergency departments with qualified individuals ~~who reflect the ethnic and racial diversity in our nation~~ **of diverse race, ethnicity, sex (including gender, gender identity, sexual orientation, pregnancy, marital status), nationality, religion, age, ability or disability, or other characteristics that do not otherwise preclude an individual emergency physician from providing equitable, competent patient care**; and

Attaining diversity with well qualified physicians in emergency medicine ~~residencies and faculties~~ that reflects our multicultural society is a desirable goal."

RESOLUTION 44

RESOLVED, That ACEP encourage electronic medical record providers to incorporate easy-to-use Prescription Monitoring Programs functionality into their products; and be it further

RESOLVED, That ACEP strongly discourage mandates for screening all emergency department patients for opioid use; and be it further

RESOLVED, That ACEP promote development of national guidelines to assist emergency physicians in their practice of prescribing opioids for acute pain.

RESOLUTION 45

RESOLVED, That ACEP establish a recommendation for appropriate timeframes for initiation of contract renewal discussions and contract negotiation deadlines to end of coverage; and be it further

RESOLVED, That ACEP oppose sudden, abrupt changes in contract groups without time for adequate transition and training.

RESOLUTION 46

RESOLVED, That ACEP research and develop a policy that addresses the impact of climate change on the health and well-being of our patients and utilize the policy statement to guide future research, training, advocacy preparedness, mitigation practices, and patient care.

RESOLUTION 47

RESOLVED, That ACEP develop a policy to reduce medical error and improve patient safety by assuring that pre-trial settlements of medical malpractice lawsuits against an emergency physician are anonymized and the learnings distributed to all members of the College and others as appropriate; actively support the elimination of non-disclosure clauses in pre-trial settlements of medical malpractice lawsuits; and report progress on this objective at the ACEP annual meeting in 2018.

RESOLUTION 48

RESOLVED, That ACEP work with the Emergency Nurses Association, International Association of Forensic Nurses, Training Institute on Strangulation Prevention, and other related organizations and stakeholders, to provide

educational and clinical resources as well as in person and enduring educational programs for emergency providers on the evaluation, radiographic investigation, and management of non-fatal strangulation; and be it further

RESOLVED, That ACEP create a policy statement on the seriousness of non-fatal strangulation and develop a clinical practice guideline for the emergency department evaluation, treatment, and management of non-fatal strangulation.

RESOLUTION 49

RESOLVED, That the American College of Emergency Physicians collaborate with the Department of Veterans Affairs, Department of Defense, the Indian Health Services, and potentially legislatures to encourage and facilitate their participation in state prescription drug monitoring programs; and be it further

RESOLVED, That the American College of Emergency Physicians collaborate with the Department of Veterans Affairs, Department of Defense, the Indian Health Services, and potentially legislatures, to encourage and facilitate their participation, to the extent consistent with federal law, a system for real-time electronic exchange of patient information, including recent emergency department visits and hospital care plans for frequent users of emergency departments.

RESOLUTION 50

RESOLVED, That ACEP create a Clinical Effectiveness Committee that is responsible for identifying, assessing, and promoting evidence-based, cost-effective emergency medicine practices.

RESOLUTION 51

RESOLVED, ACEP study and evaluate mechanisms to support practicing Emergency Physicians to help recognize potential physical and emotional limitations to clinical practice, to educate members about alternatives and opportunities for temporary interruption of active clinical practice to include mechanisms for reintegration back into clinical practice, and to support members considering career transitions including retirement; and be it further

RESOLVED, That ACEP actively engage in developing resources and communication of career transition opportunities to members, including support for members who believe they are being restricted from practice for discriminatory reasons as outlined and regulated by established federal equal employment opportunity discrimination laws.

RESOLUTION 52

RESOLVED, That ACEP endorse Syringe Services Programs for those who use injection drugs; and be it further

RESOLVED, That ACEP promote the access of Syringe Services Programs to people who inject drugs; and be it further

RESOLVED, That ACEP invest in educating its members on harm reduction techniques and the importance of Emergency Departments to partner with local Syringe Services Programs to advance the care of people who inject drugs.

RESOLUTION 53

RESOLVED, That ACEP go on record supporting scientific research to evaluate the risks and benefits of Cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available

RESOLUTION 54

RESOLVED: That ACEP adopt a policy that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis recommended by their physician

RESOLUTION 55

RESOLVED, That ACEP work with local, state, and federal bodies to provide for appropriate protections and enforcement of violations of Emergency Department patient and staff protections from violence in the workplace to provide safe and efficacious emergency care; and be it further

RESOLVED, That ACEP create model legislative and regulatory language that can be shared with state chapters addressing workplace violence.

RESOLUTION 56 (This late resolution was accepted by the Council.)

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Robert Eugene Blake, MD, FACEP, as one of the leaders in the medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Robert Eugene Blake,

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 West Virginia and the United States.

RESOLUTION 57 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians fondly remembers and honors the many contributions of James H. Creel, Jr., MD, FACEP, one of the truest pioneers and leaders in emergency medicine and emergency medical services; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of James H. Creel, Jr., MD, FACEP, his colleagues, friends, residents, staff, and students our heartfelt condolences and gratitude for his tremendous accomplishments, devotion, and service to the specialty of emergency medicine, the State of Tennessee, and the United States of America.

RESOLUTION 58 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions by Paul Berger, Jr, MD, FACEP, as one of the leaders in emergency medicine, EMS, and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife Lanie Berger, his son Paul Berger, III, DO, his friends, and his colleagues our deepest sympathy and our gratitude for having been able to learn so much from a kind, gentle, caring leader in emergency medicine and gratitude for his tremendous service to the specialty of emergency medicine and the State of Iowa.

RESOLUTION 59 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by William Wilkerson, Jr, 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 William Wilkerson, Jr, 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 Michigan and the United States.

RESOLUTION 60 *(This late resolution was accepted by the Council.)*

RESOLVED, That ACEP recognizes all ACEP members, staff, and their families that were involved in the response to Hurricanes Harvey, Irma, and Maria and commends the significant commitment they have made to the ideals of emergency medicine and the service provided to the people in the States of Texas, Louisiana, and Florida and the territories of Puerto Rico and the United States Virgin Islands.

RESOLUTION 61 *(This late resolution was accepted by the Council.)*

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Michael G. Guttenberg, DO, FACEP, FACOEP, FAEMS, 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 Michael G. Guttenberg, DO, FACEP, FACOEP, FAEMS, 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 New York State and the United States.

RESOLUTION 62 *(This late resolution was accepted by the Council.)*

RESOLVED, That ACEP lobby Congress to give CMS the authority to recognize independent Freestanding Emergency Centers as Medicare Certifiable locations of acute unscheduled healthcare in the United States in Federally Declared Disaster areas.

RESOLVED, That ACEP lobby Congress to give CMS the authority to create Critical Access Emergency Center Designation where Critical Access Hospitals no longer exist due to catastrophic destruction from natural disasters or where Critical Access Hospitals cannot be feasibly maintained leaving areas of the Country without access to Emergency Medical care.

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Commendation and memorial resolutions were not assigned to reference committees.

Resolutions 10-26 were referred to Reference Committee A. Brahim Ardolic, MD, FACEP, chaired Reference

Committee A and other members were: Patricia A. Bayless, MD, FACEP; Justin Fuehrer, DO; Mark Notash, MD, FACEP; Susanne J. Spano, MD, FACEP; Arvind Venkat, MD, FACEP; Leslie Moore, JD; and Cynthia Singh, MS.

Resolutions 27-41 and 62 were assigned to Reference Committee B. Michael Lozano, MD, FACEP, chaired Reference Committee B and other members were: Daniel Freess, MD, FACEP; Nathaniel T. Hibbs, DO, FACEP; Jeffrey F. Linzer, MD, FACEP; Heather A. Marshall, MD, FACEP; John Matheson, MD, FACEP; Ryan McBride, MPP; and Harry Monroe.

Resolutions 42-55 were referred to Reference Committee C. John H. Proctor, MD, MBA, FACEP, chaired Reference Committee C and other members were: Enrique R. Enguidanos, MD, FACEP; Heather A. Heaton, MD, FACEP; Marianna Karounos, DO, FACEP; Michael D. Smith, MD, MBA, CPE, FACEP; James M. Williams, DO, MS, FACEP; Margaret Montgomery, RN, MSN; Loren Rives, MNA; and Travis Schulz, MLS, AHIP.

At 1:00 pm a Town Hall Meeting was convened held. The topic was "The Out-of-Network & Balance Billing Conundrum: What Can We Do About It?" Ed R. Gaines, JD, CCP, served as the moderator and the discussants were W. D. "Chip" Pettigrew, III, MD, FACEP; Danyelle Redden, MD, FACEP; Nathan Schlicher, MD, JD, FACEP; and Laura Wooster, MPH.

The Candidate Forum began at 2:30 pm with candidates rotating through each of the Reference Committee meeting rooms.

At 4:46 pm the Council reconvened in the main Council meeting room to hear reports and the reading and presentation of the memorial resolutions.

Dr. Cusick introduced the Board of Directors and honored guests and then addressed the Council.

Dr. Cusick reviewed the procedure for the adoption of the 2017 memorial resolution. The Council reviewed the list of members who have passed away since the last Council meeting. Dr. McManus then presented the memorial resolution to the colleagues of Charles R. Bauer, MD, FACEP; Paul Berger, Jr., MD, FACEP; Diane Kay Bollman; Robert E. Blake, MD, FACEP; James H. Creel, Jr., MD, FACEP; Aaron T. Daggy, MD, FACEP; Michael Guttenberg, DO, FACEP; Geoffrey Renk, MD, PhD, FACEP; Salvatore Silvestri, MD; Robert Wears, MD, FACEP; and William Wilkerson, Jr., MD, FACEP. The Council honored the memory of those who passed away since the last Council meeting 2017 and adopted the memorial resolution by observing a moment of silence.

Dr. Cusick announced that the commendation resolution would be presented during the Council luncheon on Saturday, October 28, 2017.

Nicholas Jouriles, MD, FACEP, addressed the Council regarding ACEP's 50th anniversary and showed a brief video.

Vidor Friedman, MD, FACEP, presented the secretary-treasurer's report.

Alicia Kurtz, MD, addressed the Council regarding the activities of the Emergency Medicine Residents' Association.

Hans House, MD, FACEP, addressed the Council regarding the activities of the Emergency Medicine Foundation.

Peter Jacoby, MD, FACEP, addressed the Council regarding the activities of NEMPAC and the 911 Network.

Rebecca Parker, MD, FACEP, president, addressed the Council. She reflected on her past year as ACEP president and highlighted the successes of the College.

The Council recessed at 6:18 pm for the candidate reception and reconvened at 8:06 am on Saturday, October 28, 2017.

Dr. Costello reported that 405 councillors of the 410 eligible for seating had been credentialed. She then introduced the members of the Tellers, Credentials, & Elections Committee, reviewed the electronic voting

procedures, and conducted a test of the keypads using demographic and survey questions.

Mr. Wilkerson addressed the Council.

REFERENCE COMMITTEE C

Dr. Proctor presented the report of Reference Committee C. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Amended Resolution 43, Resolution 44, Resolution 49, Resolution 51, and Amended Resolution 55.

Not for adoption: Resolution 42 and Resolution 54.

For referral: Amended Resolution 45, Resolution 46, Resolution 47, Resolution 48, and Resolution 50.

Resolution 42 and Amended Resolution 43 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 43

RESOLVED, THAT ACEP EXPAND ITS POLICY STATEMENT "WORKFORCE DIVERSITY IN HEALTH CARE SETTINGS" TO HELP IDENTIFY AND PROMOTE INCLUSION OF QUALIFIED INDIVIDUALS WITH ADDITIONAL DIVERSE CHARACTERISTICS (INCLUDING RACIAL AND ETHNIC DIVERSITY, AS PER EXISTING POLICY) AND AMEND IT TO READ:

THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS BELIEVES THAT:

- HOSPITALS AND EMERGENCY PHYSICIANS SHOULD WORK TOGETHER TO PROMOTE STAFFING OF HOSPITALS AND THEIR EMERGENCY DEPARTMENTS WITH QUALIFIED INDIVIDUALS ~~WHO REFLECT THE ETHNIC AND RACIAL DIVERSITY IN OUR NATION~~ **OF DIVERSE RACE, ETHNICITY, SEX (INCLUDING GENDER, GENDER IDENTITY, SEXUAL ORIENTATION, PREGNANCY, MARITAL STATUS), NATIONALITY, RELIGION, AGE, ABILITY OR DISABILITY, ~~OR~~ AND OTHER CHARACTERISTICS THAT DO NOT OTHERWISE PRECLUDE AN INDIVIDUAL EMERGENCY PHYSICIAN FROM PROVIDING EQUITABLE, COMPETENT PATIENT CARE**; AND
- ATTAINING DIVERSITY WITH WELL-QUALIFIED PHYSICIANS IN EMERGENCY MEDICINE ~~RESIDENCIES AND FACULTIES~~ THAT REFLECTS OUR MULTICULTURAL SOCIETY IS A DESIRABLE GOAL.

AMENDED RESOLUTION 45

RESOLVED, THAT ACEP ESTABLISH A RECOMMENDATION FOR APPROPRIATE TIMEFRAMES FOR INITIATION OF CONTRACT RENEWAL DISCUSSIONS AND CONTRACT NEGOTIATION DEADLINES TO END OF COVERAGE; AND BE IT FURTHER

RESOLVED, THAT ACEP ~~OPPOSE~~ NOT SUPPORT SUDDEN, ABRUPT CHANGES IN CONTRACT GROUPS WITHOUT TIME FOR ADEQUATE TRANSITION AND TRAINING.

The committee recommended that Resolution 42 not be adopted.

It was moved THAT RESOLUTION 42 BE ADOPTED.

It was moved THAT RESOLUTION 42 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was not adopted.

The main motion was then voted on and not adopted.

The committee recommended that Amended Resolution 43 be adopted.

It was moved THAT AMENDED RESOLUTION 43 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 52 not be adopted.

It was moved THAT RESOLUTION 52 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 53 not be adopted.

It was moved THAT RESOLUTION 53 BE ADOPTED. The motion was not adopted.

The committee recommended that Amended Resolution 55 be adopted.

It was moved THAT AMENDED RESOLUTION 55 BE ADOPTED:

RESOLVED, THAT ACEP MOVE PAST POLICY CREATION AND SIMPLE AWARENESS CAMPAIGNS WITH STATE AND NATIONAL REGULATORY AGENCIES TO DEVELOP ACTIONABLE GUIDELINES AND MEASURES (E.G., PERCENT OF EVENTS WITH LEGAL OUTCOME, PAID POST-TRAUMA LEAVE, USE OF DE-ESCALATION TECHNIQUES, COUNSELING PROVIDED), TO ENSURE SAFETY IN THE EMERGENCY DEPARTMENT FOR PATIENTS AND STAFF; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH LOCAL, STATE, AND FEDERAL BODIES TO PROVIDE FOR APPROPRIATE PROTECTIONS AND ENFORCEMENT OF VIOLATIONS OF EMERGENCY DEPARTMENT PATIENT AND STAFF PROTECTIONS FROM VIOLENCE IN THE WORKPLACE TO PROVIDE SAFE AND EFFICACIOUS EMERGENCY CARE; AND BE IT FURTHER

RESOLVED, THAT ACEP CREATE MODEL LEGISLATIVE AND REGULATORY LANGUAGE THAT CAN BE SHARED WITH STATE CHAPTERS **AND HOSPITALS** ADDRESSING WORKPLACE VIOLENCE. The motion was adopted.

REFERENCE COMMITTEE A

Dr. Ardolic presented the report of Reference Committee A. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 18, Resolution 25, and Amended Resolution 26.

Not for adoption: Resolution 14, Resolution 15, Resolution 16, Resolution 17, and Resolution 19.

The authors of Resolutions 14, 15, and 16 requested that the resolutions be withdrawn. There was no objection by the Council and the resolutions were withdrawn.

The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 26

STUDY OF~~THE IMPACT & POTENTIAL MEMBERSHIP BENEFITS OF A NEW CHAPTER OR SECTION REPRESENTING~~ LOCUMS PHYSICIANS REPRESENTATION

RESOLVED, THAT THE ACEP BOARD STUDY THE IMPACT AND POTENTIAL MEMBERSHIP BENEFIT OF A NEW CHAPTER **OR SECTION** REPRESENTING LOCUMS PHYSICIANS AND REPORT BACK TO THE COUNCIL AT THE 2018 MEETING.

The committee recommended that Resolution 10 be adopted.

It was moved THAT RESOLUTION 10 BE ADOPTED.

It was moved THAT THE WORDS "CURRENT APPROVED" BE DELETED. The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Resolution 11 not be adopted.

It was moved THAT RESOLUTION 11 BE ADOPTED. The motion was not adopted.

The committee recommended that Resolution 12 be adopted.

It was moved THAT RESOLUTION 12 BE ADOPTED. The motion was adopted.

The committee recommended that Resolution 13 be adopted.

It was moved THAT RESOLUTION 13 BE ADOPTED. The motion was adopted.

The committee recommended that Amended Resolution 20 be adopted.

It was moved THAT AMENDED RESOLUTION 20 BE ADOPTED:

RESOLVED, THAT THE COUNCIL STEERING COMMITTEE CREATE EXPENDITURE LIMITATIONS TO ~~ALLOW YOUNGER~~ **ENCOURAGE ADDITIONAL** MEMBERS TO CONSIDER CANDIDACY FOR LEADERSHIP POSITIONS WITHOUT THE CONCERN FOR FINANCIAL MEANS.~~;~~ ~~AND BE IT FURTHER~~

~~RESOLVED, THAT THE CANDIDATE CAMPAIGN RULES BE AMENDED BY ADDING: "CANDIDATES WILL NOT ATTEND ANNUAL CHAPTER MEETINGS UNLESS OFFICIALLY INVITED, ON THE MEETING'S AGENDA FOR A PLANNED EDUCATIONAL ENDEAVOR, AND ACCEPT REIMBURSEMENT OF TRAVEL EXPENSES IN ACCORDANCE WITH THE CHAPTER'S POLICIES.;" AND BE IT FURTHER~~

~~RESOLVED, THAT THE COUNCIL STEERING COMMITTEE CONSIDER CHANGES IN THE ELECTION PROCESS SUCH AS:~~

- ~~REQUIRING CANDIDATES TO DISCLOSE FINANCIAL EXPENDITURES ON THEIR CANDIDACY;~~
- ~~CAPPING THE MONETARY AMOUNT THAT CAN BE USED ON ALL CANDIDATE-RELATED EXPENDITURES, INCLUDING TRAVEL, "COACHES," VIDEOS, ETC.;~~
- ~~PROHIBIT ACEP RESIDENCY AND ACEP CHAPTER VISITS FOR EACH CANDIDATE DURING THE PERIOD OF DECLARED CANDIDACY;~~
- ~~RESTRICTING PUBLICATION OF NON-SCHOLARLY WORK IN NON-PEER REVIEWED JOURNALS SUCH AS *ACEP NOW* AND OTHER EMERGENCY MEDICINE OPEN SUBSCRIPTION MEDIA; AND~~
- ~~RESTRICTING SOCIAL MEDIA "PUBLIC SERVICE ANNOUNCEMENTS."~~

It was moved THAT AMENDED RESOLUTION 20 BE REFERRED TO THE COUNCIL STEERING COMMITTEE. The motion was adopted.

The committee recommended that Resolution 21 be referred to the Council Steering Committee.

It was moved THAT RESOLUTION 21 BE REFERRED TO THE COUNCIL STEERING COMMITTEE. The motion was adopted.

The committee recommended that Amended Resolution 22 be adopted.

It was moved THAT AMENDED RESOLUTION 22 BE ADOPTED:

~~**EMERGENCY MEDICINE RESIDENCY TRAINING REQUIREMENTS FOR DUAL TRAINING PROGRAMS**~~ **FUNDING OF EMERGENCY MEDICINE TRAINING**

RESOLVED, THAT ACEP WORK WITH THE **APPROPRIATE ORGANIZATIONS TO OPTIMIZE GME FUNDING FOR ALL FORMATS OF EMERGENCY MEDICINE TRAINING.** ~~AMERICAN BOARD OF EMERGENCY MEDICINE, AND POSSIBLY THE AMERICAN BOARD OF MEDICAL SPECIALTIES, TO CREATE A NEW DEFINITION OF INITIAL RESIDENCY PERIOD~~

~~THAT WOULD PERMIT GRADUATE MEDICAL EDUCATION FUNDING FOR THE DURATION OF RESIDENCY, INCLUDING DUAL TRAINING PERIODS.~~ The motion was adopted.

The committee recommended that Amended Resolution 23 be adopted.

It was moved THAT AMENDED RESOLUTION 23 BE ADOPTED:

RESOLVED, THAT ACEP ~~MAKE IT A PRIMARY GOAL OF THE UPCOMING YEAR TO~~ WORK WITH STATE CHAPTERS TO IDENTIFY, DEVELOP, AND IMPLEMENT PROCESSES THAT ENHANCE THE RELATIONSHIP, OPTIMIZING APPROPRIATE AND TIMELY INFORMATION SHARING; AND BE IT FURTHER

RESOLVED, THAT INDIVIDUAL BOARD MEMBERS AND AN APPROPRIATE STAFF MEMBER PARTICIPATE IN REGULAR CONTACT WITH STATE CHAPTERS AND REPORT BACK TO THE COUNCIL IN 2018.~~; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP EXPLORE THE CONCEPT OF DEVELOPING REGIONAL STATE CHAPTER RELATIONSHIPS AND REPORT BACK TO THE COUNCIL ON THE FEASIBILITY AND USEFULNESS OF DOING SO.~~ The motion was adopted.

The committee recommended that Amended Resolution 24 be referred to the Board of Directors..

It was moved THAT AMENDED RESOLUTION 24 BE REFERRED TO THE BOARD OF DIRECTORS.:

MAINTENANCE OF ~~CERTIFICATION~~ COMPETENCE FOR PRACTICING EMERGENCY PHYSICIANS

RESOLVED, THAT ACEP STUDY THE NEEDS, AND COST-EFFECTIVE EVIDENCE-BASED REQUIREMENTS THAT WOULD SUPPORT PRACTICING BOARD-CERTIFIED EMERGENCY PHYSICIANS TO LEGITIMATELY DEMONSTRATE THEIR ONGOING COMPETENCE AND SKILLS NECESSARY FOR THEIR OWN PRACTICE SETTINGS AND DEVELOP APPROPRIATE MINIMUM GUIDELINES FOR APPROPRIATE "MAINTENANCE OF COMPETENCE" WITH MINIMUM AND LEGITIMATE BARRIERS TO CONTINUED PRACTICE, AND PRESENT A REPORT FOR CONSIDERATION AT THE 2018 COUNCIL MEETING.

It was moved THAT AMENDED RESOLUTION 24 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

REFERENCE COMMITTEE B

Dr. Lozano presented the report of Reference Committee B. *(Refer to the original resolutions as submitted for the text of the resolutions that were not amended or substituted.)*

The committee recommended the following resolutions by unanimous consent:

For adoption: Resolution 27, Amended Resolution 28, Amended Resolution 29, Amended Resolution 30, Amended Resolution 31, Amended Resolution 36, Amended Resolution 39, and Amended Resolution 40.

Not for adoption: Resolution 35 and Resolution 37.

For referral: Resolution 33 and Resolution 41.

Amended Resolution 31, Resolution 35, Amended Resolution 36, and Resolution 37 were extracted. The Council adopted the remaining resolutions as recommended for unanimous consent without objection.

AMENDED RESOLUTION 28

RESOLVED, THAT ACEP SUPPORT THE COVERAGE OF **ALL ADMINISTERED** MEDICATIONS FOR PATIENTS UNDER OBSERVATION STATUS **WITHOUT HAVING TO APPLY FOR REIMBURSEMENT**~~; AND BE IT FURTHER~~

RESOLVED, THAT ACEP SUPPORT A GOAL THAT PATIENT OUT-OF-POCKET EXPENSES FOR OBSERVATION BE NO GREATER THAN THE COST TO THE PATIENT FOR INPATIENT SERVICES.

AMENDED RESOLUTION 29

RESOLVED, THAT ACEP DRAFT MODEL STATE LEGISLATION AND ASSIST CHAPTERS IN ADVOCATING FOR ~~MANDATORY~~ CPR TRAINING IN SCHOOLS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH OTHER STAKEHOLDER ORGANIZATIONS~~, INCLUDING THE AMERICAN HEART ASSOCIATION AND THE AMERICAN RED CROSS,~~ TO ~~DRAFT AND~~ ADVOCATE FOR ~~FEDERAL~~ LEGISLATION ~~AND~~**TO** SUPPORT ~~TO MANDATE~~ CPR TRAINING IN SCHOOLS; AND BE IT FURTHER

RESOLVED, THAT ACEP WORK WITH OTHER STAKEHOLDER ORGANIZATIONS~~, INCLUDING THE AMERICAN HEART ASSOCIATION AND THE AMERICAN RED CROSS,~~ TO ADVOCATE FOR INCREASED CPR TRAINING ~~BY~~**FOR** LAYPERSONS

AMENDED RESOLUTION 30

~~RESOLVED, THAT ACEP REQUEST THE EMERGENCY MEDICINE FOUNDATION AND THE EMERGENCY MEDICINE RESIDENTS' ASSOCIATION TO PRIORITIZE FUNDING FOR EMERGENCY MEDICINE FACULTY AND RESIDENT RESEARCH, EMERGENCY MEDICINE RESIDENT COMPETITIONS, AND EMERGENCY MEDICINE RESIDENT PRIZES FOR FOCUSED EMERGENCY MEDICINE ECONOMIC AND OPERATIONAL MATERIAL INCLUDING STUDIES AND REPORTS THAT CAN BE USED TO EDUCATE POLICY MAKERS AND THE GENERAL PUBLIC TO DEMONSTRATE THE VALUE OF EMERGENCY MEDICINE; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP ACCELERATE THE DEVELOPMENT OF A MULTI-YEAR PUBLIC RELATIONS CAMPAIGN TO EDUCATE THE PUBLIC AND POLICY MAKERS REGARDING THE VALUE OF EMERGENCY MEDICINE; ITEMS TO EMPHASIZE SHOULD INCLUDE (BUT ARE NOT LIMITED TO) THE COST EFFECTIVENESS OF TIMELY EMERGENCY CARE; THE VALUE OF HIGH LEVEL MEDICAL CARE AND MEDICAL OPINIONS AVAILABLE 24 X 7 TO PATIENTS AND REFERRING PHYSICIANS; AND THE THREATS POSED BY OVERZEALOUS COST CUTTING BY INSURERS AND OTHERS WHO TRY TO DISCOURAGE OR LIMIT PATIENT ACCESS TO EMERGENCY DEPARTMENTS; AND BE IT FURTHER~~

~~RESOLVED, THAT A PUBLIC RELATIONS CAMPAIGN EDUCATING THE PUBLIC AND POLICY MAKERS REGARDING THE VALUE OF EMERGENCY MEDICINE UTILIZE VIRAL MARKETING TECHNIQUES SUCH AS MEMENTOS, SHORT VIDEO CLIPS, AND HUMOR TO EXPAND OUTREACH TO ALL APPROPRIATE DEMOGRAPHIC GROUPS INCLUDING GEN X, Y, AND Z AS WELL AS MILLENNIALS; AND BE IT FURTHER~~

RESOLVED, THAT A REPOSITORY OF PUBLIC RELATIONS MATERIALS DEMONSTRATING THE VALUE OF EMERGENCY MEDICINE, INCLUDING PRINTED, VIDEO, AND OTHER INFORMATION INCLUDING EMERGENCY MEDICINE ECONOMIC RESEARCH BE ASSEMBLED ON THE ACEP WEB SITE AND SUCH MATERIALS WOULD BE ACCESSIBLE TO ALL MEMBERS OF ACEP WHO WISH TO REACH SPECIFIC TARGET MARKETS; AND BE IT FURTHER

RESOLVED, THAT SPECIFIC PUBLIC RELATIONS MATERIALS REGARDING THE VALUE OF EMERGENCY MEDICINE BE DEVELOPED FOR LEGISLATORS, WHICH WOULD INCLUDE PRINTED MATERIAL AND MATERIALS IN VARIOUS ELECTRONIC FORMATS; AND BE IT FURTHER

RESOLVED, THAT THE ACEP BOARD OF DIRECTORS PROVIDE A REPORT TO THE 2018 COUNCIL ON THE DEVELOPMENT AND DISTRIBUTION OF PUBLIC RELATIONS MATERIALS DEMONSTRATING THE VALUE OF EMERGENCY MEDICINE TO POLICY MAKERS AND THE PUBLIC.

AMENDED RESOLUTION 39

~~PROHIBITION ON~~ ACEP ~~INTERFERENCE~~ INVOLVEMENT IN STATE LEGISLATIVE ACTIVITIES

RESOLVED, THAT ACEP DEVELOP POLICY THAT ADDRESSES ACEP INVOLVEMENT IN STATE LEVEL REGULATORY AND LEGISLATIVE AGENDAS, INCLUDING DIRECT LOBBYING EFFORTS, ~~WITHOUT EXPRESSED FORMAL REQUEST TO ACEP~~ **BY IN COORDINATION WITH** THE STATE CHAPTER AND ~~WITHOUT FORMAL ESTABLISHED EXPLICIT~~ **CONSISTENT WITH** ACEP POLICY~~ CONFLICT~~; AND BE IT FURTHER

RESOLVED, THAT ACEP PRESENT A POLICY THAT ADDRESSES ACEP INVOLVEMENT IN STATE LEVEL REGULATORY AND LEGISLATIVE ACTIVITIES FOR CONSIDERATION AND COMMENT AT THE 2018 COUNCIL MEETING.

AMENDED RESOLUTION 40

RESOLVED, THAT THE POLICY OF MANY THIRD PARTY PAYERS ~~INCLUDING ANTHEM~~ OF DENYING PAYMENT FOR EMERGENCY MEDICAL SERVICES IS IN OPPOSITION TO THE PRUDENT LAYPERSON DEFINITION OF AN EMERGENCY AND FEDERAL EMTALA LAWS; AND BE IT FURTHER

RESOLVED, THAT ACEP 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; AND BE IT FURTHER

RESOLVED, THAT ACEP, IN ORDER TO PROMOTE PUBLIC HEALTH AND PATIENT SAFETY, CONTINUE TO UPHOLD FEDERAL EMTALA LAWS BY PROVIDING A MEDICAL SCREENING EXAMINATION AND APPROPRIATE MEDICAL CARE TO ALL PATIENTS WHO REQUEST EMERGENCY SERVICES AND ACEP WILL ADVOCATE FOR SUBSEQUENT REIMBURSEMENT FOR SUCH SERVICES; AND BE IT FURTHER

RESOLVED, THAT ACEP CONTINUE TO ADVOCATE FOR OUR PATIENTS TO PREVENT ANY NEGATIVE CLINICAL OR FINANCIAL IMPACT CAUSED BY THE LACK OF REIMBURSEMENT FOR EMERGENCY MEDICAL SERVICES; AND BE IT FURTHER

RESOLVED, THAT ACEP PARTNER WITH AFFECTED STATES AND THE AMERICAN MEDICAL ASSOCIATION TO OPPOSE THIS HARMFUL POLICY AND THE DENIAL OF PAYMENT FOR EMERGENCY SERVICES.

The committee recommended that Amended Resolution 31 be adopted.

It was moved THAT AMENDED RESOLUTION 31 BE ADOPTED:

RESOLVED, THAT ACEP JOIN THEIR PARTNER ORGANIZATION, THE AMERICAN MEDICAL ASSOCIATION, IN SUPPORTING THE ~~DEVELOPMENT~~ **STUDY OF THE ROLE** OF ~~PILOT~~ **SUPERVISED INJECTION FFACILITIES IN DECREASING MORBIDITY AND MORTALITY DUE TO INTRAVENOUS DRUG USE** ~~WHERE PEOPLE WHO USE INTRAVENOUS DRUGS CAN INJECT SELF-PROVIDED DRUGS UNDER MEDICAL SUPERVISION~~ AND **TO DETERMINE IF** ~~ENDORSE~~ SUPERVISED INJECTION FACILITIES **ARE** ~~AS AN EFFECTIVE~~ **A POTENTIAL** PUBLIC HEALTH INTERVENTION ~~IN AREAS AND COMMUNITIES HEAVILY IMPACTED BY IV DRUG USE~~; AND BE IT FURTHER

RESOLVED, THAT THE ACEP BOARD OF DIRECTORS REPORT ITS FINDINGS AT THE 2018 COUNCIL MEETING

It was moved THAT THE RESOLUTION BE AMENDED BY SUBSTITUTION TO READ:

RESOLVED, THAT ACEP JOIN THEIR PARTNER ORGANIZATION, THE AMERICAN MEDICAL ASSOCIATION, IN SUPPORTING THE DEVELOPMENT AND STUDY OF PILOT FACILITIES WHERE PEOPLE WHO USE INTRAVENOUS DRUGS CAN INJECT SELF-PROVIDED DRUGS UNDER MEDICAL SUPERVISION AND ENDORSE SUPERVISED INJECTION FACILITIES AS A POTENTIAL PUBLIC HEALTH INTERVENTION IN AREAS AND COMMUNITIES HEAVILY IMPACTED BY IV DRUG USE. The motion was adopted.

It was moved THAT THE WORDS "FOR THEIR FEASIBILITY, EFFECTIVENESS, AND LEGAL ASPECTS" BE INSERTED AFTER THE WORD "FACILITIES." The motion was adopted.

It was moved THAT THE TITLE OF THE RESOLUTION BE AMENDED TO READ: "~~ENDORSEMENT~~ **DEVELOPMENT** OF SUPERVISED INJECTION FACILITIES." The motion was adopted.

It was moved THAT THE TITLE OF THE RESOLUTION BE AMENDED TO READ: "**DEVELOPMENT AND STUDY OF** SUPERVISED INJECTION FACILITIES." The motion was adopted.

The amended main motion was then voted on and adopted.

The committee recommended that Amended Resolution 32 be adopted.

It was moved THAT AMENDED RESOLUTION 32 BE ADOPTED:

~~RESOLVED, ACEP CONSIDERS ANY MEDICATION THAT IS USED TO TREAT OR CORRECT A LIFE-THREATENING CONDITION FOR WHICH THERE IS NO ADEQUATE SUBSTITUTE TO BE AN ESSENTIAL EMERGENCY MEDICATION, EXAMPLES OF SUCH MEDICATIONS INCLUDE BUT ARE NOT LIMITED TO EPINEPHRINE, SODIUM BICARBONATE, AND NALOXONE; AND BE IT FURTHER~~

~~RESOLVED, THAT ACEP REQUEST A MEETING WITH THE FDA REQUESTING ADEQUATE AMOUNTS OF ESSENTIAL EMERGENCY MEDICATIONS BE IN SUPPLY AT ALL TIMES; AND BE IT FURTHER~~

RESOLVED, THAT ACEP 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 BE IT FURTHER

RESOLVED, 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;

~~RESOLVED, THAT ACEP SUBMIT A RESOLUTION TO THE AMA HOUSE OF DELEGATES REGARDING ESSENTIAL MEDICINES FOR CONSIDERATION.~~ The motion was adopted.

The committee recommended that Amended Resolution 34 be adopted.

It was moved THAT AMENDED RESOLUTION 34 BE ADOPTED:

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

RESOLVED, THAT ACEP WORK WITH OTHER MEDICAL SPECIALTIES AND PATIENT ADVOCACY GROUPS TO SEEK CONGRESSIONAL LEGISLATIVE REPEAL OF THE ~~PERNICIOUS AND UNSAFE~~ GROUP PURCHASING ORGANIZATIONS' SAFE-HARBOR PROTECTION. The motion was adopted.

The committee recommended that Resolution 35 not be adopted.

It was moved THAT RESOLUTION 35 BE ADOPTED.

It was moved THAT RESOLUTION 35 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 36 be adopted.

It was moved THAT AMENDED RESOLUTION 36 BE ADOPTED:

~~RESOLVED, THAT ACEP ADVOCATE FOR PAID PARENTAL LEAVE, INCLUDING BUT NOT LIMITED TO SUPPORTING THE AMERICAN MEDICAL ASSOCIATION'S EFFORT TO STUDY THE EFFECTS OF THE FAMILY MEDICAL LEAVE ACT EXPANSION INCLUDING PAID PARENTAL LEAVE (AMA POLICY H-405.954); AND BE IT FURTHER~~

RESOLVED, THAT ACEP CONDUCT AN ENVIRONMENTAL SURVEY AND DEVELOP A PAPER ON BEST PRACTICES REGARDING ~~MATERNITY AND PATERNITY~~ **PAID PARENTAL** LEAVE FOR EMERGENCY PHYSICIANS; AND BE IT FURTHER

RESOLVED, THAT ACEP'S ~~DEVELOP A POLICY STATEMENT IN SUPPORT OF PAID PARENTAL LEAVE~~ **BOARD OF DIRECTORS REPORT THEIR FINDINGS AT THE 2018 ACEP COUNCIL.**

It was moved THAT THE THIRD RESOLVED BE AMENDED TO READ: "RESOLVED, THAT ACEP DEVELOP A POLICY STATEMENT IN SUPPORT OF PAID PARENTAL LEAVE." The motion was not adopted.

It was moved THAT AMENDED RESOLUTION 36 BE AMENDED TO READ:

RESOLVED, THAT ACEP ADVOCATE FOR PAID PARENTAL LEAVE FOR EMERGENCY PHYSICIANS; AND BE IT FURTHER

RESOLVED, THAT ACEP DEVELOP AN INFORMATION PAPER ON BEST PRACTICES REGARDING PAID PARENTAL LEAVE FOR EMERGENCY PHYSICIANS; AND BE IT FURTHER

RESOLVED, THAT ACEP'S BOARD OF DIRECTORS REPORT THEIR FINDINGS AT THE 2018 ACEP COUNCIL. The motion was adopted.

The amended main motion was then voted on and adopted.

The Council recessed at 12:00 pm for the awards luncheon and reconvened at 1:30 pm on Saturday, October 28, 2017.

The committee recommended that Resolution 37 not be adopted.

The authors of Resolution 37 requested that it be withdrawn. There was no objection by the Council and the resolution was withdrawn.

The committee recommended that Resolution 38 be referred to the Board of Directors.

It was moved THAT RESOLUTION 38 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

The committee recommended that Amended Resolution 62 be adopted.

It was moved THAT AMENDED RESOLUTION 62 BE ADOPTED:

RESOLVED, That ACEP ~~lobby Congress to give~~**advocate giving** CMS the authority to recognize independent Freestanding Emergency Centers as Medicare Certifiable locations of acute unscheduled healthcare in the United States in Federally Declared Disaster areas.

~~RESOLVED, That ACEP lobby Congress to give CMS the authority to create Critical Access Emergency Center Designation where Critical Access Hospitals no longer exist due to catastrophic destruction from natural disasters or where Critical Access Hospitals cannot be feasibly maintained leaving areas of the Country without access to Emergency Medical care.~~

It was moved THAT AMENDED RESOLUTION 62 BE REFERRED TO THE BOARD OF DIRECTORS. The motion was adopted.

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Dr. Kivela, president-elect, addressed the Council.

Dr. Costello reported that 410 of the 410 councillors eligible for seating had been credentialed.

The Tellers, Credentials, & Elections Committee conducted the Vice Speaker elections. Dr. Katz was elected

The Tellers, Credentials, & Elections Committee conducted the Board of Directors elections. Dr. Haddock and Dr. Liferidge were elected to a three-year term. Dr. Anderson and Dr. Hirshon were re-elected to a three-year term.

The Tellers, Credentials, & Elections Committee conducted the president-elect election. Dr. Rogers was elected.

There being no further business, Dr. Cusick adjourned the 2017 Council meeting at 4:08 pm on Saturday, October 28, 2017. The next meeting of the ACEP Council is scheduled for September 28-29, 2018, at the Manchester Grand Hyatt Hotel in San Diego, CA.

Respectfully submitted,

Dean Wilkerson, JD, MBA, CAE
Council Secretary

Approved by,

James M. Cusick, MD, FACEP
Council Speaker

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Steering Committee Meeting
January 18, 2017
ACEP Headquarters
Irving, TX

Minutes

Speaker James Cusick, MD, FACEP, called to order a regular meeting of the Steering Committee of the Council of the American College of Emergency Physicians at 8:02 am Central time on Wednesday, January 18, 2017, at the ACEP headquarters in Irving, TX.

Steering Committee members present for all or portions of the meeting were: David Barry, MD, FACEP; Douglas Char, MD, FACEP; James Cusick, MD, FACEP, speaker; Kathleen Clem, MD, FACEP; Alison Haddock, MD, FACEP; Jonathan Heidt, MD, FACEP; Sarah Hoper, MD, FACEP; Chadd Kraus, DO, FACEP; Aisha Liferidge, MD, FACEP; Donald Lum, MD, FACEP; Michael McCrea, MD, FACEP; John McManus, MD, FACEP, vice speaker; Orlee Panitch, MD, FACEP; Tony Salazar, MD, FACEP; Annalise Sorrentino, MD, FACEP; Jennifer Stankus, MD, JD, FACEP; and Anne Zink, MD, FACEP.

Other members and guests present for all or portions of the meeting were: Sabina Braithwaite, MD, FACEP; Marco Coppola, DO, FACEP; Jon Mark Hirshon, MD, FACEP; Hans House, MD, FACEP; Tiffany Jackson, MD; William Jaquis, MD, FACEP, vice president; Christopher Kang, MD, FACEP; Paul Kivela, MD, FACEP, president-elect; Kevin Klauer, DO, FACEP; Rebecca Parker, MD, FACEP, president; Debra Perina, MD, FACEP; John Rogers, MD,FACEP, chair of the Board; Mark Rosenberg, DO, FACEP; and Gillian Schmitz, MD, FACEP.

Staff present for all or portions of the meeting were: Rachel Donihoo; Mary Ellen Fletcher, CPC, CEDC; Laura Gore; Pawan Goyal, MD; Margaret Montgomery, RN; Sonja Montgomery, CAE; Craig Price, CAE; Sandra Schneider, MD, FACEP; Gene Scruggs; Julie Wassom; Gordon Wheeler; Dean Wilkerson, JD, MBA, CAE; and Carole Wollard.

Officer and Staff Reports
Speaker

Dr. Cusick welcomed the committee and discussed preparations for the meeting.

Vice Speaker

Dr. McManus thanked everyone for their participation.

President

Dr. Parker reported on her media interviews, the AMA Interim Meeting, assignments she has made to implement the 2016 Council resolutions, and the status of ACEP's lawsuit against the Center for Consumer Information and Insurance Oversight (CCIIO). She also encouraged everyone to attend the upcoming Leadership & Advocacy Conference.

President-Elect

Dr. Kivela reported on the plans for revamping the ACEP website, the importance of the Clinical Emergency Data Registry (CEDR), out-of-network and balance billing challenges, and the wine tasting event that will be held at the Leadership & Advocacy Conference.

Executive Director

Mr. Wilkerson welcomed everyone to the new ACEP headquarters building. He reported on the 50th anniversary activities being planned, the upcoming Wellness Summit, and the current fiscal year budget challenges with the additional expenses for CEDR, the CCIIO litigation, and other increased expenses.

Steering Committee Expectations

Dr. Cusick reminded the Steering Committee of their expectation to attend the March 12, 2017, Steering Committee subcommittee meetings in Washington, DC and the entire Leadership & Advocacy Conference March 12-15. The Steering Committee will also meet at 6:00 pm on October 26, 2017, in Washington, DC, the evening prior to the Council meeting. Steering Committee members were also reminded that supporting NEMPAC and EMF is strongly encouraged as part of their leadership role.

Councillor Allocation

Dr. Cusick reported that councillor allocation for 2017 is 410, which is an increase of 16 councillors than were allocated for the 2016 meeting. Twelve chapters gained one councillor and one chapter gained two councillors. Two new sections, Event Medicine and Pain Management, were approved and met the minimum membership requirements of 100 members by December 31, 2016, adding two new councillors for 2017. The Medical Director's Section had 74 members and did not meet the minimum membership requirement of 100 members. The other 33 sections met the minimum membership requirement of 100 members and will have a councillor for the 2017 Council meeting.

2016 Council Meeting Minutes

The Steering Committee reviewed the draft 2016 Council meeting minutes. The minutes will be provided to the 2017 Council for approval at the annual meeting.

Tellers, Credentials, & Elections Committee Report

The Steering Committee reviewed a report from the Tellers, Credentials, & Elections Committee from the 2016 Council meeting, including the results of the demographic data questions. It was suggested that the Council be reminded of the importance, purpose, and need for accurate responses to the demographic questions and that the questions not be referred to as "practice" questions for testing the keypads.

The Annual Meeting Subcommittee will review the demographic data questions and provide suggestions for this year's questions.

Distribution of Council Meeting Materials

Ms. Montgomery provided a list of Council meeting items that are currently printed and distributed by first class mail. The mailing is sent to more than 800 individuals and all of the materials are available electronically. It was noted that some of the items are valuable to receive in print as well as electronically. The committee supported removing the printed campaign flyers, the NEMPAC Council Challenge flyer, and the EMF Council Challenge flyer from the first class mailing. Printed mailing of the candidate campaign flyers is referenced in the Candidate Campaign Rules, therefore, the committee will need to revise the Campaign Rules. Electronic distribution of the campaign flyers can still occur.

2017 Council Meeting

Dr. Cusick discussed various aspects of the 2016 Council meeting and requested suggestions for potential changes for the 2017 meeting. The committee discussed the Unanimous Consent Agenda and decided not to resubmit a Council Standing Rules resolution on unanimous consent for the 2017 Council meeting. The committee also discussed whether to issue printed badges to guests and other members attending the Council meeting. There was

consensus to provide adhesive name tags at Councillor Credentialing for guests to use rather than issue printed name badges.

The Annual Meeting Subcommittee will review the Town Hall meeting format and provide suggestions for potential topics for the 2017 meeting. The subcommittee will also review the demographic questions and provide suggestions for the 2017 questions.

Council Meeting Technology

Dr. Cusick led a discussion of the technology needs and requested suggestions for potential enhancements for the Council meeting. There was consensus that the current technology works well and additional enhancements were not identified. The committee also discussed the increased use and success of social media during the meeting.

Elections Process

Dr. McManus led a discussion of the campaign and election process for candidates. Dr. Coppola provided suggestions for changing the Candidate Forum. The committee supported continuing the current format of the Candidate Forum and suggested extending the time by 30 minutes.

The committee discussed an inquiry from a member about the ability to post their comments about a particular candidate or candidates on non-ACEP sites. The Campaign Rules only reference personal social media sites, however, the member was advised against promoting candidates on non-ACEP sites. There was consensus that ACEP cannot monitor and enforce social media postings by non-candidates.

The committee reviewed the Candidate Campaign Rules.

It was moved THAT THE CANDIDATE CAMPAIGN RULES, #13.K., BE AMENDED TO READ: COMMUNICATIONS AND/OR INTERVIEWS REGARDING CANDIDACY IN EMERGENCY MEDICINE NEWSLETTERS OR PUBLICATIONS OTHER THAN THOSE PUBLISHED BY ACEP ARE PROHIBITED. PUBLICATION ~~IN PEER-REVIEWED AND RESEARCH JOURNALS~~ ON ISSUES OTHER THAN CANDIDACY ARE ALLOWED. The motion was adopted.

The committee discussed the advisability of continuing the videos of each candidate.

It was moved THAT THE CAMPAIGN VIDEOS BE DISCONTINUED. The motion was not adopted.

There were mixed reactions about the usefulness of the videos, but there was consensus to develop additional guidelines for the videos

The committee discussed travel to chapters by the candidates and concurred that it is a barrier for some individuals to seek nomination because of the time and expense. The committee agreed that limitations on the candidate travel to chapters should be explored and potentially included in the Campaign Rules, however, there is not time to revise the rules for 2017 before this year's chapter meetings begin.

The Candidate Forum Subcommittee will discuss these issues in further detail and provide their recommendations to the Steering Committee.

Action on Resolutions

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2016, 2015, and 2014 Council meetings were provided for review. The reports will be assigned to the Annual Meeting Subcommittee for further review.

Subcommittee Appointments

Dr. Cusick asked for volunteers to serve on three subcommittees. The following subcommittees were appointed:

Annual Meeting Subcommittee: Dr.Clem (Chair), Dr. Haddock, Dr. Hoper, Dr. Kraus, Dr. Lum, Dr. Salazar, and Dr. Zink.

Bylaws & Council Standing Rules Subcommittee: Dr. Heidt (Chair), Dr. Barry, Dr. Liferidge, Dr. McCrea, and Dr.Sorrentino.

Candidate Forum Subcommittee: Dr. Cusick (Chair), Dr. Barry, Dr. Char, Dr. Heidt, Dr. Lum, Dr. McCrea, Dr. Panitch, Dr. Sorrentino, Dr. Stankus, and Dr. Zink.

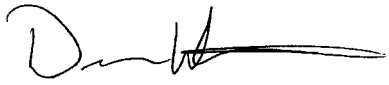
The subcommittee objectives and deadlines will be provided by e-mail. The subcommittee reports will be discussed at the June 26, 2017, Steering Committee meeting.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Monday, June 26, 2017, at the ACEP headquarters in Irving, TX.

With no further business, the meeting was adjourned at 2:45 pm Central time on Wednesday, January 18, 2017.

Respectfully submitted,



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

Approved by,

James M. Cusick, MD, FACEP
Council Speaker and Chair

American College of Emergency Physicians®
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Steering Committee Meeting
February 6, 2018
ACEP Headquarters
Irving, TX

Minutes

Speaker John McManus, MD, FACEP, called to order a regular meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:03 am Central time on Monday, February 6, 2018, at the ACEP headquarters in Irving, TX.

Steering Committee members present for all or portions of the meeting were: Michael Baker, MD, FACEP; Douglas Char, MD, FACEP; Melissa Costello, MD, FACEP; Sarah Hoper, MD, FACEP; Tiffany Jackson, MD; Gary Katz, MD, FACEP, vice speaker; Gabor Kelen, MD, FACEP; Chadd Kraus, DO, FACEP; Jeff Linzer, MD, FACEP; Heather Marshall, MD, FACEP; John McManus, MD, FACEP, speaker; Tony Salazar, MD, FACEP; Sullivan Smith, MD, FACEP; and Annalise Sorrentino, MD, FACEP.

Other members and guests present for all or portions of the meeting were: Stephen Anderson, MD, FACEP; Jon Mark Hirshon, MD, FACEP; Christopher Kang, MD, FACEP; Paul Kivela, MD, FACEP, president; Scott Pasichow, MD; John Rogers, MD, FACEP, president-elect; Gillian Schmitz, MD, FACEP; and Steven Stack, MD, FACEP.

Staff present for all or portions of the meeting were: Tanya Downing; Pat Elmes, EMT-P; Mary Ellen Fletcher, CPC, CEDC; Adam Krushinskie; David McKenzie, CAE; Margaret Montgomery, RN; Sonja Montgomery, CAE; Leslie Moore, JD; Shari Purpura; Loren Rives, MNA; Sandra Schneider, MD, FACEP; Gene Scruggs; Dean Wilkerson, JD, MBA, CAE; and Carole Wollard.

Officer and Staff Reports
Speaker

Dr. McManus welcomed everyone and discussed preparations for the meeting.

Vice Speaker

Dr. Katz thanked everyone for their participation and commitment to the College.

President

Dr. Kivela reported on the Board of Directors strategic planning retreat, the American Medical Association Interim meeting, and planning for the upcoming Leadership & Advocacy Conference.

President-Elect

Dr. Rogers reported on plans by Anthem to move forward with payment denials for certain emergency department visits. He discussed the meeting with Anthem he attended on December 21, 2017.

Executive Director

Mr. Wilkerson provided an update on several ACEP initiatives: 50th Anniversary; the Geriatric ED Accreditation Program; $600,000 grant to address opioids and mental illness; website redesign launch delayed until late March; Texas College of Emergency Physicians leasing space at ACEP; and providing management services to eight ACEP chapters.

Steering Committee Expectations

Dr. McManus reminded the Steering Committee of their expectation to attend the May 20, 2018, Steering Committee meeting in Washington, DC and the entire Leadership & Advocacy Conference May 20-235. The Steering Committee will also meet at 6:00 pm on Friday, September 28, 2018, in San Diego, the evening prior to the Council meeting. Steering Committee members were also reminded that supporting NEMPAC and EMF is strongly encouraged as part of their leadership role.

Councillor Allocation

Dr. McManus reported that councillor allocation for 2018 is 421, which is an increase of 12 councillors than were allocated for the 2017 meeting. Eleven chapters gained one councillor and one chapter gained two councillors. Three chapters lost one councillor. The new Social Emergency Medicine Section met the minimum requirements of 100 members by December 31, 2017, adding a new councillor for 2018. The Forensic Medicine Section had 98 members and will not have a councillor at the 2018 meeting. The other 35 sections met the minimum requirement of 100 members and will have a councillor for the 2018 Council meeting.

Tellers, Credentials, & Elections Committee Report

Dr. Costello presented a report from the Tellers, Credentials, & Elections Committee from the 2017 Council meeting, including the results of the demographic data questions. All 410 councillors allocated for the 2017 meeting were credentialed.

The Steering Committee discussed the Council Standing Rules (CSR) requirement to vote for four candidates for the Board of Directors on the first ballot (and sometimes subsequent ballots).

The Steering Committee also discussed the growth of the Council and whether the number of councillors should be capped. The Bylaws & CSR Subcommittee will review this issue and provide a recommendation to the Steering Committee.

The Annual Meeting Subcommittee will review the demographic data questions and provide suggestions for the 2018 questions.

2017 Council Meeting

Dr. McManus discussed various aspects of the 2017 Council meeting and requested suggestions for potential changes for the 2018 meeting. The committee agreed that the expanded format for the Candidate Forum should continue (2 hours instead of 90 minutes). It was also suggested: use the timer for all reports to the Council; the Speaker announce prior to adjourning to Reference Committees, and again after the Town Hall meeting, that entry into the rooms during the Candidate Forum is prohibited once a candidate begins speaking; and use signage to prevent entry in the rooms once a candidate begins speaking.

The Annual Meeting Subcommittee will review the Town Hall meeting format and provide suggestions for potential topics for the 2018 meeting. The subcommittee will also review the demographic questions and provide suggestions for the 2018 questions.

Leadership Diversity Task Force

Dr. Stack presented the task force's draft Council Standing Rules resolutions on "Codifying the Leadership Development Advisory Group (LDAG)," "Nominating Committee Charter Revision to Promote Diversity," and "ACEP Candidate Campaign Travel Rules." The committee provided comments on the LDAG and Nominating Committee resolutions and there was consensus to cosponsor both resolutions, subject to final review at the May 20, 2018, Steering Committee meeting. The committee agreed to discuss the proposed change to the Candidate Campaign Rules in conjunction with the elections process and Referred Resolution 20(17) Campaign Financial Reform.

Elections Process

Dr. McManus led a discussion of the campaign and election process and Referred Amended Resolution 20(17) Campaign Financial Reform. He reminded the Steering Committee that the Council Standing Rules give the Steering Committee the authority to develop and amend the Candidate Campaign Rules. Dr. Stack presented the "ACEP Candidate Campaign Travel Rules" resolution for consideration.

It was moved THAT THE STEERING COMMITTEE APPROVE AMENDING THE CANDIDATE CAMPAIGN RULES AS RECOMMENDED BY THE LEADERSHIP DIVERSITY TASK FORCE TO ADD THE FOLLOWING PREAMBLE TO THE CANDIDATE CAMPAIGN RULES:

THE ACEP COUNCIL IS RESPONSIBLE FOR ENSURING FAIR ELECTIONS THAT ALLOW THE FREE FLOW OF IDEAS BETWEEN CANDIDATES, COUNCILLORS, AND ALTERNATE COUNCILLORS TO MAXIMIZE THE PARTICIPATION OF QUALIFIED CANDIDATES IN THE ELECTION PROCESS. THE CAMPAIGN RULES ARE DESIGNED TO PROMOTE THE FOLLOWING:

- A FOCUS ON THE MERITS OF A CANDIDATE.
- EQUAL EXPOSURE TO COUNCILLORS AND ALTERNATE COUNCILLORS THROUGH ACEP MEETINGS, MEDIA, AND COMMUNICATIONS.
- EFFICIENT USE OF CAMPAIGN RESOURCES TO LIMIT CANDIDATE CAMPAIGN EXPENSES TO A REASONABLE AMOUNT NECESSARY TO PROVIDE THE CANDIDATE WITH SUFFICIENT EXPOSURE TO ACEP MEMBERS.

AND ADDING THE FOLLOWING TO PARAGRAPH 13:

A. ONCE THE NOMINATING COMMITTEE ANNOUNCES THE SLATE OF CANDIDATES FOR THE UPCOMING COUNCIL MEETING, EXCEPT FOR THEIR HOME CHAPTER, PRESIDENT-ELECT, BOARD OF DIRECTORS, SPEAKER, AND VICE SPEAKER CANDIDATES SHOULD NOT TRAVEL TO ACEP STATE CHAPTER MEETINGS UNTIL THE CONCLUSION OF THE ELECTIONS. THIS INCLUDES, BUT IS NOT LIMITED TO, EDUCATIONAL MEETINGS, CHAPTER BOARD OF DIRECTORS MEETINGS, OR CHAPTER FUND-RAISERS OTHER THAN FOR THE CANDIDATE'S HOME CHAPTER. A WRITTEN REQUEST FOR AN EXCEPTION MAY BE MADE TO THE COUNCIL SPEAKER FOR CANDIDATES NEEDING TO VISIT STATE CHAPTERS FOR PURPOSES OTHER THAN CAMPAIGNING SUCH AS LEGISLATIVE ASSISTANCE, OFFICIAL ACEP BUSINESS, OR PRIOR FACULTY COMMITMENTS TO EDUCATION PROGRAMS. IN SUCH INSTANCES, ACTIVE CAMPAIGNING IS NOT PERMITTED.
B. AFTER NOMINATIONS ARE ANNOUNCED BY THE NOMINATING COMMITTEE, PRESIDENT-ELECT, BOARD OF DIRECTORS, SPEAKER, AND VICE SPEAKER CANDIDATES MAY UTILIZE VIDEO OR AUDIO CONFERENCING METHODS TO COMMUNICATE WITH ACEP STATE CHAPTERS. THE USE OF THIS TECHNOLOGY WILL BE MONITORED BY THE COUNCIL STEERING COMMITTEE TO ENSURE FAIR USE.

The motion was adopted.

The committee also discussed the potential of holding a debate/town hall style discussion by the president-elect candidates. The Candidate Forum Subcommittee will discuss this suggestion and provide their recommendation to the Steering Committee on May 20.

Referred Resolution 21(17) Creation of an Electronic Council Forum

The Steering Committee raised several concerns about the resolution:

- cost/benefit and logistics of having an ongoing electronic Council meeting throughout the year

- limited human and financial resources
- many competing priorities and unsure that this project rises to a higher level of priority
- potential limited participation
- potential additional unwanted workload for councillors

There was consensus that the current process for conducting the annual Council meeting meets the Council's needs, but additional communication is needed to the Council about the features of the current website (external hosting by CommPartners) that is used to distribute all Council meeting materials. The website has a "chat" feature to discuss resolutions in advance of the Council meeting, in addition to using the Council e-list (c-mail) for discussion purposes. It was noted that many councillors and alternate councillors opt out of c-mail if there are numerous messages posted. Staff were directed to work with CommPartners to determine if the discussion/chat feature can be enhanced.

Resolution 25(17) Resolution Co-Sponsorship Memo

The Steering Committee discussed potential ways to address the resolution. Ms. Montgomery explained that the Council e-list, "c-mail," was created to serve as a forum for councillors to communicate throughout the year on any relevant topic, including development of resolutions in the early stages of development, in draft form, or after the resolutions have been released to the Council for the annual meeting. C-mail use has declined in recent years, perhaps because individuals experience "email fatigue" from the volume of various email accounts. Several councillors expressed concerns earlier this year, prior to the Council resolution submission deadline, when there were multiple messages posted about some draft resolutions and cosponsors were being sought. Unfortunately, several individuals requested to be removed from c-mail because of the increased number of messages. Ms. Montgomery also explained the process when multiple resolutions are submitted on the same topic. Staff attempt to work with the authors of similar resolutions to combine them, or submit one in lieu of another. Most often, the authors prefer to submit their initial resolution because of nuanced differences and/or the inability to reach consensus on the final wording of a single resolution. Dr. Katz provided a sample "Resolutions Preparation Checklist" that could be distributed to assist members with developing resolutions. The Council officers will work with staff to implement the resolution.

Action on Resolutions

Reports summarizing actions taken by the Board of Directors on resolutions adopted at the 2017, 2016, and 2015 Council meetings were provided for review. The reports were assigned to the Annual Meeting Subcommittee for further review.

Subcommittee Appointments

Dr. McManus asked for volunteers to serve on three subcommittees. The following subcommittees were appointed:

Annual Meeting Subcommittee: Dr. Salazar (Chair), Dr. Baker, Dr. Clem, Dr. Costello, Dr. Hoper, Dr. Kelen, Dr. Kraus, Dr. Linzer, Dr. Marshall, Dr. Pasichow, and Dr. Spano.

Bylaws & Council Standing Rules Subcommittee: Dr. Sorrentino (Chair), Dr. Baker, Dr. Clem, Dr. Char, Dr. Jackson, Dr. Linzer, Dr. Marshall, Dr. Pasichow, Dr. Smith, and Dr. Spano.

Candidate Forum Subcommittee: Dr. Katz (Chair), Dr. Char, Dr. Costello, Dr. Hoper, Dr. Jackson, Dr. Kelen, Dr. Kraus, Dr. Salazar, Dr. Smith, and Dr. Sorrentino.

The subcommittee objectives and deadlines will be provided by e-mail. The subcommittee reports will be discussed at the May 20, 2018, Steering Committee meeting.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Sunday, May 20, 2018, at the Grand Hyatt in Washington, DC.

With no further business, the meeting was adjourned at 2:15 pm Central time on Monday, February 6, 2018.

Respectfully submitted,

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

Approved by,

John G. McManus, Jr., MD, FACEP
Council Speaker and Chair

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Steering Committee Meeting
May 20, 2018
Grand Hyatt Washington
Washington, DC

Minutes

Speaker John McManus, MD, FACEP, called to order a regular meeting of the Council Steering Committee of the American College of Emergency Physicians at 8:07 am Eastern time on Sunday, May 20, 2018, at the Grand Hyatt Washington in Washington, DC.

Steering Committee members present for all or portions of the meeting were: Michael Baker, MD, FACEP; Douglas Char, MD, FACEP; Kathleen Clem, MD, FACEP; Melissa Costello, MD, FACEP; Sarah Hoper, MD, FACEP; Tiffany Jackson, MD; Gary Katz, MD, FACEP, vice speaker; Gabor Kelen, MD, FACEP; Chadd Kraus, DO, FACEP; Jeff Linzer, MD, FACEP; Heather Marshall, MD, FACEP; John McManus, MD, FACEP, speaker; Tony Salazar, MD, FACEP; Sullivan Smith, MD, FACEP; Annalise Sorrentino, MD, FACEP; and Susanne Spano, MD, FACEP.

Other members and guests present for all or portions of the meeting were: Stephen Anderson, MD, FACEP; Frederick Blum, MD, FACEP; Brooks Bock, MD, FACEP; Marco Coppola, DO, FACEP; James Cusick, MD, FACEP; J.T. Finnell, MD, FACEP; Vidor Friedman, MD, FACEP; Michael Gerardi, MD, FACEP; Jon Mark Hirshon, MD, FACEP; William Jaquis, MD, FACEP; Christopher Kang, MD, FACEP; Paul Kivela, MD, FACEP, president; Omar Maniya, MD; Angela Mattke, MD, FACEP; Michael McCrea, MD, FACEP; Scott Pasichow, MD; Debra Perina, MD, FACEP; John Rogers, MD, FACEP, president-elect; Mark Rosenberg, DO, FACEP; and Steven Stack, MD, FACEP.

Staff present for all or portions of the meeting were: Robert Heard, MBA, CAE; Sonja Montgomery, CAE; Sandra Schneider, MD, FACEP; and Pawan Goyal, MD, MHA.

Minutes

The minutes of the February 6, 2018, Steering Committee meeting were approved as written.

Officer and Staff Reports
Speaker

Dr. McManus thanked the Steering Committee subcommittees for their work and announced the 2018 Council awards recipients:

Council Meritorious Service Award – James Mitchiner, MD, MPH, FACEP
Council Teamwork Award – Washington Chapter
Council Horizon Award – Lisa Maurer, MD, FACEP
Council Champion in Diversity & Inclusion Award – Aisha Liferidge, MD, FACEP
Council Curmudgeon Award – Charles Pattavina, MD, FACEP

Dr. McManus announced the 2018 candidates.

President-Elect:	Vidor Friedman, MD, FACEP (FL)
	William Jaquis, MD, FACEP (MD)
Board of Directors:	L. Anthony Cirillo, MD, FACEP (RI)
	Kathleen Clem, MD, FACEP (FL)
	Francis Counselman, MD, FACEP (VA)

J.T. Finnell, MD, FACEP (IN)
Jeff Goodloe, MD, FACEP (OK)
Christopher Kang, MD, FACEP (incumbent – WA)
Michael McCrea, MD, FACEP (OH)
Mark Rosenberg, DO, FACEP (incumbent – NJ)
Thomas Sugarman, MD, FACEP (CA)

The Steering Committee discussed the number of Board candidates this year and whether there should be a set number of candidates per open position. There was consensus that the Nominating Committee should have the flexibility to put forward the best slate of candidates without limitation on the number of candidates.

Vice Speaker

Dr. Katz thanked everyone for their participation and commitment to the College.

President

Dr. Kivela reported on several key initiatives of the College.

Executive Director

Mr. Heard provided an update on Mr. Wilkerson's progress since his hip replacement surgery. He also reported on several ACEP activities: Website redesign, participation in the Clinical Emergency Data Registry, the Geriatric ED Accreditation Program, 50th Anniversary planning, $300,000 grant available to chapters regarding hemophilia, *ACEP18,* and changes to the Leadership & Advocacy Conference.

Annual Meeting Subcommittee

Dr. Salazar presented the subcommittee's report on their assigned objectives. The subcommittee reviewed the format and topics from previous Town Hall meetings and provided a list of proposed topics for the 2018 Town Hall meeting. The subcommittee did not recommend any changes to the format of the Town Hall meeting. There was consensus for the Town Hall meeting to focus on a single topic and presenting various aspects of the issue by high-level speakers/content experts and include time for Q & A. The Council officers will make the final determination about the format, topic, and speakers this summer

The subcommittee reviewed the Board's actions on 2015-2017 resolutions and concurred that the actions taken are consistent with the Council's expectations. The Actions on Resolutions reports will be updated this summer to reflect additional activity that may have occurred since February 2018. The updated reports will be provided to the 2018 Council and will also be available in the Council section of the ACEP Website. The subcommittee recommended that the Council speaker highlight some of the actions on the prior year's resolutions during his report to the Council.

The subcommittee concurred that certain demographic questions should be asked every year to analyze demographic changes within the Council and that the survey should be brief with a maximum of 10 questions. The Steering Committee reviewed the draft questions developed by the subcommittee. The questions will be finalized over the summer for approval by the Council officers.

Bylaws & Council Standing Rules Subcommittee

Dr. Sorrentino presented the subcommittee's report on their assigned objectives. The subcommittee reviewed the growth of the Council over the past 20 years and noted that growth has averaged 2.81%, (average of 9 additional councillors) per year. Various options for limiting the number of councillors were discussed, 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 to pursue limiting the maximum number, but not on the method to do so. The subcommittee prepared a draft resolution for the 2018 Council directing the Speaker 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 maximum number of councillors allowed for each component body. There was consensus to submit the resolution to the 2018 Council.

The subcommittee discussed a suggestion that the Council Standing Rules (CSR) be amended to allow that all motions to amend resolutions (based on the Reference Committee recommendations) submitted will be presented to the Council before voting on the final version of the resolution or closing debate can occur. The subcommittee discussed the amendment process and parliamentary procedure and did not reach consensus on implementing this idea or how it could be accomplished. The Steering Committee did not support developing a resolution to amend the CSR in this manner.

President-Elect's Report

Dr. Rogers addressed the Steering Committee.

Leadership Diversity Task Force

Dr. Perina presented the task force's draft Council Standing Rules resolutions "Codifying the Leadership Development Advisory Group (LDAG)" and "Nominating Committee Charter Revision to Promote Diversity."

It was moved THAT THE STEERING COMMITTEE APPROVE COSPONSORING THE COUNCIL STANDING RULES RESOLUTIONS "CODIFYING THE LEADERSHIP ADVISORY GROUP (LDAG)" AND "NOMINATING COMMITTEE CHARTER REVISION TO PROMOTE DIVERSITY." The motion was adopted.

Candidate Forum Subcommittee Report

Dr. Katz presented the subcommittee's report on their assigned objectives. He reported that the majority of the objectives will be completed this summer and during the 2018 Council meeting.

The subcommittee discussed holding a 30-minute debate/town hall discussion (not a pro/con stance) with the president-elect candidates in the main Council meeting room after the Town Hall meeting with questions posed by the subcommittee and the audience. The president-elect candidates would also be allowed to provide a one-minute closing statement. The Steering Committee supported this change to the agenda and limiting the Town Hall meeting to one hour. The Candidate Forum for the Board of Directors candidates will still occur in the Reference Committee hearing rooms from 2:45 – 4:30 pm.

The subcommittee agreed that questions for all candidates should continue to be solicited from the audience, but also through c-mail two weeks prior to the Council meeting. The subcommittee will continue to review all questions submitted and determine the questions that will be asked during the Candidate Forum.

2018 Council Meeting Agenda

Dr. McManus reviewed the Council meeting agenda, which includes the change to shorten the Town Hall meeting and add the separate Candidate Forum for the president-elect candidates.

Criteria for Council Meritorious Service Award and Council Horizon Award

The Steering Committee reviewed the criteria for the Council Meritorious Service (CMS) Award and the Council Horizon Award and discussed whether any changes should be made. There was consensus to remove the 3-year service requirement for the CMS Award and include service as an alternate councillor. There was also consensus to retain the current criteria for the Horizon Award to recognize individuals within the first five years of their Council service.

Next Meeting

The next meeting of the Council Steering Committee is scheduled for Friday, September 28, 2018, at the Manchester Grand Hyatt in San Diego, CA.

With no further business, the meeting was adjourned at 11:47 am Eastern time on Sunday, May 20, 2018.

Respectfully submitted,

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

Approved by,

John G. McManus, Jr., MD, FACEP
Council Speaker and Chair

American College of Emergency Physicians®
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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.

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
Sam Shahid, MBBS, MPH
Travis Schulz, MLS, AHIP

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

DEFINITION OF COUNCIL ACTIONS

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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*

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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. 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

American College of Emergency Physicians®
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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
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)

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

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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*
50	In Memory of John E. Campbell, MD, FACEP *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*
51	In Memory of Adib Mechrefe, MD, FACEP *Rhode Island Chapter*

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.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2018 Council

From: Dean Wilkerson, JD, MBA, FACEP
Executive Director and Council Secretary

Date: September 10, 2018

Subj: Compensation Committee Report

The Compensation Committee has not yet developed their recommendations for Board member and officer stipends for FY 2018-19. The committee will hold a meeting in San Diego on Monday, October 1 to discuss their recommendations. The committee's recommendations will be discussed by the Board at their meeting on October 4.

The Compensation Committee's report will be distributed to the Council as soon as it is available The Council will also be informed if the Board does not adopt the recommendations as proposed.

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2018 Town Hall Meeting
Saturday, September 29, 2018
Manchester Grand Hyatt, Grand Hall A-C, Lobby Level
12:45 pm – 1:45 pm

Single Payer: Has the Time Finally Arrived?

Moderator: Michael J. Gerardi, MD, FACEP

Discussants: James C. Mitchiner, MD, FACEP
Todd B. Taylor, MD, FACEP

Session Format: The Town Hall Meeting is open to everyone attending the Council meeting. Seating is open without restriction to the Council floor. Each discussant will represent their assigned position and respond to questions posed by the moderator and the participants. The audience is invited – *and expected* – to express uninhibited opinions and to ask challenging questions of the presenters.

Description: A point-counterpoint/lively debate of the findings and recommendations of the Health Care Financing Task Force will emphasize:

1. Single Payer can equal a "Medicare for All" and many other things as well.
2. Single Payer / Government-Financed health care does not necessarily mean that the government will manage it.
3. Market-based health care can exist as it does now or with Single Payer.
4. Single Payer should not be conflated with universal health care and access, although they are inextricably linked and related.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2018 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 25, 2018

Subj: Action on 2017 Resolutions

The 2017 Council considered 62 resolutions: 39 were adopted, 5 were not adopted, 5 were withdrawn, 11 were referred to the Board of Directors, and 2 were referred to the Council Steering Committee.

The attached report summarizes the actions taken on the 2017 resolutions adopted by the Council and those that were referred to the Board and to the Council Steering Committee.

The actions on resolutions are also included on the ACEP Website. This report will be added when the new Website is launched in April 2018.

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Action on 2017 Council Resolutions

Resolution 1 Commendation for James M. Cusick, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends James M. Cusick, MD, FACEP, as a practicing emergency physician rendering excellent care to the patients we serve, for his leadership in the College as Council Vice Speaker and Council Speaker over the past four years, and for his lifetime of service and dedication to the specialty of Emergency Medicine.

Action: A framed resolution was presented to Dr. Cusick.

Resolution 2 Commendation for Robert E. O'Connor, MD, MPH, FACEP

RESOLVED, That the American College of Emergency Physicians commends Robert E. O'Connor, MD, MPH, 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.

Action: A framed resolution was presented to Dr. O'Connor.

Resolution 3 Commendation for Gordon B. Wheeler

RESOLVED, That the American College of Emergency Physicians commends Gordon B. Wheeler for his service as Associate Executive Director of Public Affairs.

Action: A framed resolution was presented to Mr. Wheeler.

Resolution 4 In Memory of Charles of R. Bauer, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Charles R. Bauer, 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 Charles R. Bauer MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of Texas and the United States.

Action: A framed resolution was prepared for Dr. Bauer's family.

Resolution 5 In Memory of Diane Kay Bollman

RESOLVED, That ACEP and the Michigan College of Emergency Physicians hereby acknowledges the many contributions made by Diane Kay Bollman as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That ACEP and the Michigan College of Emergency Physicians extend to the family of Diane Kay Bollman, her friends, and her colleagues, our condolences along with our profound gratitude for her tremendous service to the specialty of emergency medicine, Michigan emergency physicians, and patients, who will never fully know her impact, across the United States and likely beyond.

Action: A framed resolution was prepared for Ms. Bollman's family.

Resolution 6 In Memory of Aaron T. Daggy, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Aaron T. Daggy, MD, FACEP, as one of the leaders in pre-hospital medicine, EMS and fire, and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Aaron T. Daggy, 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 New York and the United States.

Action: A framed resolution was prepared for Dr. Daggy's family.

Resolution 7 In Memory of Geoffrey E. Renk, MD, PhD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Geoffrey Edmund Renk, MD, PhD, 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, Lisa Flaggman, 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 South Carolina and the United States.

Action: A framed resolution was prepared for Dr. Renk's family.

Resolution 8 In Memory of Salvatore Silvestri, MD

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the contributions made by Sal Silvestri, MD, as a leader in emergency medicine and EMS; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family, friends, and colleagues of Sal Silvestri, MD, our deepest sympathy, our great sense of sadness and loss, and our gratitude for having been able to learn so much from a kind, gentle, caring leader in our emergency medicine world.

Action: A framed resolution was prepared for Dr. Silvestri's family.

Resolution 9 In Memory of Robert Wears, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Robert Wears, MD, FACEP, as one of the leaders in emergency medicine and a true pioneer of the specialty; and be it further

RESOLVED, That national ACEP and the Florida College of Emergency Physicians extends to his wife, Dianne Wears, his children and grandchildren, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialty of emergency medicine.

Action: A framed resolution was prepared for Dr. Wears' family.

Resolution 10 Chapter Bylaws Conformance Standards – Housekeeping Change – Bylaws Amendment

RESOLVED, That the ACEP Bylaws Article VI – Chapters, Section 2 – Chapter Bylaws, paragraph 1, be amended to read:

A petition for the chartering of a chapter shall be accompanied by the proposed bylaws of the chapter. No charter shall be issued until such bylaws are approved by the Board of Directors of the College. Chartered chapters must ensure that their bylaws conform to the College Bylaws and ~~to the "Guidelines for Bylaws and Model Chapter Bylaws for Chapters of the American College of Emergency Physicians."current approved~~ **chapter bylaws guidance documents**. Proposed amendments to the bylaws of a chapter shall be submitted in a format and manner designated by the College not later than 30 days following the adoption of such proposed amendments by the chapter, pursuant to its bylaws and procedures. No proposed amendment shall have any force or effect until it has been approved by the Board of Directors of the College. A proposed amendment shall be considered approved if the Board of Directors or its designee fails to give written notice of any objection within 90 days of receipt as documented by the College.

Action: The Bylaws were updated.

Resolution 12 Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 5 – Voting Rights, paragraph two, be amended to read:

"ACEP Past Presidents**,** ~~and ACEP~~ Past Speakers, **and Past Chairs of the Board,** if not certified as councillors or alternate councillors by a sponsoring body, may participate in the Council in a non-voting capacity. Members of the Board of Directors may address the Council on any matter under discussion but shall not have voting privileges in Council sessions."

Action: The Bylaws were updated.

Resolution 13 Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment

RESOLVED, That the "Debate" section, paragraph one, of the Council Standing Rules be amended to read:

"Councillors, members of the Board of Directors, past presidents, ~~and~~ past speakers**, and past chairs of the Board** wishing to debate should proceed to a designated microphone. As a courtesy, once recognized to speak, each

person should identify themselves, their affiliation (i.e., chapter, section, Board, past president, past speaker, **past chair,** etc.), and whether they are speaking "for" or "against" the motion;" and be it further

RESOLVED, That the "Nominations" section, paragraph one, of the Council Standing Rules be amended to read:

"A report from the Nominating Committee will be presented at the opening session of the Annual Council Meeting. The floor will then be open for additional nominations by any credentialed councillor, member of the Board of Directors, past president, ~~or~~ past speaker**, or past chair of the Board**, after which nominations will be closed and shall not be reopened;" and be it further

RESOLVED, That the "Past Presidents and Past Speakers Seating" section of the Council Standing Rules be amended to read:

"Past Presidents**,** ~~and~~ Past Speakers**, and Past Chairs of the Board** Seating"

"Past presidents**,** ~~and~~ past speakers**, and past chairs of the Board** of the College are invited to sit with their respective component body, must wear appropriate identification, and are granted full floor privileges except the right to vote unless otherwise eligible as a credentialed councillor."

Action: The Council Standing Rules were updated.

Resolution 18 ACEP Wellness Center Services

RESOLVED, That ACEP explore alternative funding opportunities (e.g., use of personal insurance reimbursement and/or sponsorship by third parties) to restore the traditional (and possibly expanded) services available at the Annual Conference Wellness Center; and be it further

RESOLVED, That ACEP explore ways to better promote available resources for the wellness center at the Annual Conference and in general throughout the year.

Action: Assigned to the Well-Being Committee, Corporate Development staff, and Member Communications & Marketing staff. Several changes have been made for the 2018 Wellness Center and have been publicized on the ACEP website and other ACEP communications:

- Reinstated blood draws for 2018 and increased the fee to cover the cost.
- Reviewed the burnout survey and added online capability or iPad on site.
- Moved the pet therapy booth next to the wellness pod.
- Individual tasked with a hand clicker, scanner, wall-based scanned (how to incentivize attendees to scan their own badge on a wall) have giveaways of wellness t-shirt etc. to incentivize people to scan in be counted as a visitor.
- Wellness Center backdrop with hashtag to encourage group photos.
- Increase the speaker volume and add TED talk signage.
- Allow freelance drawing instead of an artist's mural.
- Additional signage to promote the Story Booth.
- Additional seating, background music, and charging stations.
- Promote the Wellness Center on social media.
- Provide fun photo opportunities.
- Distribute buttons, t-shirts, and a water bottle with the wellness logo or #Wellness.
- Ask Wellness Champions to announce speakers.

Resolution 22 Funding of Emergency Medicine Training (as amended)

RESOLVED, That ACEP work with the appropriate organizations to optimize GME funding for all formats of emergency medicine training.

Action: Assigned to the ACEP-SAEM GME Work Group and to the Public Affairs staff for advocacy initiatives.

Resolution 23 Information Sharing, Regular ACEP/Chapter Contact, and Regional State/Chapter Relationships (as amended)

RESOLVED, That ACEP work with state chapters to identify, develop, and implement processes that enhance the relationship, optimizing appropriate and timely information sharing; and be it further

RESOLVED, That individual Board members and an appropriate staff member participate in regular contact with state chapters and report back to the Council in 2018.

Action: Assigned to the National/Chapter Relations Committee and Chapter & State Relations staff. The following strategies were implemented:

1. Implement Basecamp as a collaboration tool for sharing information and resources between chapter executives. See report on objective #5.
2. Regular communication from national to the chapters with information about Board meetings, communications from the president, and ACEP Leadership Updates.
3. Regular communication about national activities, programs, partnerships, opportunities, etc. to chapter executives and chapter presidents with encouragement to include relevant notifications in communications to chapter members as appropriate.
4. Continued to hold bi-annual all-chapter audio conferences.
5. Continued to provide funding for the Chapter Leader Visit Rotation Program (national ACEP provides funding for national leaders to visit up to 20 chapters each year).
6. Send "Welcome" letters to newly installed/elected chapter presidents (with copy to the chapter executive director). The letter highlights the resources and support provided by national ACEP to chapters.
7. Held a Chapter Leadership session at LAC18. This addition to the LAC program was for current or aspiring chapter leaders and offered strategies for effectiveness in their role. The format consisted of panel presentations with past or current chapter leaders, chapter executives and/or ACEP staff, and was moderated by ACEP Board members. Topics included state advocacy, chapter finances, how to be an effective chapter leader, how to create an effective and diverse Board, and succession planning.
8. ACEP launched a new online community, engaged. Additional community groups could be created for many topic areas or groups, such as Chapter Officers to discuss issues, share resources, ask questions and Chapter Membership Chairs to share best practices, challenges on membership recruitment, retention, and engagement.

Resolution 25 Resolution Co-Sponsorship Memo

RESOLVED, That the Council Steering Committee develop and promote a standardized format for a "co-sponsorship memo" that can be distributed through the Council listserve or other platform so that councillors may collaborate and further refine resolutions prior to submission.

Action: The Council Steering Committee discussed the resolution at their February 6, 2018, meeting. The new engagED community platform will be implemented for the Council after *ACEP18.* This platform will provide the means for collaboration and information sharing.

Resolution 26 Study of Locums Physicians Representation (as amended)

RESOLVED, That the ACEP Board study the impact and potential membership benefit of a new chapter or section representing locums physicians and report back to the Council at the 2018 meeting.

Action: The section petition has now reached more than 100 potential members. The Board approved formation of the section at their February 6, 2018, meeting. The Steering Committee discussed the resolution at their February 5, 2018, meeting and interpreted that formation of the section met the intent of the resolution. Authors of the original resolution clarified that the intent of the resolution was to conduct a study because the section may not meet be sufficient to meet the needs of locums physicians. The Membership Committee was assigned an objective for 2018-19 to conduct the study.

Resolution 27 9-1-1 Number Access and Prearrival Instructions

RESOLVED, That ACEP create a policy statement supporting 9-1-1 number access to a Public Safety Answering Points for 100% of the U.S. population at next generation 9-1-1 level; and be it further

RESOLVED, That ACEP create and advocate for broad recognition of a policy statement supporting every Public Safety Answering Point or EMS dispatch point be able to give appropriate medical prearrival instruction for bystander aid, including CPR and hemorrhage control, and include EMS physician involvement in their creation, implementation, and quality improvement activities; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to inventory and summarize models for 9-1-1 and Public Safety Answering Point funding as a resource for areas in need of increased service levels; and be it further

RESOLVED, That ACEP work with appropriate stakeholders to engage in development of model legislation incorporating enduring funding streams for 9-1-1 call centers/Public Safety Answering Points incorporating key elements including: bringing systems to at least the next generation 9-1-1 level, providing medically appropriate prearrival instructions, and incorporating EMS physician involvement in quality oversight, response profiles, and prearrival instructions.

Action: Assigned to the EMS Committee with input from the State Legislative/Regulatory Committee and Chapter & State Relations staff.

In December 2017, ACEP was invited by the National Highway Traffic Safety Administration(NHTSA) to participate as a stakeholder in the Next Generation 911 (NG911) project. The primary author of this resolution was recommended to serve as ACEP's representative on the project.

The Board approved the policy statement "Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch & Public Emergency Aid Training" in June 2018.

Resolution 28 Coverage for Patient Home Medication While Under Observation Status (as amended)

RESOLVED, That ACEP support the coverage of all administered medications for patients under observation status without having to apply for reimbursement; and be it further

RESOLVED, That ACEP support a goal that patient out-of-pocket expenses for observation be no greater than the cost to the patient for inpatient services.

Action: This resolution is a policy statement. Assigned to the Reimbursement Committee to review and determine if additional language is needed in the policy statement. Assigned to Public Affairs staff to include in federal advocacy initiatives. The Board approved the policy statement "Coverage for Patient Home Medication While Under Observation Status" in June 2018.

Resolution 29 CPR Training (as amended)

RESOLVED, That ACEP draft model state legislation and assist chapters in advocating for CPR training in schools; and be it further

RESOLVED, That ACEP work with other stakeholder organizations to advocate for legislation to support CPR training in schools; and be it further

RESOLVED, That ACEP work with other stakeholder organizations to advocate for increased CPR training for laypersons.

Action: Assigned to the State Legislative/Regulatory Committee and Chapter & State Relations staff with input from the EMS Committee. The committee collaborated with the EMS committee and obtained material from outside resources to develop a toolkit of resources. The resources are available on the ACEP website.

ACEP has taken an active role in supporting and sponsoring layperson CPR training through partnering with the Texas College of Emergency Physicians for the Texas Two-Step Hands-Only CPR training in 2017 where 6,500 were trained across the state. During EMS Week 2017, ACEP partnered with the International Association of Fire Chiefs (IAFC) and American Medical Response (AMR) to sponsor the World CPR Challenge where more than 68,000 bystanders were trained nationwide.

In June 2018, the Board approved ACEP pursuing development of a program for laypersons to stop bleeding and render CPR. A business plan is being developed.

Resolution 30 Demonstrating the Value of Emergency Medicine to Policy Makers and the Public (as amended)

RESOLVED, That a repository of public relations materials demonstrating the value of emergency medicine, including printed, video, and other information including emergency medicine economic research be assembled on the ACEP web site and such materials would be accessible to all members of ACEP who wish to reach specific target markets; and be it further

RESOLVED, That specific public relations materials regarding the value of emergency medicine be developed for legislators, which would include printed material and materials in various electronic formats; and be it further

RESOLVED, That the ACEP Board of Directors provide a report to the 2018 Council on the development and distribution of public relations materials demonstrating the value of emergency medicine to policy makers and the public.

Action: Assigned to the Public Relations Committee and Public Relations staff. The Board of Directors approved funding of up to $100,000 in October 2017 to fund a study on the value and cost effectiveness of emergency care.

A repository of materials was developed demonstrating the value of emergency medicine and is available on the ACEP website. Additionally:

- Developed a new fact sheet about the value of emergency medicine.
- As part of promoting ACEP's 50th anniversary, filmed and posted dozens of one-minute videos of members telling their stories about the value of emergency medicine.
- Developed and promoted a public opinion poll about the value of emergency medicine. The poll results found high trust and high satisfaction for emergency care.

- Continued to promote the Saving Millions campaign to policymakers and the general public Campaign tools included web and print advertising in Washington, DC, policymaker publications and included a link to ACEP's website www.SavingMillions.org.

Resolution 31 Development and Study of Supervised Injection Facilities (as amended)

RESOLVED, That ACEP join their partner organization, the American Medical Association, in supporting the development and study of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision and endorse Supervised Injection Facilities for their feasibility, effectiveness, and legal aspects as a potential public health intervention in areas and communities heavily impacted by IV drug use.

Action: Assigned to the Public Health & Injury Prevention Committee. The committee is developing an information paper and their work will continue in 2018-19.

Resolution 32 Essential Medicines (as amended)

RESOLVED, That ACEP 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 be it further

RESOLVED, 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;

Action: Assigned to the Federal Government Affairs Committee to include in ACEP's legislative priorities and to Public Affairs staff to include in federal advocacy initiatives. This issue was included in the Legislative and Regulatory Priorities for the Second Session of the 115th Congress.

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.

On September 20, 2018, ACEP President Paul Kivela, MD, MBA, FACEP, participated in a drug shortage summit hosted by the American Society of Anesthesiologists, the American Hospital Association, and the American Society of Health-System Pharmacies. The summit focused on the national security aspect of drug shortages and ways to improve the resilience of the nation's health care infrastructure. Many of the speakers were federal employees representing HHS, ASPR, FDA, CDC, and the Defense Logistics Agency (DLA) who engaged the attendees in discussions on how their programs could work better to facilitate patient care, improve transparency and communications, and more effectively utilize the supply chain capacity.

Resolution 34 Generic Injectable Drug Shortages (as amended)

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

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.

Action: Assigned to Public Affairs staff to pursue this initiative through appropriate channels, such as continued involvement with the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor, and business groups. NCHC is currently engaged in drug shortages/pricing initiatives, including the Campaign for Sustainable Rx Pricing.

ACEP met and consulted with other medical specialties 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 that a member of Congress was looking into possible legislation to repeal the safe harbor repeal but ultimately declined to do so. ACEP 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), but unfortunately it was not included in the committee report accompanying the legislative text.

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.

Resolution 36 Maternity and Paternity Leave (as amended)

RESOLVED, That ACEP advocate for paid parental leave for emergency physicians; and be it further

RESOLVED, That ACEP develop an information paper on best practices regarding paid parental leave for emergency physicians; and be it further

RESOLVED, That ACEP's Board of Directors report their findings at the 2018 ACEP Council.

Action: Assigned to the Well-Being Committee. The committee revised the "Family Leave of Absence" policy statement to include the tenets of the resolution. The Board will review the revised policy statement at their October 4, 2018, meeting.

Resolution 39 ACEP Involvement in State Legislative Activities (as amended)

RESOLVED, That ACEP develop policy that addresses ACEP involvement in state level regulatory and legislative agendas, including direct lobbying efforts, by in coordination with the state chapter and consistent with ACEP policy; and be it further

RESOLVED, That ACEP present a policy that addresses ACEP involvement in state level regulatory and legislative activities for consideration and comment at the 2018 Council meeting.

Action: Assigned to the State Legislative/Regulatory Committee. In May 2018, the Board approved the following policy: "If a conflict arises between a chapter and national ACEP regarding a state legislative issue, national ACEP leadership must consider whether the disagreement is a matter of strategy or a matter of policy. on issues of strategy, national should defer to the chapter, given the chapter's better understanding of local political dynamics. on issues of policy, national should intervene if the issue is material to the specialty or counter to existing ACEP policy. First, national ACEP should take action to find a position that is in the best interests of the specialty and the chapter by reaching out to the chapter leadership. if no compromise can be reached, then national ACEP may choose to take a position that differs from the chapter position and would become the official position of the specialty."

Additionally, the Board approved the following actions: 1) increase frequency and improve quality of communication between chapters and the national ACEP Board and staff on important state legislative issues to help prevent disagreements from arising; 2) direct the State Legislative/Regulatory Committee and the National/Chapter Relations Committee to investigate alternate methods to convene representatives from a chapter or multiple chapters for consultation between council meetings in the case of important state legislative issues requiring further urgent discussion.

Resolution 40 Reimbursement for Emergency Services (as amended)

RESOLVED, That the policy of many third party payers of denying payment for Emergency Medical Services is in opposition to the prudent layperson definition of an emergency and federal EMTALA laws; and be it further

RESOLVED, That ACEP 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; and be it further

RESOLVED, That ACEP, in order to promote public health and patient safety, continue to uphold federal EMTALA laws by providing a medical screening examination and appropriate medical care to all patients who request emergency services and ACEP will advocate for subsequent reimbursement for such services; and be it further

RESOLVED, That ACEP continue to advocate for our patients to prevent any negative clinical or financial impact caused by the lack of reimbursement for emergency medical services; and be it further

RESOLVED, That ACEP partner with affected states and the American Medical Association to oppose this harmful policy and the denial of payment for emergency services.

Action: This resolution is being addressed through the work of the Reimbursement Committee, the ACEP/EDPMA Joint Task Force on Reimbursement Issues, and federal advocacy initiatives by ACEP's Public Affairs staff. The AMA adopted a resolution in June 2017 that addresses these issues and also sent a letter to Anthem on June 29, 2017, asking Anthem to rescind the policy citing federal patient protections under PLP, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage. ACEP sent a letter to the president and CEO of Anthem on August 1, 2017, regarding their announcement to deny coverage for ED care in several states. ACEP, and many individual members, have participated in media interviews (Associated Press, Modern Healthcare, The New York Times, Time Magazine, ABC News, The Washington Post, and others) to bring national attention to Anthem's assault on the prudent layperson standard in the denial of payment for emergency services. In December 2017, ACEP issued press releases about Anthem's denial of payments in Ohio and New Hampshire. In late December 2017, ACEP met with representatives of Anthem to discuss their announced policy that ACEP contends are in violation of federal and state law protecting patients according to the prudent layperson standard. ACEP continues to meet with members of Congress to educate them about denial of payment for emergency services by several payers.

The AMA has developed model legislation, "Patient Protections from Unanticipated Out-of-Network Care Act," that includes recommended language provided by ACEP. Physicians for Fair Coverage (PFC) has formally adopted a "skinny version" of the original AMA model with the network adequacy and assignment of benefits provisions removed. The majority of the remaining PFC model mirrors the AMA bill, except that the AMA bill would set out of network payment at the lesser of the physician's actual charge or the 80th percentile of an independent charge database, and the PFC model simply sets payment at the 80th percentile of a charge database. Arguments can be made in support of either approach, but the two model bills are largely complementary and attempt to drive a positive legislative resolution to this issue that is being fought out in state legislatures across the country. The PFC model bill was introduced in Kentucky and Oklahoma. The Board of Directors will discuss the model legislation (AMA and PFC) at their February 7, 2018, meeting.

On January 16, 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25). On July 17, 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court in an effort to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients. To read the lawsuit, click here.

Following five years of meetings and attempts by ACEP staff to obtain an explanation from the United States Center for Consumer Information and Insurance Oversight (CCIIO) regarding the methodology used in the 2010 Interim Final Rule governing payments of out-of-network emergency services, ACEP filed suit on May 12, 2016, against the Departments of Health & Human Services, Labor, and Treasury ("the Departments") challenging the Greatest-of-Three ("GOT") regulation. On August 31, 2017, the U.S. District Court for the District of Columbia (the "Court") partially granted ACEP's Motion for Summary Judgment and denied the Government's Cross Motion for Summary Judgment, finding that the Departments failed to seriously respond to comments and proposed alternatives submitted by ACEP and others regarding perceived problems with the GOT regulation. On April 30, 2018, the Departments published in the *Federal Register* the "Clarification of Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act". In this final regulation, the Departments declined to revise or rescind the rule, instead reaffirming it and rejecting ACEP's proposal to use an independent database to set payment rates. On May 19, 2018, the Board of Directors approved dismissing the lawsuit based upon recommendation of legal counsel, noting that the suit was successful in providing the College with valuable information, such as the "NORC Report," and sent a strong message that ACEP will fight on behalf of the rights of its members; however, the likelihood of ultimately prevailing was low and ACEP's legal resources could be best utilized in other arenas. Based upon a Joint Stipulation of Dismissal filed with the Court on May 23, 2018, Judge Colleen Kollar-Kotelly signed the Order dismissing the case. In June 2018, the Board discussed legislative and regulatory strategies and next steps for pursuing the Greatest-of-three methodology governing payments for out-of-network emergency services with CCIIO.

Resolution 43 Expanding ACEP Policy on Workforce Diversity in Health Care Settings (as amended)

RESOLVED, That ACEP expand its policy statement "Workforce Diversity in Health Care Settings" to help identify and promote inclusion of qualified individuals with additional diverse characteristics (including racial and ethnic diversity, as per existing policy) and amend it to read:

The American College of Emergency Physicians believes that:

- Hospitals and emergency physicians should work together to promote staffing of hospitals and their emergency departments with qualified individuals of diverse race, ethnicity, sex (including gender, gender identity, sexual orientation, pregnancy, marital status), nationality, religion, age, ability or disability, and other characteristics that do not otherwise preclude an individual emergency physician from providing equitable, competent patient care; and
- Attaining diversity with well-qualified physicians in emergency medicine that reflects our multicultural society is a desirable goal.

Action: The policy statement was revised.

Resolution 44 Guidelines for Opioid Prescribing in the ED

RESOLVED, That ACEP encourage electronic medical record providers to incorporate easy-to-use Prescription Monitoring Programs functionality into their products; and be it further

RESOLVED, That ACEP strongly discourage mandates for screening all emergency department patients for opioid use; and be it further

RESOLVED, That ACEP promote development of national guidelines to assist emergency physicians in their practice of prescribing opioids for acute pain.

Action: Assigned to the Emergency Medicine Practice Committee to review ACEP's current policy statements to determine if revisions are needed and review the current resources available to determine if additional resources are needed. ACEP's clinical policy "Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department" is currently under review by the Clinical Policies Committee.

The Emergency Medicine Practice Committee reviewed the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment." The policy statement supports ACEP chapter autonomy to establish and coordinate evidence-based pain management guidelines that promote access to appropriate pain control with physician clinical judgement. The EQUAL Network has also developed guidelines in association with the EQUAL Opioid Management focus area.

On June 12, 2018, two bills were passed in the House of Representatives that were championed by ACEP:

- **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.

Resolution 49 Participation in ED Information Exchange and Prescription Drug Monitoring Systems

RESOLVED, That the American College of Emergency Physicians collaborate with the Department of Veterans Affairs, Department of Defense, the Indian Health Services, and potentially legislatures to encourage and facilitate their participation in state prescription drug monitoring programs; and be it further

RESOLVED, That the American College of Emergency Physicians collaborate with the Department of Veterans Affairs, Department of Defense, the Indian Health Services, and potentially legislatures, to encourage and facilitate their participation, to the extent consistent with federal law, a system for real-time electronic exchange of patient information, including recent emergency department visits and hospital care plans for frequent users of emergency departments.

Action: Assigned to Public Affairs staff to work with the cited agencies and to Chapter & State Relations staff to support chapter advocacy efforts for adoption of EDIE programs and implementation of effective state prescription drug monitoring programs. ACEP's Legislative and Regulatory Priorities for the Second Session of the 115th Congress include "support funding for voluntary, interstate prescription drug monitoring programs" and "promote DoD, VA, and HIS prescription data sharing with state PDMPs."

An ACEP-developed provision that requires the Department of Defense to share controlled substance prescribing information of TRICARE beneficiaries with State Prescription Drug Monitoring Programs was successfully passed into law as part of H.R.5515, the John S. McCain National Defense Authorization Act for Fiscal Year 2019. ACEP staff worked closely with Representative Mike Turner (D-OH) to develop this legislative effort and ensure its inclusion in this year's defense authorization bill.

Resolution 51 Retirement or Interruption of Clinical Emergency Medicine Practice

RESOLVED, ACEP study and evaluate mechanisms to support practicing emergency physicians to help recognize potential physical and emotional limitations to clinical practice, to educate members about alternatives and opportunities for temporary interruption of active clinical practice to include mechanisms for reintegration back into clinical practice, and to support members considering career transitions including retirement; and be it further

RESOLVED, That ACEP actively engage in developing resources and communication of career transition opportunities to members, including support for members who believe they are being restricted from practice for discriminatory reasons as outlined and regulated by established federal equal employment opportunity discrimination laws.

Action: Assigned to the Well-Being Committee to review ACEP's current resources, including the report developed by the ACEP/ABEM Aging Physician Task Force, and develop additional resources as needed, specifically to address interruption of clinical emergency medicine practice. Work is in progress and will continue in 2018-19.

Resolution 52 Support for Harm Reduction and Syringe Services Programs

RESOLVED, That ACEP endorse Syringe Services Programs for those who use injection drugs; and be it further

RESOLVED, That ACEP promote the access of Syringe Services Programs to people who inject drugs; and be it further

RESOLVED, That ACEP invest in educating its members on harm reduction techniques and the importance of Emergency Departments to partner with local Syringe Services Programs to advance the care of people who inject drugs.

Action: Assigned to the Public Health & Injury Prevention Committee. The committee is developing an information paper and their work will continue in 2018-19.

Resolution 55 Workplace Violence (as amended)

RESOLVED, That ACEP move past policy creation and simple awareness campaigns with state and national regulatory agencies to develop actionable guidelines and measures (e.g., percent of events with legal outcome, paid post-trauma leave, use of de-escalation techniques, counseling provided), to ensure safety in the Emergency Department for patients and staff; and be it further

RESOLVED, That ACEP work with local, state, and federal bodies to provide for appropriate protections and enforcement of violations of Emergency Department patient and staff protections from violence in the workplace to provide safe and efficacious emergency care; and be it further

RESOLVED, That ACEP create model legislative and regulatory language that can be shared with state chapters and hospitals addressing workplace violence

Action: Assigned to the State Legislative/Regulatory Committee and to Public Affairs staff for federal advocacy initiatives. This issue was included in the Legislative and Regulatory Priorities for the Second Session of the 115th Congress. The State Legislative/Regulatory Committee has compiled information and resources that will be used to develop a toolkit for chapters

Resolution 56 In Memory of Robert E. Blake, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Robert Eugene Blake, MD, FACEP, as one of the leaders in the medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Robert Eugene Blake, 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 West Virginia and the United States.

Action: A framed resolution was prepared for Dr. Blake's family.

Resolution 57 In Memory of James H. Creel, Jr., MD, FACEP

RESOLVED, That the American College of Emergency Physicians fondly remembers and honors the many contributions of James H. Creel, Jr., MD, FACEP, one of the truest pioneers and leaders in emergency medicine and emergency medical services; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of James H. Creel, Jr., MD, FACEP, his colleagues, friends, residents, staff, and students our heartfelt condolences and gratitude for his tremendous accomplishments, devotion, and service to the specialty of emergency medicine, the State of Tennessee, and the United States of America.

Action: A framed resolution was prepared for Dr. Creel's family.

Resolution 58 In Memory of Paul Berger, Jr., MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions by Paul Berger, Jr, MD, FACEP, as one of the leaders in emergency medicine, EMS, and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to his wife Lanie Berger, his son Paul Berger, III, DO, his friends, and his colleagues our deepest sympathy and our gratitude for having been able to learn so much from a kind, gentle, caring leader in emergency medicine and gratitude for his tremendous service to the specialty of emergency medicine and the State of Iowa.

Action: A framed resolution was prepared for Dr. Berger's family.

Resolution 59 In Memory of William Wilkerson, Jr., MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by William Wilkerson, Jr, 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 William Wilkerson, Jr, 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 Michigan and the United States.

Action: A framed resolution was prepared for Dr. Wilkerson's family.

Resolution 60 Commendation for First Responders to 2017 Hurricanes

RESOLVED, That ACEP recognizes all ACEP members, staff, and their families that were involved in the response to Hurricanes Harvey, Irma, and Maria and commends the significant commitment they have made to the ideals of emergency medicine and the service provided to the people in the States of Texas, Louisiana, and Florida and the territories of Puerto Rico and the United States Virgin Islands.

Action: The resolution was read aloud at the Council Awards Luncheon and all first responders were thanked for their service.

Resolution 61 In Memory of Michael G. Guttenberg, DO, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by Michael G. Guttenberg, DO, FACEP, FACOEP, FAEMS, 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 Michael G. Guttenberg, DO, FACEP, FACOEP, FAEMS, 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 New York State and the United States.

Action: A framed resolution was prepared for Dr. Guttenberg's family.

Referred Resolutions

Resolution 20 Campaign Financial Reform – to the Steering Committee (as amended)

RESOLVED, That the Council Steering Committee create expenditure limitations to ~~allow younger~~ **encourage additional** members to consider candidacy for leadership positions without the concern for financial means.~~; and be it further~~

~~RESOLVED, That the Candidate Campaign Rules be amended by adding: "Candidates will not attend annual chapter meetings unless officially invited, on the meeting's agenda for a planned educational endeavor, and accept reimbursement of travel expenses in accordance with the chapter's policies.;" and be it further~~

~~RESOLVED, That the Council Steering Committee consider changes in the election process such as:~~

- ~~requiring candidates to disclose financial expenditures on their candidacy;~~
- ~~capping the monetary amount that can be used on all candidate-related expenditures, including travel, "coaches," videos, etc.;~~
- ~~prohibit ACEP residency and ACEP chapter visits for each candidate during the period of declared candidacy;~~
- ~~restricting publication of non-scholarly work in non-peer reviewed journals such as *ACEP Now* and other Emergency Medicine open subscription media; and~~
- ~~restricting social media "public service announcements."~~

Action: Assigned to the Council Steering Committee for discussion at the February 6, 2018, meeting. The Steering Committee approved adding the following information to the Candidate Campaign Rules #13:

a. Once the Nominating Committee announces the slate of candidates for the upcoming Council meeting, except for their home chapter, President-Elect, Board of Directors, Speaker, and Vice Speaker candidates should not travel to ACEP state chapter meetings until the conclusion of the elections. This includes, but is not limited to, educational meetings, chapter Board of Directors meetings, or chapter fund-raisers other than for the candidate's home chapter. A written request for an exception may be made to the Council Speaker for candidates needing to visit state chapters for purposes other than campaigning such as legislative assistance, official ACEP business, or prior faculty commitments to education programs. In such instances, active campaigning is not permitted.
b. After nominations are announced by the Nominating Committee, President-Elect, Board of Directors, Speaker, and Vice Speaker candidates may utilize video or audio conferencing methods to communicate with ACEP state chapters. The use of this technology will be monitored by the Council Steering Committee to ensure fair use.

Resolution 21 Creation of an Electronic Council Forum – to the Steering Committee

RESOLVED, That the Board of Directors task the appropriate committees to create a year round forum for councillors to introduce, debate, and vote on resolutions; and be it further

RESOLVED, That the results of the votes in the electronic Council forum be nonbinding resolutions to offer ACEP leadership expeditious guidance on emergent issues; and be it further

RESOLVED, That the electronic Council forum product feature include a user experience that can be used during the annual Council meeting to receive and display proposed amendments in real time during discussion and voting.

Action: Assigned to the Council Steering Committee for discussion at the February 6, 2018, meeting. There was consensus that the current process for conducting the annual Council meeting meets the Council's needs, but additional communication is needed to the Council about the features of the current Council meeting website that is used to distribute all Council meeting materials. The website has a "chat" feature to discuss resolutions in advance of the Council meeting, in addition to using the Council e-list (c-mail) for discussion purposes. The new engagED community platform will be implemented for the Council after *ACEP18.* This platform will replace the Council e-list and will allow collaboration and information sharing.

Resolution 24 Maintenance of Competence for Practicing Emergency Physicians (as amended)

RESOLVED, That ACEP study the needs, and cost-effective evidence-based requirements that would support practicing board-certified emergency physicians to legitimately demonstrate their ongoing competence and skills

necessary for their own practice settings and develop appropriate minimum guidelines for appropriate "maintenance of competence" with minimum and legitimate barriers to continued practice, and present a report for consideration at the 2018 Council meeting.

Action: The Board of Directors will continue to dialogue and collaborate with ABEM and ABMS and monitor their activities on this issue. ABEM held a Summit on October 2-3, 2017, to discuss modifications and alternatives to the ConCert exam. Representatives from ACEP attended the Summit.

An article appeared in the July 2018 issue of *ACEP Now* highlighting ABEMS's efforts to create a new process for continuing certification by offering an alternative to the ConCert Examination. The working name of the alternative is "MyEMCert". ABEM is pursuing several critical activities including redefining the purpose of continuing certification for ABEM and developing success metrics. All diplomates have been invited to complete a survey to confirm and further explore the information ABEM received during the calls with 25 state chapters in 2017. Additional surveys will be used to refine the design of MyEMCert. ABEM has also begun addressing content issues for the alternative, including,

- Defining how many total modules there will be
- Determining how long each module will be
- Identifying how many modules a diplomate will be required to complete
- Determining the best way to incorporate enhanced learning
- Creating the content blueprint for the modules
- Planning and initiating the exam development process
- Exploring how to integrate LLS (Part II) and KJS (Part III) requirements and activities

Additionally, diplomate continuous certification requirements are being revised to include the alternative and a phase-in schedule is in the planning stage.

The ACEP Board of Directors continue to dialogue and collaborate with ABEM and ABMS and monitor their activities on this issue.

Resolution 33 Immigrant and Non-Citizen Access to Care

RESOLVED, That ACEP develop model hospital policy language similar to the "Delivery of Care to Undocumented Persons" policy that physicians can access and present to their hospital systems for implementation; and be it further

RESOLVED, That ACEP 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 physicians can ensure the policy is communicated in the languages most relevant to their patient populations.

Action: Assigned to the Emergency Medicine Practice Committee to review and provide a recommendation to the Board regarding further action on the resolution.

The committee reviewed the current policy statement "Delivery of Care to Undocumented Persons." Revisions were recommended to include reference to safe zones. The revised policy statement was approved by the Board in June 2018.

Resolution 35 Legislation Requiring Hyperbaric Medicine Facility Accreditation for Federal Payment

RESOLVED, That ACEP work with the Undersea & Hyperbaric Medical Society and the ACEP Undersea & Hyperbaric Medicine Section to petition and advocate for CMS to require that hyperbaric facilities be accredited to receive federal payment.

Action: The Undersea & Hyperbaric Medicine Society drafted a letter to CMS outlining the rationale for requiring facility accreditation and requested ACEP to sign on to the letter. Leaders of ACEP's Undersea and Hyperbaric Medicine Section reviewed and revised the letter and recommended ACEP's endorsement. The Board of Directors approved sending the letter to CMS at their February 7, 2018, meeting.

Resolution 38 Prescription Drug Pricing

RESOLVED, That ACEP create a policy statement that:

- recognizes the threat that unaffordable prices of medications used to treat acute and chronic diseases poses to our patients and the challenges this imposes upon the emergency medical system;
- supports the negotiation of drug prices under Medicare Part D;
- supports the importation of prescription drugs; and
- supports value-based pharmaceutical pricing; and be it further

RESOLVED, That ACEP work with the American Medical Association and other stakeholders to support

regulatory and legislative efforts to address these issues.

Action: Assigned to the Emergency Medicine Practice Committee to review and provide a recommendation to the Board regarding further action on the resolution.

ACEP is a member of the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor, and business groups. NCHC is currently engaged in drug shortages/pricing initiatives, including the Campaign for Sustainable Rx Pricing.

ACEP's Legislative and Regulatory Priorities for the Second Session of the 115th Congress include "promote access to affordable medications for emergency patients and monitor legislative activities regarding excessive drug pricing."

The Emergency Medicine Practice Committee developed the policy statement, "Prescription Drug Pricing." It was approved by the Board in June 2018.

Resolution 41 Reimbursement for Hepatitis C Virus Testing in the ED

RESOLVED, That ACEP encourage the adoption of state laws that allow for reimbursement for HCV testing in settings beyond the primary care setting including the Emergency Department.

Action: Assigned to the Reimbursement Committee to review and provide a recommendation to the Board regarding further action on the resolution. Work on this objective will continue in 2018-19.

Resolution 45 Group Contract Negotiation to End-of-Term Timeframes

RESOLVED, That ACEP establish a recommendation for appropriate timeframes for initiation of contract renewal discussions and contract negotiation deadlines to end of coverage; and be it further

RESOLVED, That ACEP ~~oppose~~ **not support** sudden, abrupt changes in contract groups without time for adequate transition and training.

Action: Assigned to the Contracts Transitions Task Force. The task force developed the information paper "Emergency Department Physician Group Staffing Contract Transition." It is available on ACEP website in addition to other contract resources.

Resolution 46 Impact of Climate Change on Patient Health and Implications for Emergency Physicians

RESOLVED, That ACEP research and develop a policy that addresses the impact of climate change on the health and well-being of our patients and utilize the policy statement to guide future research, training, advocacy preparedness, mitigation practices, and patient care.

Action: Assigned to the Public Health & Injury Prevention Committee to review and provide a recommendation to the Board regarding further action on the resolution. The Public Health & Injury Prevention Committee developed the policy statement " Impact of Climate Change on Public Health and Implications for Emergency Medicine" and it was approved by the Board of Directors in June 2018.

Resolution 47 Improving Patient Safety Through Transparency in Medical Malpractice Settlements

RESOLVED, That ACEP develop a policy to reduce medical error and improve patient safety by assuring that pre-trial settlements of medical malpractice lawsuits against an emergency physician are anonymized and the learnings distributed to all members of the College and others as appropriate; actively support the elimination of non-disclosure clauses in pre-trial settlements of medical malpractice lawsuits; and report progress on this objective at the ACEP annual meeting in 2018.

Action: Assigned to the Medical-Legal Committee to review and provide a recommendation to the Board regarding further action on the resolution. In June 2018, the Board of Directors approved the committee's recommendation to not pursue the recommendations contained in the resolution at this time. An objective was assigned to the committee for 2018-19 to explore opportunities to use information from the National Practitioner Data Bank or related closed claims materials that might provide teachable information that may help reduce medical errors and improve patient safety.

Resolution 48 Non-Fatal Strangulation

RESOLVED, That ACEP work with the Emergency Nurses Association, International Association of Forensic Nurses, Training Institute on Strangulation Prevention, and other related organizations and stakeholders, to provide educational and clinical resources as well as in person and enduring educational programs for emergency providers on the evaluation, radiographic investigation, and management of non-fatal strangulation; and be it further

RESOLVED, That ACEP create a policy statement on the seriousness of non-fatal strangulation and develop a clinical practice guideline for the emergency department evaluation, treatment, and management of non-fatal strangulation.

Action: Assigned to the Clinical Policies Committee to review and provide a recommendation to the Board regarding further action on this resolution. The committee conducted an initial literature review and the committee concluded there is not enough evidence to develop a clinical policy on the topic. The committee will provide a recommendation to the Board in September 2018 regarding possible other work, such as educational materials or program.

Resolution 50 Promoting Clinical Effectiveness in Emergency Medicine

RESOLVED, That ACEP create a Clinical Effectiveness Committee that is responsible for identifying, assessing, and promoting evidence-based, cost-effective emergency medicine practices.

Action: Assigned to ACEP senior staff to review and provide a recommendation to the Board regarding further action on the resolution.

Resolution 62 Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States (as amended)

RESOLVED, That ACEP ~~lobby Congress to give~~**advocate giving** CMS the authority to recognize independent Freestanding Emergency Centers as Medicare Certifiable locations of acute unscheduled healthcare in the United States in Federally Declared Disaster areas.

~~RESOLVED, That ACEP lobby Congress to give CMS the authority to create Critical Access Emergency Center Designation where Critical Access Hospitals no longer exist due to catastrophic destruction from natural disasters or where Critical Access Hospitals cannot be feasibly maintained leaving areas of the Country without access to Emergency Medical care.~~

Action: Assigned to the Federal Government Affairs Committee to review and provide a recommendation regarding further action on this resolution.

The Board of Directors discussed this resolution at their December 2017 retreat. On December 14, 2017, ACEP sent a letter to the Chairman of the Commerce, Justice, and Science Subcommittee of the House Committee on Appropriations requesting support for the disaster supplemental appropriations bill to ensure freestanding emergency care facilities and their emergency physicians are eligible for any federal assistance appropriated to offset the ongoing losses associated with uncompensated care provided to Medicare beneficiaries affected by Hurricane Harvey. The letter provided specific language that could be inserted in the bill.

ACEP's Legislative & Regulatory Priorities for the Second Session of the 115th Congress include "monitoring legislative actions regarding oversight, licensing, and reimbursement for independent freestanding emergency centers."

In August 2018, ACEP supported the Emergency Care Improvement Act that allows for independent freestanding EDs that meet criteria to bill Medicare for a certain amount of facility-side reimbursement, depending on geography and acuity. The legislation contains specific language to protect professional-side reimbursement by Medicare at full physician fee schedule amounts at all acuity levels and will also bring the facilities under federal EMTALA requirements.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2018 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 11, 2018

Subj: Action on 2016 Resolutions

The 2016 Council considered 31 resolutions: 24 were adopted, 2 were not adopted, and 5 were referred to the Board of Directors.

The attached report summarizes the actions taken on the 2016 resolutions adopted by the Council and those that were referred to the Board.

The actions on resolutions reports are also included on the ACEP Website.

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American College of Emergency Physicians
ADVANCING EMERGENCY CARE

Action on 2016 Council Resolutions

Resolution 1 Commendation for Michael J. Gerardi, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Michael J. Gerardi, MD, FACEP, for his exemplary service, leadership, and commitment to the College, the specialty of emergency medicine, and to the patients we serve.

Action: A framed resolution was presented to Dr. Gerardi.

Resolution 2 In Memory of Kenneth L. DeHart, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Kenneth L. DeHart, 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 Kenneth L. DeHart, 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 South Carolina and the United States.

Action: A framed resolution was prepared for Dr. DeHart's family.

Resolution 4 Legacy Fellows – Housekeeping Change – Bylaws Amendment

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 2 – Fellow Status, be amended to read:

> "Fellows shall be authorized to use the letters FACEP in conjunction with professional activities. **Members previously designated as ACEP Fellows under any prior criteria shall retain Fellow status.** Maintenance of Fellow status requires continued membership in the College. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

Action: The Bylaws were updated.

Resolution 6 Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians (as amended)

RESOLVED, That the ACEP Board of Directors create a task force to study issues specific to Senior/Late Career Emergency Physicians. The task force shall make recommendations regarding identified issues to the Board, which shall deliver an update on this matter to the 2017 ACEP Council.

Action: The American Board of Emergency Medicine conducted a substantial review of cognitive skill and physician age and used data from their ConCert exam. An ACEP/ABEM Task Force on the Aging Physician was appointed and their final report was accepted by the ACEP Board of Directors at their October 26, 2017 meeting.

Resolution 7 Diversity in Emergency Medicine Leadership (as amended)

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.

Action: The resolution was addressed through the work of the Diversity & Inclusion Task Force, the Leadership Development Advisory Group (LDAG), the Leadership Diversity Task Force (LDTF), and the National/Chapter Relations Committee. The majority of ACEP's 26 committees were assigned objectives in the 2016-17 committee year to address diversity and inclusion. In January 2018, the Council Steering Committee approved changes to the Candidate Campaign Rules recommended by the LDTF and in May 2018 agreed to cosponsor two resolutions for the 2018 Council: 1) Codifying the LDAG in the Council Standing Rules, and 2) Nominating Committee Revision to Promote Diversity. The Board of Directors also agreed to cosponsor the resolutions. In May 2018, the Board of Directors approved two recommendations from the LDTF: 1) collecting 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; and 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. The Diversity & Inclusion Task Force has submitted its final report to the Board of Directors for review at their September 28, 2018, meeting. Focus groups will be held at *ACEP18* regarding diversity in emergency medicine. The Diversity & Inclusion & Health Equity Section will continue to work on the strategies developed by the Diversity & Inclusion Task Force.

Resolution 9 Accreditation Standards for Freestanding Emergency Centers

RESOLVED, That ACEP explore the possibility of setting ACEP-endorsed minimum accreditation standards for freestanding emergency centers; and be it further

RESOLVED, That ACEP explore the feasibility of ACEP serving as an accrediting (not licensing) entity for freestanding emergency centers, where they are allowed by state law.

Action: A task force was appointed with representation from the Freestanding Emergency Centers Section. A report with the following recommendations was provided to the Board in May 2018: 1) Develop an obtainable standard for FECs aspiring to achieve ACEP Accreditation. 2) Establish protocols for FECs obtaining ACEP Accreditation related to staffing, laboratory and imaging services, documentation, quality improvement (QI), billing practicing, EMS integration, public education, signage, and ethics. 3) Establish a national set of standards for FECs that could be referred to as a unified national resource for legislators, insurers, and physicians. 4) Create standards for ACEP Accreditation that will be beneficial to patients, emergency physicians, and ACEP. The Board accepted the task force report for information. The Board requested additional information about The Joint Commission's accreditation of FECs. The Board will continue discussions about FEC accreditation, including whether to develop a business plan, at their September 28, 2018, meeting.

Resolution 11 CMS Recognition of Independently Licensed Freestanding Emergency Centers

RESOLVED, That ACEP lobby to MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided; and be it further

RESOLVED, That ACEP suggest the AMA lobby MedPAC and CMS that all licensed emergency centers, regardless of being hospital based or independent, be subject to the same regulations and payment for the technical component of care provided.

Action: Assigned the first resolved to Public Affairs staff to include in advocacy and regulatory initiatives. Assigned the second resolved to the AMA Section Council on Emergency Medicine.

ACEP staff discussed this issue with MedPAC's Executive Director, Mark Miller, as well as with the director of CMS' outpatient payment program Marc Hartstein. Both individuals reiterated the methods CMS uses to collect cost data as the basis for adjusting Medicare reimbursements. This same approach was used several years ago, which resulted in Type A and Type B emergency department designations based on 24/7 emergency department versus less than 24/7 availability for reductions in the "technical" (facility payments in the Outpatient Prospective Payment System) for Type B facilities.

The AMA Section Council on Emergency Medicine recommended to the Board of Directors that no further action be taken on the resolution at this time. The Board did not adopt the recommendation and discussed the resolution at their December 2017 retreat. On December 14, 2017, ACEP sent a letter to the Chairman of the Commerce, Justice, and Science Subcomittee of the House Committee on Appropriations requesting support for the disaster supplemental appropriations bill to ensure freestanding emergency care facilities and their emergency physicians are eligible for any federal assistance appropriated to offset the ongoing losses associated with uncompensated care provided to Medicare beneficiaries affected by Hurricane Harvey. The letter provided specific language that could be inserted in the bill.

ACEP's Legislative & Regulatory Priorities for the Second Session of the 115th Congress included: 1) monitoring legislative initiatives that acknowledge the role of FECs and other health care delivery models as crucial to encouraging coverage innovation; 2) monitoring growth and compliance issues for FECs; and 3) monitoring legislative actions regarding oversight, licensing, and reimbursement for independent FECs. freestanding emergency centers."

Resolution 13 ED Boarding and Overcrowding is a Public Health Emergency (as amended)

RESOLVED, That ACEP request that the Secretary of the Department of Health and Human Services (HHS) under section 319 of the Public Health Service (PHS) Act determines that emergency department boarding and hallway care is an immediate threat to the public health and public safety; and be it further

RESOLVED, That ACEP work with the United States Department of Health and Human Services, the United States Public Health Service, The Joint Commission, and other appropriate stakeholders to determine the next action steps to be taken to reduce emergency department crowding and boarding with a report back to the ACEP Council at the Council's next scheduled meeting; and be it further

RESOLVED, That ACEP publicly promote the following as sustainable solutions to hospital crowding which have the highest impact on patient safety, hospital capacity, ICU availability, and costs:

1. Smoothing of elective admissions as a mechanism for sustained improvement in hospital capacity.
2. Early discharge strategies (e.g., 11:00 am discharges, scheduled discharges, staggered discharges) as a mechanism for sustained improvement in hospital capacity.
3. Enhanced weekend discharges as a mechanism for sustained improvement in hospital capacity.
4. The requirement for a genuine institutional solution to boarding when there is no hospital capacity, which must include both providing additional staff as needed AND redistributing the majority of ED boarders to other areas of the hospital.
5. The concept of a true 24/7 hospital.

Action: Assigned first resolved to Public Affairs staff to include in advocacy initiatives and the third resolved to the Public Relations Committee to develop messaging.

ACEP continues to work with HHS and the appropriate committees of jurisdiction to identify emergency department boarding solutions, which include a variety of options. This issue was addressed specifically in comment letters responding to the 2018 proposed Medicare Physician Fee Schedule and the 2018 proposed Outpatient Prospective Payment System rules. ACEP met with The Joint Commission in June 2017 and with other stakeholders to address and eliminate boarding in the ED.

Regarding the second resolved, in June 2016, the Board reviewed the updated information paper, "Emergency Department Crowding High-Impact Solutions" The Emergency Medicine Practice Committee and representatives from the Emergency Nurses Association, the Society of Emergency Medicine Physician Assistants, and the American College of Osteopathic Emergency Physicians collaborated on the revisions. ACEP has continued to hold meetings with The Joint Commission and other organizations about boarding.

The Public Relations Committee updated ACEP's crowding and boarding messaging to include the solutions proposed in the resolution. Boarding solutions were promoted to news media organizations, including WLOS-TV in Ashville, NC, which received ACEP's journalism award, an Emmy, and an Edward R. Murrow award.

ACEP sponsored the first Hospital Flow Conference in Boston, MA in May 2017.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 processes discussed do not add cost or staff, are associated with significant and sometimes dramatic savings to the institution, and focus on a small number of practically proven key processes that can dramatically improve overall hospital capacity. The conference provided an introduction to these processes, followed by workshops to discuss the practical details, both procedural and political, in implementing institutional change. The faculty included individuals who have had firsthand experience in implementing these processes at their own institutions. A second Hospital Flow Conference was held July 25, 2018, and was cosponsored by the American Hospital Association. Crowding and boarding resources are available on ACEP's web site.

Resolution 14 Development & Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in EDs (as amended)

RESOLVED, That the ACEP promote the development and application of throughput quality data measures and dashboard reporting for behavioral health patients in EDs; and be it further

RESOLVED, That ACEP endorse integration of a dashboard for reporting and tracking of behavioral health patients boarding in EDs in electronic health record systems as a means for linking to broader priority systems, for communicating the impact of boarded behavioral health patients, and to further collaborate with all appropriate health care and government stakeholders.

Action: Assigned to the Quality & Patient Safety Committee. In June 2017, the Board approved the committee's recommendation to develop a toolkit for reporting of behavioral health patients that can be implemented independently in Emergency Departments. The Clinical Emergency Department Registry (CEDR) currently has dashboard functionality and the ED throughput measures are included in the registry and reportable to CMS for the Quality Payment Program (QPP). CMS currently collects data on CMS OP-18c measure for arrival to ED departure time for psychiatric and mental health patients and CMS ED-2c measure for admit decision to ED departure time for psychiatric and mental health patients. The Quality Improvement & Patient Safety (QIPS) Section is currently working on an ACEP-funded grant titled "Best Practices for Reducing Behavioral Health Patient Length of Stay in the Emergency Department White Paper." The paper will address issues pertinent to the length of stay of behavioral

health patients in the ED and describe best practices to reduce length of stay. The section will apply for another section grant in the next cycle to develop the toolkit.

Resolution 15 Enactment of Narrow Networks Requirements (as amended)

RESOLVED, That ACEP shall create a study of the impact of narrow networks laws and potential solutions that address balance billing issues without increasing the burden on the patient; and be it further

RESOLVED, That ACEP dedicate resources and support to ensure any proposed legislation regarding narrow networks protects fair payment for emergency medical care.

Action: Assigned to Public Affairs staff to discuss with ACEP's health policy consultants and to Chapter & State Relations staff for recommendations.

Two bills were introduced in Congress, the "End Surprise Billing Act" (H.R. 817/S. 284), which would limit how much an out-of-network hospital or provider could be reimbursed for their services to the in-network or participating provider rate and prohibit balance billing. ACEP opposed these bills.

The "Patient Freedom Act" (S. 191), was introduced by Sens. Bill Cassidy (R-LA), Susan Collins (R-ME), Shelley Moore Capito (R-WV), and Johnny Isakson (R-GA) that would limit reimbursement for emergency medical services for individuals with a Health Savings Account to the "cash price" for these services or 85% of the usual, customary, and reasonable (UCR) charge. ACEP worked with these offices to modify the language to the 85th percentile (not percent) of UCR.

In June 2017, the ACEP Board of Directors approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider. The model legislation was shared with chapters and is important for state legislatures that are considering out-of-network and balance billing legislation and look to emergency medicine for guidance.

The Public Relations Committee developed a "Fair Coverage" campaign about out-of-network issues, which counters health insurance industry statements about "surprise billing." The campaign focuses on coverage for emergency patients, not payment for physicians. Committee members also participated in a "letters to the editor campaign" promoting ACEP's key fair coverage messages and participated as cast members of ACEP's parody Cigna video. The video served to promote ACEP's fair coverage campaign messages and generated more than 300,000 views on Facebook and YouTube, and resulted in a meeting with Cigna. The messaging was tested with focus groups consisting of policymaker audiences.

Network adequacy and fair payment for out of network services was a constant emphasis of state advocacy in 2016-17. State legislation related to network adequacy was included in the legislative tracking reports provided to chapters. Staff also participated in meetings and communications with other hospital based specialties about proposals regarding network adequacy and the sufficiency of efforts by regulators to enforce existing laws.

The AMA adopted a resolution in June 2017 that addresses these issues and sent a letter to Anthem on June 29, 2017, asking Anthem to rescind the policy citing federal patient protections under PLP, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage. ACEP sent a letter to the president and CEO of Anthem on August 1, 2017, regarding their announcement to deny coverage for ED care in several states. ACEP, and many individual members, have participated in media interviews (Associated Press, Modern Healthcare, The New York Times, Time Magazine, ABC News, The Washington Post, and others) to bring national attention to Anthem's assault on the prudent layperson standard in the denial of payment for emergency services. In December 2017, ACEP issued press releases about Anthem's denial of payments in Ohio and New Hampshire. In late December 2017, ACEP met with representatives of Anthem to discuss their announced policy that ACEP contends are in violation of federal and state law protecting patients according to the prudent layperson standard. ACEP continues to meet with members of Congress to educate them about denial of payment for emergency services by several payers.

The AMA developed model legislation, "Patient Protections from Unanticipated Out-of-Network Care Act," that includes recommended language provided by ACEP. Physicians for Fair Coverage (PFC) has formally adopted a "skinny version" of the original AMA model with the network adequacy and assignment of benefits provisions removed. The majority of the remaining PFC model mirrors the AMA bill, except that the AMA bill would set out of network payment at the lesser of the physician's actual charge or the 80th percentile of an independent charge database, and the PFC model simply sets payment at the 80th percentile of a charge database. Arguments can be made in support of either approach, but the two model bills are largely complementary and attempt to drive a positive legislative resolution to this issue that is being fought out in state legislatures across the country. The PFC model bill was introduced in Kentucky and Oklahoma. The Board of Directors will discuss the model legislation (AMA and PFC) at their February 7, 2018, meeting.

On January 16, 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25). On July 17, 2018,

ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court in an effort to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients. To read the lawsuit, click here.

Following five years of meetings and attempts by ACEP staff to obtain an explanation from the United States Center for Consumer Information and Insurance Oversight (CCIIO) regarding the methodology used in the 2010 Interim Final Rule governing payments of out-of-network emergency services, ACEP filed suit on May 12, 2016, against the Departments of Health & Human Services, Labor, and Treasury ("the Departments") challenging the Greatest-of-Three ("GOT") regulation. On August 31, 2017, the U.S. District Court for the District of Columbia (the "Court") partially granted ACEP's Motion for Summary Judgment and denied the Government's Cross Motion for Summary Judgment, finding that the Departments failed to seriously respond to comments and proposed alternatives submitted by ACEP and others regarding perceived problems with the GOT regulation. On April 30, 2018, the Departments published in the *Federal Register* the "Clarification of Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act". In this final regulation, the Departments declined to revise or rescind the rule, instead reaffirming it and rejecting ACEP's proposal to use an independent database to set payment rates. On May 19, 2018, the Board of Directors approved dismissing the lawsuit based upon recommendation of legal counsel, noting that the suit was successful in providing the College with valuable information, such as the "NORC Report," and sent a strong message that ACEP will fight on behalf of the rights of its members; however, the likelihood of ultimately prevailing was low and ACEP's legal resources could be best utilized in other arenas. Based upon a Joint Stipulation of Dismissal filed with the Court on May 23, 2018, Judge Colleen Kollar-Kotelly signed the Order dismissing the case. In June 2018, the Board discussed legislative and regulatory strategies and next steps for pursuing the Greatest-of-three methodology governing payments for out-of-network emergency services with CCIIO.

Resolution 16 Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. (as amended)

RESOLVED, That ACEP develop a report or information paper analyzing the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where Emergency Departments in Critical Access and Rural Hospitals that have closed, or are in-the process of closing.

Action: In 2015, Sen. Chuck Grassley's (R-IA) office developed a paper outlining the unique challenges rural hospitals face and the need to protect emergency medical services in these rural communities. Based on the findings of the white paper, ACEP worked with Sens. Grassley, Amy Klobuchar (D-MN), and Cory Gardner (R-CO) to develop legislation (REACH Act) that would allow a Critical Access Hospital (CAH) to voluntarily convert to a new category of hospital, the Rural Emergency Hospital (REH), if it eliminated all inpatient services and maintained 24-hour emergency medical care, among other things. ACEP met with Senator Grassley's health legislative assistant and health policy fellow on January 10, 2017, to discuss ACEP's positions heading into ACA reform and the REACH Act. Senator Grassley re-introduced the bill, S. 1130, in the first session of the 115th Congress. ACEP continues to support the bill.

On December 14, 2017, ACEP sent a letter to the Chairman of the Commerce, Justice, and Science Subcomittee of the House Committee on Appropriations requesting support for the disaster supplemental appropriations bill to ensure freestanding emergency care facilities and their emergency physicians are eligible for any federal assistance appropriated to offset the ongoing losses associated with uncompensated care provided to Medicare beneficiaries affected by Hurricane Harvey. The letter provided specific language that could be inserted in the bill.

ACEP's Legislative & Regulatory Priorities for the Second Session of the 115th Congress included "monitoring legislative actions regarding oversight, licensing, and reimbursement for independent freestanding emergency centers."

Resolution 18 Opposition to CMS Mandating Treatment Expectations (as amended)

RESOLVED, That ACEP work with CMS regarding mandated reporting standards that may result in harm to patients without the recognition of evidence based care of individual patients; and be it further

RESOLVED, That ACEP actively communicate to members and hospitals the dangers that quality indicators could present harm to potential patients, and the importance of physician autonomy in treatment.

Action: Assigned first resolved to Public Affairs staff to include in advocacy initiatives. Assigned second resolved to the Public Relations Committee to develop messaging.

A similar resolution was submitted to the AMA, from ACEP members, and it was referred to the Board of Trustees:

Development of Quality Measures with Appropriate Exclusions and Review Processes H-450.927

1. Our AMA will advocate for quality measures, including those in the Hospital Inpatient Quality Reporting Program, to have appropriate exclusions to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making, and for denominators of quality measures to be appropriately defined to ensure patients for whom the treatment may not be appropriate are adjusted for or excluded.
2. Our AMA will advocate for CMS to allow for any proposed quality measures to be reviewed by the appropriate medical specialty societies prior to adoption.

Resolution 19 Health Care Financing Task Force (as amended)

RESOLVED, That ACEP create a Health Care Financing Task Force as originally intended to study alternative health care financing models, including single-payer, that foster competition and preserve patient choice and that the task force report to the 2017 ACEP Council regarding its investigation.

Action: A task force was appointed in June 2017. The name was changed to "Single-Payer Task Force" to differentiate it from the previously appointed Health Care Financing Task Force that has focused on alternate payment models. The task force examined the essential elements of a health care system that should be funded by the US citizens through the federal government and potential supplemental health insurance plans to cover other benefits. The Board of Directors will review the final report from the task force at their September 28, 2018, meeting and will then be distributed to the Council. The 2018 Council Town Hall Meeting topic is "Single-Payer: Has the Time Finally Arrived?" The task force report will serve as a foundation for the discussion.

Resolution 20 Support & Advocacy for 24/7 Hyperbaric Medicine Availability

RESOLVED, That the American College of Emergency Physicians work with the Undersea & Hyperbaric Medical Society (UHMS) and the Divers Alert Network (DAN) to support and advocate for improved 24/7 emergency hyperbaric medicine availability across the United States to provide timely and appropriate treatment to patients in need.

Action: Assigned to Public Affairs staff to include in advocacy initiatives, in collaboration with UHMS and DAN.

ACEP supported a legislative effort to authorize the Department of Defense to provide hyperbaric oxygen therapy (HBOT) to service members with post-traumatic stress disorder (PTSD) or traumatic brain injuries (TBIs) as part of the FY 18 National Defense Authorization Act. This language is included in the House-approved version of the bill (H.R. 2810), but not its Senate counterpart. However, based on projections by the Congressional Budget Office (CBO) of what it would cost to implement this treatment option at the roughly 50 military facilities that could house such equipment, the Department of Defense is not expected to offer this service.

Resolution 21 Best Practices for Harm Reduction Strategies

RESOLVED, That ACEP develop guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning Substance Use Disorder patients to sustainable long-term treatment programs from the ED; and be it further

RESOLVED, That ACEP provide educational resources to ED providers for improving direct referral of Substance Use Disorder patients to treatment.

Action: Assigned to the Emergency Medicine Practice Committee and the Public Health Committee.

There are resources on the ACEP Website that address alcohol screening and brief intervention in the ED. Other resources include the Sobering Centers and "Alcohol Screening in the ED" information papers. The alcohol screening information paper was submitted to *Annals of Emergency Medicine* for publication consideration. It was not accepted and then was submitted to the *Western Journal of Emergency Medicine* and accepted.

There are currently three ACEP policy statements that address alcohol misuse: "Addressing the Public Safety Dangers Associated with Impaired or Distracted Driving," "Alcohol Screening in the Emergency Department" and "Alcohol Taxation."

The Emergency Medicine Practice Committee compiled resources on opioid counseling and reversal agents. The resources were reviewed by the Board in October 2017 and are available on the ACEP Website. The committee also compiled information compiled on nine alternatives to opioids for use in the ED. The content is being used to develop a web-based application; development of the app began in December 2017.

The policy statement Optimizing the Treatment of Acute Pain in the Emergency Department was approved by the Board in April 2017. Additional resources available on the ACEP Website. The Public Health & Injury Prevention Committee was assigned an objective in 2016-17 to "Develop an information paper on the transition of

care for patients seen in the ED with substance abuse issues (e.g., "warm handoffs," sobering centers, prescribing Suboxone, etc.). The committee prepared an information paper focused on transitions of care for patients with opioid abuse issues. The information paper addresses screening for opiate abuse, symptomatic relief for withdrawal, prescribing Naloxone, and referral to treatment centers. The Pain Management Section continues to develop resources on pain management and addiction medicine.

Resolution 22 Court Ordered Forensic Evidence Collection in the ED

RESOLVED, That ACEP study the moral and ethical responsibilities of emergency physicians within the context of court-ordered forensic collection of evidence in the context of patient refusal of consent, and if appropriate, develop policy to support emergency physicians' professional responsibilities when in conflict with court-ordered forensic collection of evidence and or medical treatment.

Action: Assigned to the Ethics Committee and the Medical-Legal Committee. The committees collaborated to revise the policy statement "Law Enforcement Information Gathering in the ED" and it was approved by the Board in June 2017.

Resolution 23 Medication Assisted Therapy for Patients with Substance Use Disorders in the ED (as amended)

RESOLVED, That ACEP review the evidence on ED-initiated treatment of patients with substance use disorders to provide emergency physician education; and be it further

RESOLVED, That ACEP support, through reimbursement and practice regulation advocacy, the availability and access of novel induction programs from the Emergency Department.

Action: Assigned to the Emergency Medicine Practice Committee and the Public Health & Injury Prevention Committee. The Public Health & Injury Prevention Committee prepared an information paper on Medication Assisted Therapy.

The Emergency Medicine Practice Committee compiled resources on opioid counseling and reversal agents. The resources were reviewed by the Board in October 2017 and are available on the ACEP Website. The committee also compiled information compiled on nine alternatives to opioids for use in the ED. The content is being used to develop a web-based application; development of the app began in December 2017.

Comprehensive list of work ACEP has done regarding opioids and Medication Assisted Therapy:

- Upcoming MAT Waiver training at ACEP18 Preconference.
  - Weblink: https://www.acep.org/acep18/education/mat-waiver-training/#sm.00000pj3tdieicd24u88t8fvgqs9n
- The ACEP Emergency Quality Network (E-QUAL) is a CMS funded Support and Alignment Network of the Transforming Clinical Practice Initiative that recently launched the **E-QUAL Network Opioid Initiative**. The aim for this initiative includes helping EDs to implement treatment options to opioids for pain, improve opioid prescribing and adopt harm reduction strategies such as naloxone prescribing and MAT. More information can be found on the ACEP E-QUAL Opioid Initiative Website. As a part of this initiatives many education resources are freely available including presentations and webinars on topics such as:
  - Alternatives to Opioids
  - Safe Opioid Prescribing
  - Treating Patients with Opioid-Use Disorder (OUD) in the ED
  - Treating OUD in the ED: Cutting-Edge Care
  - Setting Up a Buprenorphine Program in the ED
- ACEP has developed a point of care, beside tool to support clinicians as they utilize alternate pain treatments, called the **MAP tool**, which is available on the ACEP website. (www.acrp.org/map)
- **Podcasts** on ACEP Frontline, hosted by Dr. Ryan Stanton, including:
  - Eric Ketcham, MD and Kathryn Hawk, MD – MAT 3-day Rule
- Dr. Ryan Stanton discusses the MAT 3-Rule for prescribing buprenorphine for the opioid use disorder patient. Recorded live at LAC18, ACEP experts Dr. Eric Ketcham and Dr. Kathryn Hawk talk about how helping the patient with opioid withdrawal symptoms, they are more likely to continue on a path to help and recovery.
- https://soundcloud.com/acep-frontline/eric-ketcham-md-and-kathryn-hawk-md-mat-3-rule
  - Medication Assisted Treatment EMPRN Survey Results

- Dr. Ryan Stanton discusses Medication Assisted Treatment as a for patients with opioid use disorder. ACEP experts Dr. Eric Ketcham and Dr. Kathryn Hawk share the results of a survey from the Emergency Medicine Practice Research Network (EMPRN) about current practices for patients with an addiction disorder.
- https://soundcloud.com/acep-frontline/eric-ketcham-md-and-kathryn-hawk-md-emprn-medication-assisted-treatment-survey-results
    - ALTO Update, LAC18
        - Dr. Ryan Stanton talks to Dr. Alexis LaPietra, DO, FACEP, and Dr. Mark Rosenberg, DO, FACEP, about being better stewards of opioids and the emergency departments role in the opioid crisis. They discuss innovations in pain management and how to safely and more effectively treat the patient without opioids. At St Joseph Regional Medical Center in NJ, they have seen an 82% reduction in the prescriptions of opioids using ALTO (Alternatives to Opioids). "Its real simple, if you're not part of the solution, you're part of the problem."
        - https://soundcloud.com/acep-frontline/alexis-lapietra-do-facep-and-mark-rosenberg-do-facep-alto-update-lac18

- ACEP also has multiple **publications** in Annals of Emergency Medicine (which has over 36,000 subscribers) and ACEP Now (which have 40,000 BPA audited subscribes) including:
    - Opportunities for Prevention and Intervention of Opioid Overdose in the Emergency Department.
    - Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department.
    - Sometimes Opioids Are Necessary
    - Buprenorphine Explained, And Opioid Addiction Treatment Tips
- ACEP has also developed and launched numerous **educational products**, including those providing free opportunities for Continuing Medical Education (CME), such as:
    - Opioid Wave I – Free CME
        - Introduction
        - Harm Reduction
        - Treating Opioid Use Disorder in the ED
    - Solving the Pharmacological Mystery of Buprenorphine - June 2018 (CME Now Article - FREE - 1.0 CME)
    - CME Now: Why Addiction is Not Just a "Tox" Problem (Article - FREE - 1.0 CME)

Resolution 24 Mental Health Boarding Solutions (as amended)

RESOLVED, That ACEP partner with stakeholders including the American Psychiatric Association, the Substance Abuse and Mental Health Services Administration, the National Alliance of Mental Illness, and other interested parties, to develop model practices focused on building bed capacity, enhancing alternatives, and reducing the length of stay for mental health patients in EDs; and be it further

RESOLVED, That ACEP develop and share these ED mental health best practices designed to reduce ED mental health visits, reduce ED mental health boarding, and improve the overall care of patients who board in our EDs; and be it further

RESOLVED, That ACEP work with the Agency for Healthcare Research and Quality and other appropriate stakeholders to develop community and hospital based benchmark performance metrics for ED mental health flow and psychiatric facilities acceptance of patients.

Action: This resolution is being addressed primarily by the Coalition on Psychiatric Emergencies. The Coalition stemmed from a psychiatric emergency summit held in December 2014 comprised of multiple stakeholder groups from emergency medicine, emergency psychiatry, and patient advocacy to improve the treatment of psychiatric emergencies for patients and providers. The overarching goals of the Coalition are to bring awareness and recognition to the national challenges surrounding psychiatric emergencies and work collaboratively to address these problems and create change. There are four working groups (Education, Research, Operations/Boarding, Advocacy) each with their own objectives and tasks. A repository of resources is available on the Emergency Medicine Foundation Website.

The Coalition sponsored a research consensus conference on December 7, 2016, with experts from around the country, on the evidence that rapid treatment of patients with acute mental health disorders leads to better patient outcomes. The goal of the conference was to address underlying questions related to time to treatment, and if early intervention can affect patient outcomes. Breakout sessions included: acute psychosis, depression and suicidality,

substance use disorder and agitation in the elderly. Manuscripts are being developed and will be sent to peer reviewed publications for consideration.

The Coalition worked with ACEP's Emergency Medicine Practice Committee to develop the information paper, Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department, on best practices for boarding patients with mental health disorders. A podcast was developed and is available on the ACEP website.

The Clinical Policies Committee revised the Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department and it was approved by the Board in January 2017.

In 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 Emergency Departments. The Clinical Emergency Department Registry (CEDR) currently has dashboard functionality and the ED throughput measures are included in the registry and reportable to CMS for the Quality Payment Program (QPP). CMS currently collects data on CMS OP-18c measure for arrival to ED departure time for psychiatric and mental health patients and CMS ED-2c measure for admit decision to ED departure time for psychiatric and mental health patients. The Quality Improvement & Patient Safety (QIPS) Section is currently working on an ACEP-funded grant titled "Best Practices for Reducing Behavioral Health Patient Length of Stay in the Emergency Department White Paper." The paper will address issues pertinent to the length of stay of behavioral health patients in the ED and describe best practices to reduce length of stay. The section will apply for another section grant in the next cycle to develop the toolkit.

Resolution 25 Military Medics Integration into Civilian EMS (as amended)

RESOLVED, That the American College of Emergency Physicians, in order to promote high quality, safe, and efficient emergency medicine care, support current state and federal initiatives for accelerated training to allow transition of current military pre-hospital personnel to the civilian sector and which recognize the current level of training and experience of military medical specialist providers in our nation's service.

Action: Assigned to the EMS Committee to develop a policy statement and to Public Affairs and State Legislative staff to include in federal and state advocacy initiatives.

The EMS Committee worked with several members with past military experience as well as representatives from the Government Services Chapter to develop a draft policy statement. The committee also reviewed current projects underway that are supported by the National Association of State EMS Officials (NASEMSO), the National Association of EMS Educators (NAEMSE), the National Association of EMTs (NAEMT) and the National Registry of EMT's (NREMT) on military to civilian EMS transition to ensure ACEP's policy is consistent with these initiatives. The Board approved the policy statement "Support for Transition of Military Medics into Civilian EMS Careers" in June 2017.

Resolution 26 Opposition of Exclusive Imaging Contracts Limiting Clinical Ultrasound Use and Billing by Emergency Physicians (as amended)

RESOLVED, That ACEP supports users of emergency ultrasound with a statement declaring opposition to the use of exclusive imaging contracts to limit the use of emergency ultrasound by non-radiology specialists and the billing for such services; and be it further

RESOLVED, That ACEP continue to support emergency physicians working to develop and implement emergency ultrasound programs who face opposition in hospitals where radiologists or others hold exclusive imaging contracts.

Action: Assigned to the Emergency Medicine Practice Committee and the Emergency Ultrasound Section to develop a policy statement. The Board approved the policy statement "Advocacy for Emergency Department Ultrasound Privilege and Practice" in June 2017.

Resolution 27 Pediatric Surgery Centers

RESOLVED, That ACEP dispute the current Pediatric Surgery Center Guidelines and work with appropriate stakeholders to amend the guidelines; and be it further

RESOLVED, That ACEP reaffirm the Guidelines for the Care of Children in the Emergency Department as the standard for pediatric emergency care.

Action: Assigned to the Pediatric Emergency Medicine Committee. The committee was assigned objective in 2016-17 to work with the Pediatric Surgery Society to revise the guidelines.

ACEP discussed concerns with the leadership of the Pediatric Surgical Society and the American College of Surgeons (ACS) in March 2017. ACEP met with leaders of the American Academy of Pediatrics (AAP) during the 2017 ACEP Advanced Pediatric Emergency Medicine Assembly. AAP indicated they were not aware of the concerns prior to this meeting and agreed to review their processes on endorsement of documents and involve ACEP in future

revisions of the Pediatric Surgery Center Guidelines. The ACEP Board had further discussions on this issue at their June 2017 meeting and a letter was sent to ACS on August 28, 2017. ACS responded on September 25, 2017, providing additional background about development of the Guidelines and agreed to include representation from ACEP in future revisions.

Resolution 28 Reimbursement for Opioid Counseling

RESOLVED, That ACEP develop a strategy to seek reimbursement for counseling on safe opiate use, reversal agent instruction, and drug abuse counseling for our patients; and be it further

RESOLVED, ACEP develop a toolkit and education for implementing safe opioid use, reversal agent instruction, and drug abuse counseling in our Emergency Departments.

Action: Assigned first resolved to the Coding & Nomenclature Committee. Assigned second resolved to the Emergency Medicine Practice Committee.

The Emergency Medicine Practice Committee compiled resources on opioid counseling and reversal agents. The resources were reviewed by the Board in October 2017 and are available on the ACEP Website. The Coding & Nomenclature Advisory Committee developed a CPT code change proposal developed describing opioid counseling, including a discussion of risk and symptoms of overdose and the appropriate steps to discuss should one of these occur. The proposal was submitted to the CPT Editorial Panel for review at the September 2017 meeting. Unfortunately, the proposal was not adopted.

Resolution 29 The Opioid Epidemic – A Leadership Role for ACEP (as amended)

RESOLVED, That ACEP advocates and supports the training and equipping of all first responders, including police, fire, and EMS personnel to use injectable and nasal spray Naloxone; and be it further

RESOLVED, That ACEP advocates and supports that appropriately trained pharmacists be able to dispense Naloxone without prescription; and be it further

RESOLVED, That ACEP develop a comprehensive policy on the prevention and treatment of the opioid use disorder epidemic including innovative treatments.

Action: Assigned to the Emergency Medicine Practice Committee (EMPC) to review current policies and resources and determine if revisions or additional resources are needed. The following resources and activities were identified:

- 2012 Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department. The Clinical Policies Committee has started work on a revision to this policy that will be completed in 2018. The critical questions were finalized and literature searches completed. The literature was obtained and grading began in late 2017.
- Naloxone Prescriptions by Emergency Physicians policy statement approved October 2015.
- Naloxone Access and Utilization for Suspected Opioid Overdoses policy statement approved June 2016.
- Optimizing the Treatment of Acute Pain in the Emergency Department policy statement approved April 2017.
- 2014 PREP Equipment for Ground Ambulances. Naloxone is listed under required equipment for advanced life support (ALS) emergency ground ambulances.
- *ACEP Website Resources:* In September 2014, the Emergency Medicine Practice Committee compiled resources on opioid prescribing in the ED, including information on the scope of the problem, resources on pain management in the ED, state initiatives, regulatory information, prescribing guidelines, prescription drug monitoring programs, and patient education materials and treatment resources.
- Emergency Medicine Practice Committee 2016-17 objective to "Work with the Pain Management Section to compile and develop resources for opiate free emergency departments." Information was compiled on nine alternatives to opioids for use in the ED. The content is being used to develop a web-based application; development of the app began in December 2017.
- Public Health & Injury Prevention Committee 2016-17 objective to "Develop an information paper on the transition of care for patients seen in the ED with substance abuse issues (e.g., "warm handoffs," sobering centers, prescribing Suboxone, etc.). The committee prepared an information paper focused on transitions of care for patients with opioid abuse issues. The paper addresses screening for opiate abuse, symptomatic relief for withdrawal, prescribing Naloxone, and referral to treatment centers.
- The Pain Management Section continues to develop resources on pain management and addiction medicine.
- State Legislative/Regulatory Committee 2016-17 objective expanding and updating previous work to "research and report on successful approaches to opioid prescribing legislation impacting EDs, with a focus on state mandates related to PDMP's, the use of clinical guidelines, programs with state agencies (e.g., "warm hand off" programs and expansion of local treatment programs) and the availability of naloxone." A panel discussion was held at the 2017 Leadership & Advocacy Conference that featured creative responses led by ACEP members to

the opioid crisis in Paterson, NJ and northwestern NM. The committee is developing a tool kit of legislative resources that will be available on ACEP's website.

- State legislative staff tracks legislation related to opioid prescribing, PDMP's, and the availability of naloxone, and provides that information to state chapters.

In April 2017, the Board approved the committee's recommendation to take no further action and concurred that the intent of the resolution was addressed.

Resolution 31 Opposing the Development of Sublingual Sufentanil (as amended)

RESOLVED, That ACEP actively oppose the FDA approval of sublingual formulations of synthetic fentanyl analogs, including sufentanil, via direct testimony or other means that the Board may find suitable.

Action: Assigned to the EMS Committee to obtain more information and provide a recommendation to the Board. The resolution was initiated because of the pharmaceutical company contacting EMS providers and indicating that EMS was supportive of the development. A letter was sent to the FDA in January 2017 opposing the use of sublingual fentanyl by EMS and in civilian emergency departments. ACEP leaders have had multiple discussions with the pharmaceutical company that developed the drug to inform them of ACEP's concerns.

Referred Resolutions

Resolution 8 Opposition to Required High Stakes Secured Examination for Maintenance of Certification

RESOLVED, That ACEP work with members, other interested organizations, and interested certifying bodies to develop reasonable, evidence based, cost-effective, and time sensitive methods to allow individual practitioners options to demonstrate or verify their content knowledge for continued practice in Emergency Medicine.

Action: The officers of ACEP and ABEM met several times since the 2016 Council meeting to discuss these issues. ACEP has relayed the growing discontent among some ACEP members with the Maintenance of Certification (MOC) process and particularly the high-stakes ConCert exam. ABEM is active in exploring alternative approaches to physician assessment. This exploration includes detailed analyses of every pilot project in which other specialty boards are involved. ABEM informs ACEP that it is participating in direct discussions and research consortia with other American Board of Medical Specialties (ABMS) specialty boards to understand the strengths and weaknesses of alternative forms of longitudinal assessment. Unfortunately, the pilots of other specialty boards are so new that outcomes or validity data are extremely limited. ABEM has assembled panels of senior ABEM leaders to explore modification and options to the ConCert examination. ABEM held a special Board meeting in September 2017 to explore modifications and options to the ConCert examination and held a national ConCert Summit October 2-3, 2017, that included representatives from every emergency medicine organization to explore modifications and options to the ConCert examination. ABEM is looking to keep the ConCert examination as an option and decrease the anxiety, cost, and consequence of the ConCert examination as an assessment option for some diplomates. Additionally, ACEP, along with dozens of other specialty societies and state medical societies met with ABMS and its certifying boards in early December 2017 to discuss concerns regarding both MOC and the high-stakes exams.

An article appeared in the July 2018 issue of *ACEP Now* highlighting ABEMS's efforts to create a new process for continuing certification by offering an alternative to the ConCert Examination. The working name of the alternative is "MyEMCert". ABEM is pursuing several critical activities including redefining the purpose of continuing certification for ABEM and developing success metrics. All diplomates have been invited to complete a survey to confirm and further explore the information ABEM received during the calls with 25 state chapters in 2017. Additional surveys will be used to refine the design of MyEMCert. ABEM has also begun addressing content issues for the alternative, including,

- Defining how many total modules there will be
- Determining how long each module will be
- Identifying how many modules a diplomate will be required to complete
- Determining the best way to incorporate enhanced learning
- Creating the content blueprint for the modules
- Planning and initiating the exam development process
- Exploring how to integrate LLS (Part II) and KJS (Part III) requirements and activities

Additionally, diplomate continuous certification requirements are being revised to include the alternative and a phase-in schedule is in the planning stage.

The ACEP Board of Directors continue to dialogue and collaborate with ABEM and ABMS and monitor their activities on this issue.

Resolution 10 Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use

RESOLVED, That ACEP adopt and support a national policy that the possession of small amounts of marijuana for personal use be decriminalized; and be it further

RESOLVED, That ACEP submit a resolution to the American Medical Association for national action on decriminalization of possession of small amounts of marijuana for personal use.

Action: Assigned to the Ethics Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committee to review and provide a recommendation to the Board regarding further action on the resolution.

The Ethics Committee was initially assigned as the lead committee to work on the resolution, but opined that this was not an ethical issue and the work should be led by the Public Health & Injury Prevention Committee. The resolution was subsequently assigned to the Emergency Medicine Practice Committee as this committee was also assigned Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED. After extensive discussion, there was not a consensus on a recommendation to the Board. A two-question survey was developed and shared with the four committees identified to review this resolution. The questions asked were: 1) Should ACEP adopt a policy supporting decriminalization of marijuana? and 2) Should ACEP submit a resolution to the AMA in support of decriminalization? While approximately 67% of the respondents were opposed to ACEP adopting a policy in favor of decriminalization of marijuana, all but one of the comments were in opposition. Others commented they were in favor of decriminalization of position of small amounts of marijuana, but did not believe it was an issue for ACEP to address. After review of the survey results and consideration of the comments, the Emergency Medicine Practice Committee recommended that no further action be taken on the resolution. The Board approved the committee's recommendation in June 2017.

Resolution 12 Collaboration with Non-Medical Entities on Quality and Standards (as amended)

RESOLVED, That the American College of Emergency Physicians reach out and build coalitions with non-medical organizations involved in developing non-clinical quality standards that include an evaluation of the cost of providing the highest level quality of care.

Action: Assigned to the Quality & Patient Safety Committee. In June 2017, the Board approved the committee's recommendation to support new and existing partnerships with non-medical organizations involved in developing quality standards including: 1) renewing membership in the National Quality Forum; 2) continue participation in Technical Expert Panels (TEP) that developing quality measures for CMS; and 3) conduct outreach and communications with international associations for emergency physicians, such as the Canadian Association of Emergency Physicians (CAEP) and other organizations within the International Federation of Emergency Medicine (IFEM), for international visibility and collaboration for ACEP.

Resolution 17 Insurance Collection of Beneficiary Deductibles (as amended)

RESOLVED, 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 be it further

RESOLVED, 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.

Action: Assigned to the Federal Government Affairs Committee to review and provide a recommendation to the Board regarding further action on the resolution. The committee did not support adding this issue 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. The Board approved the committee's recommendation at their October 26, 2017, meeting.

The AMA 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.

In June 2017, the ACEP Board of Directors approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider. The model legislation was shared with chapters and is important for state legislatures that are considering out-of-network and balance billing legislation and look to emergency medicine for guidance.

Resolution 30 Treatment of Marijuana Intoxication in the ED

RESOLVED, That ACEP investigate the scope of treatment of marijuana intoxication in the ED that has legal implications; and be it further

RESOLVED, That ACEP determines if there are state or federal laws that provide guidance to emergency physicians in the treatment of marijuana intoxication in the ED; and be it further

RESOLVED, That the Board of Directors assign an appropriate committee or task force to answer clinically relevant questions that address the need to care for ED patients with possible marijuana (or other drug) intoxication; and be it further

RESOLVED, That ACEP investigate how other medical specialties address the treatment of marijuana intoxication in other clinical settings; and be it further

RESOLVED, That ACEP provide the resources necessary to coordinate the treatment of marijuana intoxication in the ED.

Action: Assigned to the Emergency Medicine Practice Committee, the Public Health Committee, and the State Legislative/Regulatory Committee to review and provide a recommendation to the Board regarding further action on the resolution. A thorough analysis was conducted and in June 2017, the Board approved the committee's recommendation to take no further action on the first, second, and fourth resolveds; assign the third resolved to the Toxicology Section or other body for additional work; and for the fifth resolved, educate ED providers to document diagnosis of marijuana intoxication and make subsequent efforts to correlate the 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 focus on determining the resources needed to coordinate treatment of marijuana intoxication.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2018 Council

From: Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary

Date: September 10, 2018

Subj: Action on 2015 Resolutions

The 2015 Council considered 52 resolutions: 37 were adopted, 7 were not adopted, one was withdrawn, one was not discussed, and 6 were referred to the Board of Directors.

The attached report summarizes the actions taken on the 2015 resolutions adopted by the Council and those that were referred to the Board.

The actions on resolutions reports are also included on the ACEP Website.

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Action on 2015 Council Resolutions

Resolution 1 Commendation for Marsha D. Ford, MD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Marsha D. Ford, MD, FACEP, for her service as an emergency physician, scholar, and patient advocate and for her lifelong dedication to the advancement of the specialty of Emergency Medicine.

Action: A framed resolution was presented to Dr. Ford.

Resolution 2 Commendation for Kevin M. Klauer, DO, EJD, FACEP

RESOLVED, That the American College of Emergency Physicians commends Kevin M. Klauer, DO, EJD, FACEP, for his service as Council Speaker and Council Vice Speaker and for his commitment and dedication to the specialty of emergency medicine and to the patients we serve.

Action: A framed resolution was presented to Dr. Klauer.

Resolution 3 Commendation for Alexander M. Rosenau, DO, CPE, FACEP

RESOLVED, That the American College of Emergency Physicians commends Alexander M. Rosenau, DO, CPE, FACEP, for his outstanding service, leadership, and commitment to the specialty of emergency medicine and to the College.

Action: A framed resolution was presented to Dr. Rosenau.

Resolution 4 In Memory of Stanley M. Zydlo, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Stanley M. Zydlo, Jr., MD, FACEP, as one of the leaders in emergency medicine and a true pioneer of EMS; and be it further

RESOLVED, That national ACEP and the Illinois College of Emergency Physicians extends to his wife, Joyce Reid, his children and grandchildren, his friends, and his colleagues our condolences and gratitude for his tremendous service to the specialties of Emergency Medicine and Emergency Medical Services.

Action: A framed resolution was prepared and sent to the family of Dr. Zydlo.

Resolution 5 EMRA Councillor Allocation – Bylaws Amendment

RESOLVED, That the ACEP Bylaws, Article VIII – Council, Section 1 – Composition of the Council, paragraph three, be amended to read:

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

Action: The Bylaws were updated.

Resolution 6 Fellowship Criteria – Bylaws Amendment

RESOLVED, That the ACEP Bylaws Article V – ACEP Fellows, Section 1 – Eligibility, be amended by deletion of criterion number four:

Fellows of the College shall meet the following criteria:

1. Be regular or international members for three continuous years immediately prior to election.
2. Be certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics.
3. Meet the following requirements demonstrating evidence of high professional standing at some time during their professional career prior to application.
   A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of residency training, and;

B. Satisfaction of at least three of the following individual criteria during their professional career:
   1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
   2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
   3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
   4. active involvement in emergency medicine administration or departmental affairs;
   5. active involvement in an emergency medical services system;
   6. research in emergency medicine;
   7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
   8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
   9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
   10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

~~4. Provide a written letter of recommendation from their chapter, as attested by the chapter president or chapter executive director, or two letters of recommendation from current Fellows of the College.~~

Action: The Bylaws were updated.

Resolution 11 Ethical Violations by Non-ACEP Members (as amended)

RESOLVED, That ACEP shall extend the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" to include non-ACEP members whose actions involve ACEP members; and be it further

RESOLVED, That ACEP's current "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" shall be modified to reflect that any disciplinary actions taken by ACEP and involving non-ACEP members will be reported to the expert's own professional society and may be reported to the expert's state licensing board for further action; and be it further

RESOLVED, That ACEP shall create a summary to be distributed to expert witnesses in cases involving ACEP members putting those experts on notice that:

The expert's testimony is subject to review by ACEP and ACEP's Ethics Committee.

1. Regardless of the expert's specialty or professional society membership, if the expert's testimony is found to be unethical, the expert will subject to:
   a. Admonishment by ACEP.
   b. Public reporting of such admonishment in an appropriate ACEP publication.
   c. Reporting of such admonishment to any professional society or medical organization to which the expert belongs.
   d. Reporting of such admonishment to the expert's state medical licensing board.

Action: Assigned to the Ethics Committee (lead committee) and the Medical-Legal Committee. Note: this resolution cannot be implemented until the "Procedures for Addressing Charges of Ethical Violations and Other Misconduct" are amended, which will require a College Manual resolution.

The Ethics Committee and the Medical-Legal Committee had differing viewpoints about the resolution and presented their recommendations to the Board in June 2016. The Board assigned a workgroup of Board members and members of both committees to develop recommendations for implementation of the resolution. A conference call was held and preliminary work was begun. The Board of Directors will discuss this resolution and its implementation at their September 28, 2018, meeting.

Resolution 12 Searchable Council Resolution Database (as amended)

RESOLVED, That ACEP improve the existing database of all prior Council resolutions submitted for discussion, designed for use by the ACEP membership, to include the relevant background material, adopted amendments, final disposition of each resolution, and any references to subsequent ACEP action such as a result of the resolution, to improve search functionality, and to publicize this tool to future councillors.

Action: The database was developed and staff have begun uploading the resolutions. The database will be accessible through the ACEP Website.

Resolution 13 ACEP and the Pharmaceutical Industry (as amended)

RESOLVED, That ACEP evaluate the expanding role and cost for pharmaceuticals affecting the practice of emergency medicine and identify and collaborate, where appropriate, with interested parties/stakeholders, including pharmaceutical manufacturers and others to best assure an appropriate, cost-effective, sustainable, access to emergency care treatments and identify methods to best facilitate dissemination of factual and data driven information about alternative uses of medications and develop appropriate policies to support this effort and report back to the ACEP Council in 2016.

Action: Assigned to Public Affairs staff and to utilize consultants as needed.

In 2012, ACEP helped secure the reauthorization of the Prescription Drug User Fee Act (PDUFA), the "Food and Drug Administration Safety and Innovation Act" (FDASIA), that substantially amended the Food, Drug & Cosmetic Act's (FDCA) drug shortage provisions. FDASIA 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. Additionally, 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 is a member of the National Coalition on Health Care (NCHC), which is an alliance of national health care, consumer, labor, and business groups working to achieve affordable, high-value health care for patients. The NCHC is promoting several concepts to curb prescription drug prices, including: accelerated FDA review of competitor drugs, prescription drug pricing transparency, increased comparative effectiveness research and improved access to generic biosimilar drugs. The NCHC has established the Campaign for Sustainable Rx Pricing (CSRXP). This subgroup is a non-partisan coalition of organizations engaged in the drug pricing debate and that is developing bi-partisan, market-based solutions to lower drug prices in the United States.

In late August 2016, several ACEP members briefed House Judiciary Committee staff on the price history and availability of naloxone and buprenorphine and how these changes have subsequently affected availability of these drugs for emergency patients. This discussion led directly to the invitation for an ACEP witness to testify at the September 22, 2016, hearing conducted by the House Judiciary Regulatory Reform Subcommittee to discuss rising drug prices.

In response to actions taken by the AMA House of Delegates at the 2015 Interim Meeting, the AMA Board of Trustees appointed a 13-member Task Force on Pharmaceutical Costs consisting of representatives of AMA councils, state medical associations, and national medical specialty societies, to provide guidance on AMA advocacy and grassroots efforts aimed at addressing pharmaceutical costs. Between January and May 2016, the task force held four meetings/conference calls and reached agreement that the first phase of the AMA grassroots campaign should focus on increasing drug pricing transparency among pharmaceutical companies, pharmacy benefit managers and health plans. Board of Trustees Report 10-I-16 summarizes the work of the Task Force and describes the first phase of the grassroots campaign. An online petition calling on Congress to demand that pharmaceutical companies, pharmacy benefit managers, and health plans introduce greater transparency in the processes for determining prescription drug prices was promoted in late summer 2016 on the AMA's Patients' Acton Network (PAN) and other cause-oriented websites (e.g., standunited.org and care2.org). More than 62,000 individuals have signed the petition. On November 1, 2016, consistent with the recommendations of the task force, the AMA launched TruthInRx.org, which seeks to highlight the lack of transparency and inherent unfairness involved in prescription drug pricing. The interactive microsite allows supporters to take action, from sending a message to Congress to sharing content with their own social networks. Notably:

- The overall design of the microsite uses pharmaceutical, scientific and technical industries as inspiration for creative design, and vibrant, energetic colors help emphasize important points throughout the site, such as facts, figures and callouts
- The homepage immediately takes the user through an interactive experience after he/she lands on the site, scrolling through the labels of a drug box to learn about the lack of transparency in drug pricing.
- The interior pages include a campaign page that opens with a striking visual related to understanding the issue; a "your stories" page that engages the audience to share content with their social networks, including a meme generator, prepopulated tweets/Facebook posts and a traditional submit your own story option for users; a "get involved" page that houses the traditional take action features, allowing users the ability to contact Congress via email, phone and social media; and a "get informed" page that houses a variety of resources for the user to explore to gain more knowledge on the issue.

An AMA press statement announcing TruthInRx.org was also released. ACEP promoted the link to the microsite via the PAN and the Physicians' Grassroots Network and used other online and social media promotion to aid in the launch. The microsite was also featured at the AMA grassroots booth at the AMA Interim Meeting in November 2016 and related materials were distributed to the AMA House of Delegates.

Resolution 17 Electronic Nicotine Delivery Systems

RESOLVED, That ACEP support legislative and regulatory efforts to control the use of electronic nicotine delivery systems and regulate the toxicity of vapor(s) produced for primary and second hand exposures; and be it further

RESOLVED, That ACEP develop recommendations for tobacco and nicotine cessation that avoid the use of unregulated electronic nicotine delivery systems; and be it further

RESOLVED, That ACEP promote awareness of the risk of primary inhalation injury and direct toxicity from electronic nicotine delivery systems to ACEP members and the physician community as a whole.

Action: Assigned first resolved to Chapter & State Relations staff and Public Affairs staff to include in state and federal advocacy initiatives. Assigned second and third resolveds to the Public Health & Injury Prevention Committee.

This issue was included in the state advocacy reports provided to the chapters.

The Public Health & Injury Prevention Committee developed the revised policy statement "Tobacco and Nicotine Products – Public Policy Measures" and recommended : 1) incorporating updates on the rapidly growing body of research on tobacco cessation and electronic nicotine delivery systems into the curriculum at ACEP *Scientific Assembly* and similar academic and professional forums; and 2) partnering with other medical professional organizations committed to tobacco control, such as the American College of Preventive Medicine, focused on primary prevention to increase reach, improve messaging coherence, and provide a template for future collaboration on prevention-based issues. The Board approved the policy statement and the committee's recommendations in October 2016.

Resolution 19 Graduate Medical Education Funding (as amended)

RESOLVED, That ACEP work with the agencies that provide graduate medical education funding to create measures to ensure that all institutions that receive graduate medical education funding be required to maintain publicly available records of the distribution and utilization of these funds.

Action: Assigned to the Academic Affairs Committee and to consult with Public Affairs staff as needed regarding legislative and regulatory issues related to GME funding. The Academic Affairs Committee worked in collaboration with the ACEP-SAEM GME Work Group to address this resolution.

The 2014 Institute of Medicine (IOM) report called for additional transparency and accountability in GME payments. The committee reviewed and discussed these issues at length, consulted with ACEP's Federal Government Affairs Committee and State Legislative/Regulatory Committee, institutional finance officials, graduate medical education officials, as well as other stakeholders to address this matter and to explore rules governing funding utilization and reporting by institutions receiving funding from the CMS. Additionally, the committee consulted with the ACEP-SAEM GME Work Group that has worked on this important issue for some time. The Academic Affairs Committee agreed with the ACEP-SAEM GME Work Group's opinion that until more information and data become available, the resolution to create measures to ensure maintenance of publicly available records of GME funding is premature. While all agree the resolution has merit and greater transparency on how the funds are used is needed, it may have the unintended consequence of reducing funding, particularly indirect medical expenses (IME). time. Per a request for proposal (RFP), the ACEP-SAEM GME Work Group collected additional research to further define the potential benefits AND risks of transparency. There is at least one state (Michigan) whose Medicaid department attempted to institute a "boilerplate" set of expectations for institutional reporting of GME funding use, including IME. According to specialists in GME financing and institutional finance managers, this is nearly impossible to do. Health Policy Alternatives, Inc., ACEP's health policy consultant, provided opinions on Michigan's Boilerplate document for the ACEP-SAEM Work Group. At present, CMS has no reporting requirements on spending and does not appear to have any available annual reports on GME expenses, utilization, etc. The agency's focus is to ensure no duplicative or excessive payments are made to the institutions. The Inspector General made GME and IME a priority and investigated the Intern/Resident Information System (IRIS) reporting processes, hospital IME, whether IME payments are calculated correctly, and whether they are in accordance with federal regulations.

In June 2016, the Board approved delaying engaging in discussions with CMS regarding GME funding transparency and accountability until reporting requirements are further defined and researched and potential consequences are studied. The GME Work Group drafted an RFP to address the value of emergency medicine

residency programs to institutions and hospitals. The ACEP-SAEM Working Group continues to collect data to address this issue.

Resolution 20 Group Purchasing Effects on Patient Care (as amended)

RESOLVED, That ACEP study the effects on patient care from the lack of availability of appropriate medications and medical equipment due to group purchasing practices, medication shortages, and orphan product restrictions; and be it further

RESOLVED, That ACEP work with stakeholders such as the American Medical Association to develop model legislation that protects physicians from liability as a result of the inability to provide optimal care due to lack of appropriate medical devices or pharmaceuticals to diagnose and treat emergency patients.

Action: Assigned first resolved to the Emergency Medicine Practice Committee and second resolved to the AMA Section Council on Emergency Medicine.

The Emergency Medicine Practice Committee developed survey questions on the lack of availability of appropriate medication and medical equipment due to medication shortages that were included in an Emergency Medicine Practice Research Network (EMPRN) survey distributed in early July. Results from the survey were compiled, reviewed by the Board in October 2016, and communicated to ACEP members. Information on group purchasing and the potential effects on medication shortages are available on the ACEP website.

The AMA Section Council on Emergency Medicine conferred with AMA staff who indicated they were unaware of any action that would likely impact a physician for failure to administer a medication or use a device if it was not available to the physician. Further, they believed joint and severable liability reforms that exist in several states would sufficiently protect physicians should any such action like this surface. ACEP and the AMA already support joint and severable liability reform. ACEP's Medical–Legal Committee concurred with the AMA's position and responded affirmatively that no separate action was warranted.

See additional information about medication shortages and the AMA's actions in the report for Resolution 13.

Resolution 21 Healthcare Information Exchanges (as amended)

RESOLVED, That ACEP identify a recommended standard for ED information summary contained in Healthcare Information Exchanges; and be it further

RESOLVED, That ACEP work with relevant stakeholders to identify and promote the standard that allows for notification (in the ED electronic health record) of the existence of applicable Healthcare Information Exchange data; and be it further

RESOLVED, That ACEP promote the standardized requirements to the Healthcare Information Exchanges currently in the process of development.

Action: Assigned to the ED Information Systems Task Force that was appointed to address Amended Resolution 20(14). The 2014 resolution 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. The task force is continuing their work in FY 2018-19.

Collective Medical Technologies (CMT) entered into a corporate sponsor agreement and exclusive partnership with ACEP in April 2016 to aid in the promotion and support of the CMT's Emergency Department Information Exchange (EDIE) program. EDIE, also called PreManage ED, collects data from all EDs visited by a patient, packages that data into actionable insights, and then delivers the information to emergency physicians via real-time notifications during the patient visit.

Resolution 22 Increasing Use of Advance Directives by Designation on Drivers Licenses (as amended)

RESOLVED, That ACEP support efforts to encourage adults of all ages and states of health to talk with family, friends, spiritual advisors, health professionals, and physicians about advance directives and to record and keep these wishes updated.

Action: Assigned to the Public Relations Committee to develop public media campaign materials for distribution.

The committee developed and distributed a press release on advance directives and posted an article on ACEP's public website EmergencyCareforYou.org.

Resolution 23 Integrating Emergency Care Into the Greater Healthcare System

RESOLVED, That ACEP pursue reimbursement strategies to promote care coordination in the Emergency Department; and be it further

RESOLVED, That ACEP promote reimbursement strategies to incentivize ED's to perform intensive case management to optimize ED utilization for high utilizers; and be it further

RESOLVED, That ACEP promote effective ED information sharing systems across health systems to facilitate care coordination and effective resource utilization.

Action: Assigned first two resolveds to the Alternative Payment Models (APM) Task Force. Assigned third resolved to ED Information System Task Force that was assigned to address Amended Resolution 20(14) and Amended Resolution 21(15). ACEP's partnership agreement with CMT (see comments on Resolution 21) addresses the third resolved.

The APM Task Force considered and analyzed several APMs and two were developed: Acute Unscheduled Care Model (AUCM) and Alternative Acute Care Model (AACM). On September 6, 2018, the Acute Unscheduled Care Model (AUCM) was recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to the Secretary of the Department of Health and Human Services (HHS) for full implementation. The PTAC, which includes 10 members appointed by the Government Accountability Office (GAO), were unanimous in their support of the model. With PTAC's endorsement, ACEP can begin discussions with the Centers for Medicare & Medicaid Services (CMS) about implementation. ACEP issued a press release to announce this accomplishment.

The ED Information Systems Task Force is continuing their work in FY 2018-19.

Resolution 27 Reimbursement for Ultrasound Performed by Emergency Physicians (as amended)

RESOLVED, That ACEP develop a statement declaring that insurance companies and other payers reimburse emergency physicians for ultrasound studies and services that they perform and interpret as separate and identifiable procedures while providing patient care services in the Emergency Department; and be it further

RESOLVED, That ACEP support efforts to reduce payment denials for appropriately performed and documented clinical ultrasonography.

Action: Assigned to the Reimbursement Committee in consultation with the Emergency Ultrasound Section.

The Reimbursement Committee developed the policy statement, "Payment for Ultrasound Services in the Emergency Department." It was approved by the Board in June 2016.

Resolution 29 Support for Drug "Take-Back" Programs (as amended)

RESOLVED, That ACEP supports the development of drug "take-back" programs at no cost to patients; and be it further

RESOLVED, That the AMA Section Council on Emergency Medicine consider submitting a resolution to the American Medical Association to support drug "take-back" programs.

Action: The first resolved is a policy statement. It was assigned to the Public Health & Injury Prevention Committee to review and determine if any additional information was needed to develop a policy statement. The second resolved was assigned to the AMA Section Council on Emergency Medicine to discuss submitting a resolution to the AMA.

The Public Health & Injury Prevention Committee developed the policy statement, "Drug Take Back Programs." It was approved by the Board in June 2016.

The AMA Section Council on Emergency Medicine determined that the AMA has policy in support of drug take-back programs:

> "Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs H-135.936
> 1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications. 2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations. 3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling."

Resolution 31 American Board of Medical Specialties Maintenance of Certification and Maintenance of Licensure (as amended)

RESOLVED, That ACEP communicate its appreciation to ABEM for its efforts to be sensitive to the practicing emergency physician in interpreting the American Board of Medical Specialties (ABMS) mandates; and be it further

RESOLVED, That ACEP develop policy supporting the American Board of Medical Specialties Maintenance of Certification as appropriate support for state medical license Maintenance of Licensure, but actively oppose mandates that require or link Maintenance of Certification as the only pathway for ongoing Maintenance of Licensure; and be it further

RESOLVED, That ACEP develop policy that specifically opposes efforts of specialty boards to become the independent sole source and for profit autonomous entities mandating continuing education credit and uncontrolled fiduciary and financial autonomy for emergency physicians.

Action: Assigned to the Academic Affairs Committee. In October 2016, the Board approved the committee's recommendations to 1) communicates appreciation to ABEM for its efforts in the realm of ABMS mandates; 2) take no further action *at this time* regarding development of a policy opposing mandates linking maintenance of certification as the only path to maintenance of licensure; and 3) take no further action *at this time* regarding development of a policy opposing specialty boards as the sole source mandating continuing education credit. ACEP worked with ABEM on maintenance of certification/maintenance of licensure (MOC/MOL) issues as well as Resolution 8(16) Opposition to Required High Stakes Secured Examination for Maintenance of Certification that was referred to the Board by the 2016 Council. ACEP relayed the growing discontent among some ACEP members with the MOC process and particularly the high-stakes ConCert exam. ABEM held a special Board meeting in September 2017 to explore modifications and options to the ConCert examination and held a national ConCert Summit October 2-3, 2017, that included representatives from every emergency medicine organization to explore modifications and options to the ConCert examination. ACEP, along with dozens of other specialty societies and state medical societies, met with ABMS and its certifying boards in early December 2017 to discuss concerns regarding both MOC and the high-stakes exams. In February 2018, the ABEM Board approved alternative to the ConCert as well as modifications to the existing ConCert. An article was published in *ACEPNow* in July 2018 announcing the changes.

Resolution 32 Critical Communications for ED Radiology Findings (as amended)

RESOLVED, That ACEP work with the American College of Radiology to develop a joint best practice guideline regarding imaging findings that should be communicated in real-time and in a closed-loop manner by the radiologist to the emergency provider, weighing the benefit of immediate communication of critical information against the risk of excessive interruptions in provider workflow.

Action: Assigned to the Emergency Medicine Practice Committee and include representation from the American College of Radiology in development of the policy statement.

The Emergency Medicine Practice Committee developed "Guiding Principles for Critical Communication for Emergency Department Radiology Findings." The principles were reviewed by the Board in April 2016. ACEP leaders met with leaders of the American College of Radiology (ACR) in June 2016. ACR expressed interest in a joint writing task force to address communication between radiology and emergency physicians. The Emergency Medicine Practice Committee was assigned an objective for 2016-17 to incorporate the "Guiding Principles" into existing policy. ACR communicated its support to work with ACEP to revise the policy statement, "Intrepretation of Imaging Diagnostic Studies." A draft revision was completed and sent to ACR in September 2017 for review. Feedback was received from ACR in December 2017. While there were several comments received, the most significant concern raised by ACR was the inclusion of language addressing reimbursement for emergency physicians. It was recommended by the ACR reviewers that the language addressing reimbursement be eliminated from the policy. The Emergency Medicine Practice Committee agreed that language concerning reimbursement should be retained in the policy, although softened to indicate any provider providing contemporaneous interpretations is entitled to reimbursement. The ACEP Board of Directors reviewed revised policy statements at their February and April 2018 meeting and in June 2018 approved the revised policy statement "Interpretation of Diagnostic Imaging Tests." ACR has been asked to endorse the policy statement, but they may decline since all of their comments were not incorporated.

Resolution 33 Defining and Transparency in Urgent Care Centers (as amended)

RESOLVED, That ACEP create a policy statement defining an urgent care center in order to protect patients by ensuring accurate consumer information as to provider qualifications, resources available, and value to make informed decisions when seeking care; and be it further

RESOLVED, That ACEP work with state and federal stakeholders to advocate for appropriate regulatory standards for urgent care centers.

Action: Assigned first resolved to the Emergency Medicine Practice in consultation with the Freestanding Emergency Centers Section. Assigned second resolved to the State Legislative/Regulatory Committee for state advocacy initiatives and Public Affairs staff for federal advocacy initiatives.

The Emergency Medicine Practice developed the policy statement "Urgent Care Centers" with input from the Freestanding Emergency Care Section. It was approved by the Board in October 2016.

This issue was included in the weekly legislative tracking reports provided to state chapters. It was also addressed with AMA staff and other relevant stakeholders.

Resolution 34 Enabling Access to Epinephrine for Anaphylaxis (as amended)

RESOLVED, That ACEP, in conjunction with other interested organizations, evaluate state efforts to provide timely access to epinephrine for anaphylaxis, including current state legislation that includes liability protection for appropriate use, public education, awareness and timely access, including cost effective mechanisms for availability of devices that may be used for bystander or self-administration, and report back to the Council in 2016.

Action: Assigned to the State Legislative/Regulatory Committee. The committee provided a report to the Board in October 2016. At the federal level, in 2013, President Obama signed into law the School Access to Emergency Epinephrine Act, which encourages schools to stock epinephrine (epi) for severe asthma attacks and allergic reactions. The law also made changes to the Children's Asthma and Treatment Grants Program so that HHS will give preferential funding to a state's asthma treatment grants if: 1) the state maintains an emergency supply of epi; 2) permit trained personnel at the school to administer the epi; and 3) develop a plan for ensuring trained personnel are available to administer epi during all hours of the school day. All states currently have legislation in place addressing epi in schools. However, the legislation varies by state. In most states, except West Virginia and Alabama, students are allowed to carry their own epi device. Most states require the student to have physician authorization, but there is no physician authorization mandate in Idaho, Iowa, and West Virginia. Most states have a student competency requirement, except Arizona, Colorado, Florida, Idaho, Illinois, Iowa, Michigan, New Jersey, Rhode Island, West Virginia, and Wisconsin. In most states, the school nurse and/or a staff administrator can give the epi; however, in Minnesota, only the nurse can give the epi. In Idaho, Maine, and North Dakota neither the nurse nor a staff administrator can give the epi and only the student can self-administer. Approximately 50% of states allow and/or require stockpiling of epi at schools. Most states have a release from liability, except for Delaware, Idaho, Indiana, Maine, Massachusetts, Pennsylvania, and Texas. This information was compiled from The Network for Public Health Law (the Network) and Food, Allergy, Research and Education (FARE). Both are non-profit organizations that maintain current information on state school laws. There is also legislation in many states to allow other places such as restaurants, children's camps, adventure parks, and other "entities" to have access to epi. The Network provides a brief review of all legislation on "entities" as well as the state-by-state legislation. Currently, 27 states have entity stocking epi laws and six states have pending legislation. Seventeen states do not have laws or pending legislation on entities stocking epi. All 27 states that allow entity stocking have training requirements and liability exemptions for the entity administering the program, the employees that give the epi, and the healthcare professional that prescribed and dispensed the drug. ACEP has information on the website with the 2016 proposed legislation in the states and it includes information about the adopted 2016 Epi Pen legislation. There is no legislation that addresses how to pay for epi. Currently, one company (Mylan, the makers of EpiPen) holds 90% of the US market on epi. The cost of an EpiPen has increased 400% since 2008. Senator Amy Klobuchar (D-MN) has called for a Judiciary Committee inquiry into the pricing and an investigation by the Federal Trade Commission and the company has faced a barrage of media criticism and complaints from patient advocates based on its pricing practices. The American Academy of Allergy, Asthma and Immunology introduced the Airline Access to Emergency Epinephrine Act (S1972).

Resolution 35 Emergency Department Detox Guidelines (as amended)

RESOLVED, That ACEP create clinical practice guidelines for treatment of patients presenting to the emergency department in opioid or benzodiazepine withdrawal; and be it further

RESOLVED, That ACEP create a practice resource to educate emergency providers about the science of opioid and benzodiazepine addiction.

Action: Assigned to the Clinical Policies Committee. This issue is included in the revision of the 2012 opioid clinical policy currently in progress. The critical questions were finalized and literature searches completed. The literature was obtained and grading began in the fall 2017. Many comments were received on the draft opioid critical questions asking why a question on benzodiazepine withdrawal was included in an opioid policy, as they are two different topics. The committee is developing a policy statement on benzodiazepine withdrawal because there is not enough evidence to create a clinical policy solely on benzodiazepine withdrawal.

Resolution 36 Establishing State and National POLST/EOL Registries (as amended)

RESOLVED, That ACEP support the use of and implementation of POLST (or equivalent) programs as a means of honoring our patients' end of life wishes; and be it further

RESOLVED, That ACEP partner with organizations such as the American Medical Association, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, Hospice and Palliative Nurses Association, AARP, and all others it deems fit to advocate for and support the creation of state and/or a national POLST/EOL database(s) that can be accessed by emergency physicians and EMS responders in times of crisis and uncertainty around a patient's end-of-life care; and be it further

RESOLVED, That ACEP provide education for emergency physicians regarding the utilization of POLST forms and encourage ACEP members to become familiar with their state's POLST (or equivalent) program; and be it further

RESOLVED, That ACEP continue to promote advanced care and end-of-life planning and coordination as a best practice.

Action: This resolution was addressed in ACEP's Strategic Plan: "Engage chapters and other medical organizations to promote Physician Orders for Life Sustaining Treatment (POLST) and other effective advance directive documents." Assigned third resolved to the Palliative Medicine Section.

Articles on POLST were published in *ACEP Now* as well as other palliative care principles in the emergency department. A plan was developed to distribute POLST CME materials to chapters, encourage their use, and encourage advocacy efforts in states without adequate POLST laws.

The Palliative Medicine Section worked with the State Legislative/Regulatory Committee to address the assigned third resolved. Over the past several years ACEP has engaged on issues of palliative medicine, end-of-life (EOL) care and advanced directives as they relate to emergency medicine. Many of ACEP's existing efforts were outlined in the background of the resolution. The collaborative work we sought to identify new opportunities for our organization to build on its educational efforts in the area of the POLST paradigm. The primary challenge in providing effective and targeted education for our membership is the significant state-to-state variability in the maturity of their POLST paradigm. Some states, such as Oregon, have a widely used POLST program while other states such as Arkansas do not have any sort of program in place. The National POLST Paradigm website provides a helpful map with some information about progress in each state (http://polst.org/programs-in-your-state/). However, even within categories on this map, there are major differences that would have a significant impact on providers. For example, both Indiana and Texas are categorized as "developing." In Indiana, POLST forms are widely available and seen regularly by EPs on shift, at least on a regional basis. In Texas, most EPs have no familiarity with the program or associated forms. To provide practice-relevant education to ACEP members would require tailoring such education to each state. For this reason some outreach efforts initially considered were believed to be impractical. For example, providing an article for each chapter to publish in their chapter newsletter (if they so wished) regarding the POLST paradigm was considered. However, each article would need to be written by someone personally familiar with the program in that state; the workgroup did not include that depth of expertise. A similar challenge exists for any programming reaching a nationwide audience, including lectures at ACEP's annual conference. To encourage physicians to learn about their own state programs, several articles were published in *ACEP Now* about the POLST issue. In 2015, there were two articles about the complexities of the paradigm. Per our offer to provide additional materials for publication the editors may publish more information about this program in the future. EMRA's publication, *EM Resident,* published an article in the June/July 2016 issue, "*POLST: Guiding Providers in End of Life Care.*" The article was co-authored by a member of the workgroup about the POLST paradigm and was targeted at the new generation of emergency physicians. As an additional education outreach, information about the POLST paradigm was included in eCME course developed by ACEP. ACEP's MOC/MOL Subcommittee developed an ABEM-approved MOC Part IV PI-CME activity on palliative care that also addressed POLST. The product was released in 2017-18. A workgroup member served as the content expert assigned to integrate information about POLST into the final product.

A table was located outside the 2016 Council meeting with information and content experts available to discuss and answer questions about POLST.

The Ethics Committee worked with the Palliative Medicine Section to develop the "Guidelines for Emergency Physicians on the Interpretation of Physician Orders for Life-Sustaining Therapy." The guidelines were approved by the Board in April 2017.

Resolution 37 Intravenous Ketamine for Pain Management in the ED (as amended)

RESOLVED, That ACEP collaborate with the Emergency Nurses Association, the American Association of Emergency Nurse Practitioners, the Society of Emergency Medicine Physician Assistants, and other emergency care provider organizations 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 be it further

RESOLVED, That the position statement developed by ACEP and the other stakeholders on the use of sub-dissociative ketamine be distributed to all state nursing boards.

Action: Assigned to the Emergency Medicine Practice Committee and to include representatives from ENA, AAENP, SEMPA, and others as appropriate.

The committee considered addressing the use of sub-dissociative ketamine in the "Optimizing the Treatment of Acute Pain in the Emergency Department" policy statement but determined that a separate policy statement was

needed in addition to a Policy Resource and Education Paper (PREP). The Board approved the policy statement "Sub-dissociative Dose Ketamine for Analgesia" and reviewed the PREP in October 2017.

Resolution 38 Patient Satisfaction Scores in Safe Prescribing (as amended)

RESOLVED, That ACEP opposes any non-evidence based financial incentives predicated on patient satisfaction scores; and be it further

RESOLVED, That ACEP work with stakeholders to create a quality measure that is related to safe prescribing of controlled medications; and be it further

RESOLVED, That the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Action: The first resolved is a policy statement. Assigned to the Emergency Medicine Practice Committee to review ACEP's current policy statements regarding patient satisfaction surveys/scores and determine if any revisions are needed or whether an additional policy statement should be developed. Assigned second resolved to the Quality & Patient Safety Committee. Assigned third resolved to the AMA Section Council on Emergency Medicine.

The Emergency Medicine Practice Committee revised the policy statement, "Patient Satisfaction Surveys" with the new title "Patient Experience of Care Surveys." It was approved by the Board in June 2016.

The AMA Section Council on Emergency Medicine supported and advocated ACEP's position in discussions about ED-PEC and HCAHPS as patient satisfaction scores that need revision.

Resolution 41 Procedural Credentialing Requirements (as amended)

RESOLVED, That ACEP work within its several committees and sections charged with quality, emergency medicine practice, and rural emergency medicine to research and recommend such credentialing models to maintain the rural/underserved presence without undue hardship on ED physicians or result in a greater lack of board certified/board eligible emergency physicians in these areas; and be it further

RESOLVED, That ACEP develop a policy statement and information for dissemination regarding appropriate emergency medicine credentialing models for rural/underserved areas; and be it further

RESOLVED, That ACEP work with hospital accreditation bodies, the Centers for Medicare & Medicaid Services, the American Hospital Association, and related state hospital, regulatory, and certification organizations to recommend appropriate credentialing standards for ED physicians and facilities in rural/underserved areas.

Action: The Emergency Medicine Practice Committee was assigned an objective for 2016-17 to explore development of a policy statement and other information for dissemination regarding appropriate emergency medicine credentialing models for rural/underserved areas and to work with the Rural Emergency Medicine Section and other committees as needed. The Board approved revisions to the policy statement, "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" and reviewed the revised PREP in April 2017.

Resolution 42 Prolonged Emergency Department Boarding (as amended)

RESOLVED, That ACEP 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; and be it further

RESOLVED, That ACEP 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.

Action: Assigned to the Emergency Medicine Practice Committee. Representatives from the Emergency Nurses Association, the Society of Emergency Medicine Physician Assistants, and the American College of Osteopathic Emergency Physicians worked with the committee to revise the information paper "ED Crowding: High Impact Solutions." The revised paper was reviewed by the Board in June 2016 and distributed to members and stakeholder organizations. Additional resources are available on the ACEP Website

Resolution 43 Required CME Burden (as amended)

RESOLVED, That ACEP, in order to promote high quality, safe, and efficient emergency medicine care address the fact that requiring a significant amount of concentrated continuing medical education in specific areas annually will lead to reduced ongoing education in other clinical areas important to the practice of emergency medicine (such as Pediatrics, Infectious Disease, Gastroenterology, Endocrinology, etc.), resulting in the unintended consequence of reducing physician readiness to care for the ED patients not included in the Time Critical Diagnosis

initiative; and be it further

RESOLVED, That ACEP work with organizations such as the American Hospital Association, the American Heart Association, and related state hospital organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to be able to readily care for all emergency department patients without costly and redundant requirements, unless found to be necessary for individual physicians based on assessment and oversight by the ED medical director.

Action: Assigned to the Emergency Medicine Practice Committee. The policy statement, "CME Burden," was approved by the Board in April 2016.

Resolution 45 Telemedicine Appropriate Support and Controls

RESOLVED, That ACEP investigate and evaluate the positive, negative, and potential unintended consequences of telemedicine; and be it further

RESOLVED, That ACEP develop appropriate policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Action: Assigned to the Emergency Medicine Practice Committee to develop a policy statement on telemedicine in conjunction with the Emergency Telemedicine Section.

The policy statement, "Emergency Medicine Telemedicine," was approved by the Board in January 2016. The Ethics Committee developed the policy statement, "Ethical Use of Telemedicine in Emergency Care," that was approved by the Board in June 2016.

Resolution 46 Transitioning Out of Medical Practice

RESOLVED, That ACEP dedicate member resources towards the study and education of how best to transition out of the clinical practice of Emergency Medicine.

Action: Assigned to the Well-Being Committee to review the Emergency Medicine Practice Committee's paper on careers outside of the emergency department and determine if any additional information and resources should be developed.

The Well-Being Committee reviewed the Emergency Medicine Practice Committee's information paper on this topic and added information on opportunities in education, subspecialties, and event medicine. The Board reviewed the revised information paper, "Hospital Employment and Careers Outside the ED," in June 2016.

Resolution 47 In Memory of Marshall T. Morgan, MD

RESOLVED, That the American College of Emergency Physicians honors Marshall T. Morgan, MD, for his thoughtful, professional demeanor, his superb patient care skills, true compassion for all those he encountered, and his exemplary leadership in emergency medicine and the house of medicine.

Action: A framed resolution was prepared and sent to the family of Dr. Morgan.

Resolution 48 In Memory of Richard P. O'Brien, MD, FACEP

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted communicator and self-described "radio enthusiast," Richard P. O'Brien, MD, FACEP, and extends condolences and gratitude to his family and friends for his service to the specialty of emergency medicine and to patient care.

Action: A framed resolution was prepared and sent to the family of Dr. O'Brien.

Resolution 49 In Memory of Leah Anne Davis, DO

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honor the contributions made by Leah Anne Davis, DO, as one of the future leaders in Emergency Medicine; and be it further

RESOLVED, That national ACEP and the Illinois Chapter extends to her family, friends, and colleagues our sympathy, great sense of sadness and loss, our gratitude for having been able to share a part of her life, and for her service to the specialty of Emergency Medicine

Action: A framed resolution was prepared and sent to the family of Dr. Davis.

Resolution 50 In Memory of Marvin Leibovich, MD, FACEP

RESOLVED, That the American College of Emergency Physicians fondly honors Marvin Leibovich, MD, FACEP, as one of the pioneers and leaders in the specialty of emergency medicine; and be it further

RESOLVED, That national ACEP join with the Arkansas Chapter in extending our memorium and gratitude to Dr. Leibovich for a life well lived in the service of others.

Action: A framed resolution was prepared and sent to the family of Dr. Leibovich.

Resolution 51 In Memory of Michael G. Hughes, MD, FACEP

RESOLVED, That the American College of Emergency Physicians recognizes with gratitude and honor the contributions made by Michael G. Hughes, MD, FACEP, to the specialty of emergency medicine in Massachusetts and in his service to our country's armed forces; and be it further

RESOLVED, That ACEP extends to the family, friends, and colleagues of Dr. Hughes our sympathy, our great sense of sadness and loss, and our gratitude for having been able to share a part of his life

Action: A framed resolution was prepared and sent to the family of Dr. Hughes.

Resolution 52 Commendation for David Blunk

RESOLVED, That the American College of Emergency Physicians formally commends David Blunk for his dedicated efforts, leadership, and mentoring at both the state and local levels as the Executive Director of the Pennsylvania College of Emergency Physicians.

Action: A framed resolution was presented to Mr. Blunk.

Council Standing Rules Resolution

Resolution 9 Electronic Submission of Resolution Amendments

RESOLVED, That the "Resolutions" section of the Council Standing Rules, paragraph three, be amended to read:

All motions for substantive amendments to resolutions must be submitted in writing **through the electronic means provided to the Council during the annual meeting, with the exception of technical difficulties preventing such electronic submission,** signed by the author, and presented to the Council prior to being considered. When appropriate, amendments will be distributed or projected for viewing.

Action: The Council Standing Rules were updated.

Referred Resolutions

Resolution 18 ER is for Emergencies

RESOLVED, That ACEP work with the American Medical Association and other interested parties to study the possibility of expanding the "ER is for Emergencies" program to a national scale.

Action: Assigned to the State Legislative/Regulatory Committee for review and to provide a recommendation to the Board regarding further action on this resolution and to consult with the AMA Section Council on Emergency Medicine as needed.

The committee sought advice from the Washington Chapter and members of the AMA Section Council on Emergency Medicine. Since October 2015, some internal changes have occurred within the Washington State Medical Association (WSMA) regarding the issue. By acquiescing to the WA-ACEP desire to bring this EM-specific issue to ACEP first and the resulting referral to the ACEP Board, the momentum was lost within the WSMA to bring the issue before the AMA. The AMA Section Council on Emergency Medicine representatives also noted that this is a specialty-specific issue and is not the usual type of resolution brought before the AMA without specific requests or action items expected by the AMA. Additionally, it was discussed that other states (specifically, Oregon) have used the Washington experience to tailor initiatives to their state without specifically adopting the "ER is for Emergencies" program, but instead adapting components of the "Seven Best Practices" that were believed to be most effective in their particular climate. In October 2016, the Board approved the committee's recommendation to take no further action at this time and continue to promote the spirit of the resolution by supporting state chapters with similar initiatives.

Resolution 24 Interstate Medical Licensure Compact Legislation and Opposition to National Medical License

RESOLVED, That ACEP evaluate the proposed state legislative language, often referred to as the "Interstate Medical Licensure Compact," allowing reciprocity by state physician licensing boards for board certified physicians, for its potential effect on emergency physicians' practice and the potential for unintended consequences.

Action: Assigned to the State Legislative/Regulatory Committee for review and to provide a recommendation to the Board regarding further action on this resolution. The committee identified resources and in October 2016 the Board approved the committee's recommendation to distribute the information to members and chapters.

There were ongoing discussions about how to improve the process of allowing physicians to practice in more than one state. In response to these discussions, the Interstate Medical Licensure Compact (IMLC) is a voluntary pathway that streamlines the ability for a physician to obtain a license in multiple states, while still allowing state medical boards to retain their regulatory oversight capacity. Currently, the process to obtain licensure in multiple states remains cumbersome. For initial licensure, basic standards remain uniform on a national level. However, states have implemented their own additional requirements for granting and renewing medical licenses for physicians. These include variable timetables for licensure renewal, CME requirements including formal course work, and potential face-to-face interviews with members of the state medical board.[2] State agencies can then take many months to process their applications. In 2013, the Federation of State Medical Boards (FSMB) House of Delegates adopted a resolution to help improve the process of license portability. This initiative, known as the Interstate Medical Licensure Compact (IMLC), received support from the American Medical Association House of Delegates in 2014. Currently, 17 states have enacted legislation to enable the state to participate in the IMLC, and 10 additional states have introduced legislation to advance the measure. The IMLC is a **voluntary** option designed to streamline the current process and make it easier for physicians to obtain full, unrestricted licenses to practice in multiple states. The IMLC reduces the administrative and cost barriers previously faced by physicians providing in-person care in multiple states. The IMLC is also an important mechanism that will support physicians who are interested in using telemedicine technologies while ensuring that the state where the patient receives care is able to provide oversight and ensure accountability with state medical practice laws and standards of care. The Interstate Medical Licensure Compact Commission is the entity charged with administering the IMLC. The Commission held several public meetings from October 2015 to August 2016, published a rule open to comment, and developed the IMLC's technical and data infrastructure. The interstate medical licensure compact was launched April 6, 2017.

Resolution 28 Standards for Fair Payment of Emergency Physicians

RESOLVED, That ACEP develop a set of standards for fair payment for Emergency Physician services, and compliance with which to be included in the next edition of America's Emergency Environment, A State by State Report Card;" and be it further

RESOLVED, That ACEP devote increased resources to monitor the state-by-state status and changes in law concerning the standards for fair payment of Emergency Physicians and establish a single point of contact at the national level as a resource for assisting all chapters; and be it further

RESOLVED, That ACEP shall work with other **medical** specialties~~, ambulatory services,~~ and hospitals to develop Model Fair Payment Legislation and then devote resources to promoting adoption in every state; and be it further

~~RESOLVED, That ACEP shall use its influence with the National Emergency Medicine Political Action Committee to devote resources to developing state-by-state influence upon each state's legislative and regulatory process; and be it further~~

RESOLVED, That ACEP work with the Emergency Medicine Foundation to research, publish, and disseminate the detrimental effects of legislation that limits the rights of emergency physicians to fairly bill and collect, and to develop effective educational materials explaining the facts concerning emergency physician billing and collection, for use at the national and local level in educating legislators, regulators, policy-makers, and the public; and be it further

RESOLVED, That ACEP ~~and the Emergency Medicine Action Fund develop and support~~ **explore the development of** a national "strike team" that can be deployed by ACEP leadership to help chapters in states where emergency physicians are facing an immediate legislative threat to the fair payment process.

Action: This resolution was addressed primarily through the work of the ACEP/EDPMA Task Force on Reimbursement Issues. It was also assigned to the Reimbursement Committee, State Legislative/Regulatory Committee, and Federal Government Affairs Committee for review and to provide a recommendation to the Board regarding further action on this resolution.

In the summer of 2015, ACEP President Dr. Michael Gerardi appointed an ACEP/EDPMA Joint Task Force to study reimbursement issues. The subgroup working on balance billing issues considered concerns created by narrow networks with regard to those issues. The task force, working in conjunction with ACEP's State

Legislative/Regulatory Committee and Reimbursement Committee, produced a series of studies, "Strategies to Address Balance Billing and Out of Network (OON) Benefits for Professional Emergency Care Services" and "Situation Report: Balance Billing Legislation." Those documents were approved by the Board in April 2016. Additional resources are available on the ACEP website.

In December 2015, network adequacy and out of network reimbursement was an issue included on the agenda of a national call for state chapter leaders and lobbyists. In the 2015-16 fiscal year, the State Legislative/Regulatory Committee recommended, and the Board approved, Public Policy Grants for the Georgia and Florida chapters to address these issues and ACEP staff and member experts provided consultative services to assist numerous other chapters dealing with out of network payment legislation or regulation. Beginning in January 2016, ACEP leaders and staff began holding meetings with the American Society of Anesthesiologists about collaborating on network adequacy and balance billing issues at the state level. The collaboration subsequently expanded to include other hospital-based specialties and the AMA.

ACEP filed suit against the federal government on May 12, 2016. Following a federal government decision in favor of health insurance companies, the suit was filed against the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are "out of network" because of a medical emergency. A motion for summary judgement was filed on November 18, 2016. The government filed its Cross Motion for Summary Judgement and Opposition to Summary Judgement on December 9, 2016. ACEP filed its response by January 20, 2016. The U.S. District Court for the District of Columbia partially granted ACEP's Motion for Summary Judgment on August 31, 2017 and denied the Government's counter motion regarding its lawsuit against the federal government to contest a regulation that impedes emergency physicians from receiving accurate usual and customary payment for out-of-network services. The court remanded the matter back to the Centers for Medicare & Medicaid Services for further explanation of the regulation, saying that comments submitted to the federal departments (Departments of Health & Human Services, Labor, and Treasury) during its development expressed "concerns about the rule – for example, that the methods it used to set payments were not transparent and could be manipulated by insurers. The Parties (ACEP and the federal Departments) were ordered to file a "joint status report" by October 30, 2017. On April 30, 2018, the Departments published in the *Federal Register* the "Clarification of Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act". In the document, the Departments declined to revise or rescind the rule, instead reaffirming it and rejecting ACEP's proposal to use an independent database to set payment rates. They explained that the Departments do not have the authority to establish or maintain such a database and that it would be costly and time consuming to oversee one. The Departments further explained that, in its current form, the rule is sufficiently transparent because insurers and plans are required to disclose information upon request to a plan participant or their authorized representative related to how they calculate their "usual, customary, and reasonable" amount. On May 1, 2018, the parties filed a Joint Status Report with the Court, requesting thirty (30) days for ACEP to evaluate the Departments' response and possible next steps. The Court granted the request and the parties will file another Joint Status Report no later than June 1, 2018. In May 2018, the Board of Directors approved dismissing the lawsuit.

ACEP provided funding to the Florida, Georgia, and Texas chapters in 2016 to support their efforts on out-of-network/balance billing legislation. The Emergency Medicine Action Fund has provided additional funding to the Georgia Chapter. ACEP continues to hold strategy meetings on out-of-network/balance billing with multiple stakeholders.

The AMA House of Delegates adopted the following resolution at the June 2017 annual meeting:

> "RESOLVED, That our American Medical Association work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the "prudent layperson" standard of determining when to seek emergency care."

The AMA sent a letter on June 29, 2017, asking Anthem to rescind the policy citing federal patient protections under prudent layperson, forcing patients to make clinical judgment calls without proper training, and reducing the value of having health insurance coverage.

Another resolution adopted by the AMA in June, which originated from ACEP, brought together a large coalition of stakeholders from multiple states and specialties to protect out-of-network coverage for patients. The resolution calls for the AMA to join ACEP and the Physicians for Fair Coverage coalition to fight the surprise insurance gaps patients are experiencing while providing fair payment to emergency physicians.

In June 2017, the ACEP Board of Directors approved model legislation for payment of out-of-network services, which was prepared by the ACEP/EDMA Joint Task Force on Reimbursement. The model legislation includes a provision for payment directly to the provider. The model legislation was shared with chapters and is important for state legislatures that are considering out-of-network and balance billing legislation and look to emergency medicine for guidance.

ACEP sent a letter to the president and CEO of Anthem on August 1, 2017, regarding their announcement to deny coverage for ED care in several states. ACEP, and many individual members, have participated in media interviews (Associated Press, Modern Healthcare, The New York Times, Time Magazine, ABC News, The Washington Post, and others) to bring national attention to Anthem's assault on the prudent layperson standard in the denial of payment for emergency services. In December 2017, ACEP issued press releases about Anthem's denial of payments in Ohio and New Hampshire. In late December 2017, ACEP met with representatives of Anthem to discuss their announced policy that ACEP contends are in violation of federal and state law protecting patients according to the prudent layperson standard. ACEP continues to meet with members of Congress to educate them about denial of payment for emergency services by several payers.

The AMA has developed model legislation, "Patient Protections from Unanticipated Out-of-Network Care Act," that includes recommended language provided by ACEP. Physicians for Fair Coverage (PFC) has formally adopted a "skinny version" of the original AMA model with the network adequacy and assignment of benefits provisions removed. The majority of the remaining PFC model mirrors the AMA bill, except that the AMA bill would set out of network payment at the lesser of the physician's actual charge or the 80th percentile of an independent charge database, and the PFC model simply sets payment at the 80th percentile of a charge database. Arguments can be made in support of either approach, but the two model bills are largely complementary and attempt to drive a positive legislative resolution to this issue that is being fought out in state legislatures across the country. The PFC model bill was introduced in Kentucky and Oklahoma. The Board of Directors will discuss the model legislation (AMA and PFC) at their February 7, 2018, meeting.

On January 16, 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25). On July 17, 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients.

Resolution 30 Use of Body Cameras Worn by Law Enforcement in the ED

RESOLVED, That ACEP modify and extend its current policy statement "Recording Devices in the Emergency Department" to promote and endorse the expectation of patient privacy and limitations on recording devices by law enforcement personnel, visitors, and other individuals or organizations, during the provision of healthcare to patients in the emergency department; and be it further

RESOLVED, That ACEP promote a position that institutions and physicians should restrict the use of recording devices during patient care and in areas in which discussions containing confidential, HIPAA-protected patient information are likely to occur within the Emergency Department.

Action: Assigned to the Ethics Committee for review and to provide a recommendation to the Board regarding further action on this resolution. The committee revised the policy statement, "Recording Devices in the Emergency Department" and it was approved by the Board in January 2017.

Resolution 39 Patient Satisfaction Scores in Emergency Medicine

~~RESOLVED, That ACEP acknowledges that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, and many components of medical care not under physician control; and be it further~~

RESOLVED, That ACEP ~~opposes~~ **reaffirm its opposition to** the use of patient satisfaction surveys **that have not been validated** for physician credentialing or for emergency medicine practice financial incentives or disincentives, **consistent with current ACEP policy**.

Action: Assigned to the Emergency Medicine Practice Committee for review and to provide a recommendation to the Board regarding further action on this resolution.

The committee revised the policy statement, "Patient Satisfaction Surveys" with the new title "Patient Experience of Care Surveys." It was approved by the Board in June 2016.

Resolution 44 State Medical Board Review of Emergency Medicine Practice

RESOLVED, That ACEP survey and summarize member experience with potential inappropriate or onerous review of Emergency Medicine practice by state licensing boards; and be it further

RESOLVED, That state medical licensing board peer review of emergency medicine practice should be by board certified emergency physicians practicing in similar circumstances utilizing recognized standards of care; and be it further

RESOLVED, That ACEP evaluate the implications of developing policy to support state licensing board review of egregious expert medical testimony, including, but not limited to, simplified "out of state" physicians

"certificates" to provide authority over expert medical testimony; and be it further

RESOLVED, That ACEP develop policy to support state licensing board review and sanctioning of physicians providing egregious standards of care for testimony in medical liability cases.

Action: Assigned to the Medical-Legal Committee for review and to provide a recommendation to the Board regarding further action on this resolution. The committee developed the policy statement "State Medical Board Peer Review" and it was approved by the Board in October 2017.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

President-Elect Candidates

acep Scientific Assembly SAN DIEGO, CA 18

ACEP 50 YEARS

American College of Emergency Physicians®
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2018 President-Elect Candidates

Jon Mark Hirshon, MD, PhD, MPH, FACEP

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William P. Jaquis, MD, FACEP

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American College of Emergency Physicians®
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2018 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

Jon Mark Hirshon, MD, PhD, FACEP

Question #1: **What is the most common public misperception about emergency physicians that you would like to dispel?**

The public and policy makers perceive emergency physicians as "the good guys"- in an old western movie, we would be the heroes wearing white hats. We work days, nights, weekends, holidays- one of us will always be found in the emergency department no matter what time of day or night. We are trained diagnosticians who quickly sort through a huge mass of frequently confusing and incomplete information in order to come up with an evaluation algorithm and likely diagnosis. We are found rushing to emergencies and disasters in order to help and not fleeing due to fear. We hold dying patient's hands and comfort bereaved families. We are many things to many people, but it is important for the public to not misperceive us as superheroes. We are hard-working, dedicated, thoughtful, professionals who care about our patients and our colleagues, but we do not have superhuman or supernatural powers; we are not infallible.

I've had to intubate my own resident who was in respiratory distress, perform a lumbar puncture on a colleague and friend with an intractable headache, and care for other friends and co-workers with many different medical problems throughout my career. It is part of my job, and I am proud to do it. We are blessed with a job that has meaning, is well respected and makes a difference- both for individuals and for society. However, at times I feel like Atlas holding a massive globe on my shoulders. We are faced with many heavy burdens, including increasing health system demands, electronic medical record complexity and changing practice environments. We need institutional and system support in order to be able to do our job in the best way possible. It is critical that we let colleagues, politicians and the public know we are dedicated, hard-working and caring professionals, but that we need support in order to assure we can deliver the highest quality emergency care possible.

Question #2: **As ACEP president, how would you help unify the house of emergency medicine? Are there any impediments that you see as particularly challenging?**

Unifying the house of emergency medicine requires us to work together despite our differences. While this may sound simple, there many impediments and obstacles to accomplishing this important goal. Unifying the house of emergency medicine remains a challenge, as we have a multitude of opinions and perspectives. While a diversity of opinions is important for strength and for the growth of emergency medicine, at times these perspectives can be diametrically opposed. We need to find areas of agreement, which are many, and work collaboratively on these. On other topics where agreement is more difficult, we need to be able to respectfully and professionally disagree. There is no room for *ad hominem* attacks. Division weakens us as a specialty and diminishes our voice. We need a clear and unified voice in order to be heard above the cacophonous din found in our state capitols and in Washington, D.C.

There is an old African proverb- *If you want to go fast, go alone. If you want to go far, go together.* This proverb has been a guiding principle of my career; I consistently work to build bridges and break down barriers. This is true during my time on the ACEP Board of Directors as well as in my other professional activities. With the support of ACEP, I helped to create and now lead the Emergency Department Sickle Cell Care Coalition (EDSC^3). This is a collaboration of multiple public, governmental and professional partners whose purpose is to provide a national forum dedicated to the improvement of the emergency care of patients with sickle cell disease in the United States. Outside of ACEP, for over a dozen years, I have worked in the Middle East as the principal investigator on a NIH funded injury research training project in Egypt and now Sudan. Through this project, we have helped to develop and promote emergency medicine and improved trauma care collaboratively with many different academic, private and governmental partners. We have trained over 1000 physicians, produced multiple papers and developed many relationships. We have gone far because we have worked together.

Dr. Paul Kivela has worked hard during his presidency to improve the relationships between the various emergency medicine specialty societies and find areas of collaboration and agreement. This has been a frequent topic of discussion during our Board meetings. The June Board meeting, at which Dr. John Rogers submitted his resignation as president-elect, was turbulent and challenging in many ways. As Dr. Roger's stated in his email to the ACEP Council, he did what he thought was best, not only for the College but for our specialty. His words remain eloquent: "we are siblings in the EM family, and allies in a common cause: to provide the best care possible to patients, to advance the science of our craft, and to

improve the lives of those who practice it." These are great words from a thoughtful, dedicated leader. In the end, *if we want to go far, we must go together.* This will allow the unity we need to assure access to high quality emergency care.

Question #3: **What are the biggest internal and external threats to emergency medicine and how will you address them?**

The other night, during a busy shift, a mid-sixties woman came into my emergency department via ambulance with hypotension and inferior changes concerning for a ST-elevation MI on the EMS transmitted EKG. Upon arrival, we confirmed the EKG changes, activated the catheter lab and shortly thereafter, the patient went upstairs for catherization and stenting. The system worked- a life was saved! Unfortunately, our dysfunctional, fragmented U.S. health care system is under siege and threatened from many directions, both internally and externally. While the system worked today for my patient, will it work tomorrow for your patient or your family member with an acute life-threatening emergency?

Assuring appropriate financial and societal support remains a critical external threat to for emergency medicine. Long time emergency physician Paul Seward recently penned an article on Stat News describing emergency departments as "the 'chewing gum and duct tape' holding together U.S. health care". As the cost of health care in the U.S. has skyrocketed, emergency departments are viewed as the health care safety net- or as stated by a previous U.S. president: *"I mean, people have access to health care in America," he said. "After all, you just go to an emergency room."* Out of pocket medical expenses are mounting astronomically while insurance companies are making record profits. Many Americans are only one medical emergency away from poverty or homelessness. We, as frontline providers, see this on a daily basis. Our emergency departments may be our neighbors' front door to the hospital, but it is our window to the problems seen in our communities.

ACEP must, and I will, continue to fight to assure high quality emergency care for all Americans. This is a multi-pronged approach, including legal, educational and lobbying activities on both federal and state levels. Last summer, while having lunch with my Senator Ben Cardin, the federal champion of the prudent layperson standard, he was shocked to learn that prudent layperson was under siege again. We are now suing, along with the Medical Association of Georgia, Anthem Blue Cross and Blue Shield of Georgia because of their policy allowing for retrospective denial for some care delivered in emergency departments. Previously, we sued the U.S. Department of Health and Human Services (HHS) to require transparency of data and fair insurance coverage for emergency patients who are "out of network" because of a medical emergency. Our lobbying and educational efforts include almost daily interactions with policy makers and regulators, including high quality, effective presentations at the RVS Update Committee to assure that we are paid for the work that we do. We must, and I will, fight to make sure that we receive fair compensation for the care we deliver through supporting legal action, developing coalitions and partnerships and testifying in front of politicians and the public.

However, assuring fair compensation is only one external threat we face. The ever-increasing regulatory burden remains a significant problem, negatively impacting our productivity and our well-being. We face this concretely on a daily basis with the growing burden of documentation as enforced by our electronic medical records. For every 5 minutes I spend with a patient, I spend 15 to 20 minutes chained to a computer documenting. This negatively impacts my rapport with patients, co-workers and trainees. Reducing administrative burdens is critical and was a central theme of my testimony earlier this year before the House Committee on Ways and Means' Health Subcommittee on reducing administrative burdens for physicians in the Medicare program. Decreasing regulatory burden and improving our work environment are critical aspects of improved care delivery and emergency physician well-being. This will be a critical objective of my time as ACEP President.

Internally, we are faced with the challenge of unifying the multiple voices in emergency medicine into a strong and effective chorus. We are a diverse group and bring many different perspectives together in order to care for our varied patients. Companies with greater diversity have been shown to be more successful from a business perspective. ACEP will be more successful through embracing diversity, and not just gender and race diversity, but the many aspects of our practices- gender, race, ethnicity, large groups, small groups, academics, rural providers, young physicians, individuals near retirement, etc. Together, we can agree on specific topics and issues and work together collaboratively on these. This will strengthen our voice. On other topics, we can continue to disagree respectfully and professionally without personal attacks. Speaking with one voice will allow us to be heard above the discordant clamor found in Washington, D.C. and in many state capitols.

Emergency physicians are caring, thoughtful professionals. We work hard, and we play hard. We care about our patients and for our colleagues. ACEP and emergency medicine play a critical and ever-increasing role within the health care system. I will work together with our many partners forcefully advocate for emergency medicine and to sustain and to grow the support for our important work. Working together we can, and we will, make a difference.

CANDIDATE DATA SHEET

Jon Mark Hirshon, MD, PhD, MPH, FACEP

Contact Information

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E-Mail: jhirshon@acep.org

Current and Past Professional Position(s)

My current position is as Professor, Department of Emergency Medicine and Department of Epidemiology and Public Health, University of Maryland, School of Medicine. I am also Senior Vice-Chair of the University of Maryland, Baltimore Institutional Review Board. Prior positions include assistant professor at University of Maryland School of Medicine and Johns Hopkins School of Medicine, as well as prior clinical employment in several community emergency departments in Baltimore, Maryland.

Education (include internships and residency information)

1984	Bachelor of Arts, Biology and French Literature, University of California, Santa Cruz
1990	Doctor of Medicine, University of Southern California, School of Medicine
1990–1993	Emergency Medicine Residency, Johns Hopkins Hospital, Johns Hopkins University
1994–1995	Preventive Medicine Residency, Johns Hopkins Bloomberg School of Public Health,
1994	Master in Public Health, Johns Hopkins Bloomberg School of Public Health, Special Emphasis on International Health
2011	Doctor of Philosophy in Epidemiology, Department of Epidemiology and Public Health, University of Maryland School of Medicine

Certifications

1991–current	Diplomate, National Board of Medical Examiners
1994, 2004, 2014	Diplomate, American Board of Emergency Medicine
1997–current	Fellow, American College of Emergency Physicians
1998–current	Fellow, American Academy of Emergency Medicine
2002, 2012	Diplomate, American Board of Preventive Medicine
2002–current	Fellow, American College of Preventive Medicine

Professional Societies

1990–current	Alpha Omega Alpha Medical Honor Society
1998–current	American Academy of Emergency Medicine (fellow)
1997–current	American College of Emergency Physicians (fellow)
2002–current	American College of Preventive Medicine (fellow)
1994–current	Delta Omega Public Health Honor Society
1993-current	Society for Academic Emergency Medicine
2011-current	African Federation of Emergency Medicine
2016-current	American Medical Association

National ACEP Activities – List your most significant accomplishments

1996-2006	Member, then Chair, Public Health Committee

2001–2010	ACEP Liaison to the American Public Health Association
2002–2003	Terrorism Response Task Force
2003	ACEP Representative to the Institute of Medicine's Meeting on Committee on Smallpox Vaccination Program Implementation
2004–2008	Tellers, Credentials, & Elections Committee
2004–2008	Scientific Review Committee
2006–2008	Council Steering Committee
2006–2007	Finance Committee
2006–current	International Ambassador to Egypt (starting 2006) and Sudan (starting 2016)
2006–2009	National Report Card Task Force, Chair, Data Subcommittee
2008	Hero of Emergency Medicine, American College of Emergency Physicians
2008–2009	ACEP Liaison to the Healthy People Consortium
2011-current	Member, International Ambassador Program Committee
2011-2013	Chair, National Report Card Task Force
March 16th, 2014	Testified before the Subcommittee on Oversight and Investigations of the House of Representatives' Energy and Commerce Committee concerning access to emergency care related to mental health and the shortage of psychiatric services.
2014-current	***National Board of Directors***, multiple tasks and roles, including: Liaison/member to the following committees and task forces: Clinical Policies Committee, Coding & Nomenclature Committee, ED Health Information Technology Safety Task Force, Epidemic Expert Panel, Finance Committee, Freestanding Emergency Centers Task Force, National/Chapter Relations Committee, Nominations Committee, Reimbursement Committee, ACEP/SAEM Research Work Group, State Legislative/Regulatory Committee Liaison to the following sections: Air Medical Transport, Emergency Medicine Informatics, Emergency Medicine Practice Management and Health Policy, Wilderness Medicine Chair, Emergency Department Sickle Cell Care Collaborative (EDSC^3), a private/public partnership, which provides a national forum dedicated to the improvement of the emergency care of patients with SCD in the United States.

ACEP Chapter Activities – List your most significant accomplishments

2000–2001	Board of Directors
2000–current	Education Committee
2001–2002	Treasurer
2001–2014	Representative or Alternate Representative from Maryland ACEP to the National ACEP Governing Council
2001–current	Public Policy Committee
2002–2004	Vice-President
2004–2007	President
2007	Award in Appreciation for Outstanding Leadership, Dedication and Support of Emergency Medicine as President, Maryland Chapter, ACEP
2007–2009	Immediate Past President
2015	Physician of the Year, 2015. Maryland Chapter, ACEP

Practice Profile

Total hours devoted to emergency medicine practice per year: **2000** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **40** % Research **15** % Teaching **20** % Administration **25** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

My primary clinical site is a busy, academic emergency department with an approximate annual volume of 65,000 adults. In this location, I work closely with residents, students and advance practice providers. Teaching is an important aspect of the work I do, but I also see patients by myself. In addition to the inner-city, adult population that we serve, we are a tertiary referral center that receives many referrals from around the state. Of note, the State of Maryland is a unique practice environment because of our Global Budget Revenue hospital funding model, which is a population-based payment model that caps total hospital revenue growth. This model, which is starting to be replicated in other states, is driving substantial practice changes including increased pressure to decrease hospital admissions and to coordinate patient care.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

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CANDIDATE DISCLOSURE STATEMENT

Jon Mark Hirshon, MD, PhD, MPH, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: University of Maryland School of Medicine

Address: 110 S. Paca Street, 6th Floor, Suite 200

Baltimore, Maryland 21201

Position Held: Professor, Senior Vice-Chair of the Institutional Review Board

Type of Organization: University

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: Maryland Chapter, ACEP

Address: 1211 Cathedral Street

Baltimore, Maryland 21201

Type of Organization: Professional Society

Duration on the Board: 2000-2009

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE

☒ If YES, Please Describe:

I am a consultant and advisory board member to Pfizer, Inc. concerning the medical care and treatment of patients with sickle cell disease.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Jon Mark Hirshon Date July 22, 2018

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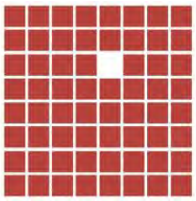
www.mdacep.org



Maryland Chapter
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

August 14, 2018

Dear Colleagues,

On behalf of Maryland ACEP, it is with pride that we enthusiastically support Dr. Jon Mark Hirshon's candidacy for ACEP President-Elect. Our Chapter wholeheartedly endorses his candidacy because we know that his leadership will benefit both the College and specialty during these trying times in the U.S. health care system. He is uniquely qualified because he is a dedicated and respected practicing clinician, an enthusiastic leader, a keen organizer, a master of the data concerning the emergency care environment. He is a man with the wisdom, knowledge and vision to help improve access to high quality emergency care in the U.S. and globally. He is the type of leader we need to continue moving ACEP forward.

It is important to list some of his accomplishments to demonstrate Dr. Hirshon's solid and deep experiences in emergency medicine. For many years, he has been an integral and vital member of Maryland ACEP. He is a Past President of Maryland ACEP, having completed the executive offices of Secretary, Vice President and President. His passion for our patients, our colleagues and our organization is evidenced by his dedication to ACEP's legislative efforts, both within Maryland and nationally. He was a national ACEP Councillor or Alternate Councillor for approximately 15 years prior to his election to the Board of Directors. Additional roles included service on ACEP's Steering Committee and Task Force Chair for the 2014 ACEP Report Card. This second position not only demonstrated his keen intellect and knowledge of the multitude of forces impacting emergency care today, but also highlighted his skill and ability to promote ACEP to television, radio and print media.

Dr. Jon Mark Hirshon is a well-respected national and international leader in public health and emergency medicine. He is the Senior Vice Chair of the University of Maryland's Institutional Review Board and is a former director of the Charles McC. Mathias, Jr. National Study Center for Trauma and EMS. He has been the principal investigator on over $8 million in federal research and training grants. He has taught emergency physicians, residents and medical students domestically and in the Middle East. Dr. Hirshon serves as a role model and mentor by practicing high quality clinical emergency

medicine while broadening the frontiers of scientific knowledge through collaborative research efforts.

His vision, leadership and contributions of time as a volunteer while working to enhance the profession of emergency medicine, improve patient care and his extraordinary efforts toward optimal emergency medicine practices are inspiring. His career has been dedicated to delivery of the very finest quality of emergency care which has included not only his personal commitment to emergency medicine, but a greater calling to the education of others and himself, advocacy for patients, and support of organizations and causes beyond himself, all of which have benefited by his national and international efforts to further emergency medicine.

Maryland ACEP was also honored to select Dr. Hirshon as the "Physician of the Year 2015." His career constantly and consistently demonstrates his passion for emergency medicine, his belief in life long education, his commitment to public health and, most importantly, his dedication to the delivery of the highest possible quality of emergency care to those in need.

Clearly, Dr. Hirshon has worked tirelessly to improve access to emergency care and to promote emergency medicine, both in the U.S. and globally. He is a superb candidate and Maryland ACEP is honored to support his candidacy for ACEP President-Elect.

Respectfully,

Orlee Panitch

Orlee Panitch, MD, FACEP
Maryland ACEP President

Jon Mark Hirshon, MD, PhD, MPH, FACEP

Dear Friends and Colleagues,

Every day that I work in the emergency department, I face the same challenges and problems that you face. Problems that include:

- Boarded patients
- Prolonged psychiatric stays
- Work place violence
- Too much time in front of computers instead of in front of patients.

And let's be clear, none of us went to medical school for this. Wellness includes both when we play and when we work. Something needs to be done to improve our lives within the emergency department.

There is an old African proverb- *If you want to go fast, go alone. If you want to go far, go together.* This proverb has been a guiding principle of my career; I consistently work to build bridges and break down barriers. This is true during my time on the ACEP Board of Directors as well as in my other professional activities. It has been both an honor and a privilege to serve you as a member of the ACEP Board of Directors and to passionately advocate for you, our patients, and our profession

In addition to the daily challenges we face in our clinical work are the divisions and conflicts within the house of emergency medicine. As we all know, ACEP has had its share of controversy over the past three months. We are a diverse group and bring many different perspectives together in order to care for our varied patients. Our strength springs from our diversity. However, we are faced with the challenge of unifying the multiple voices in emergency medicine into a strong and effective chorus.

You may ask, why I am running for ACEP president-elect? *I am running because I know I can make a difference.*

What will I do for you as ACEP President? *Fight to improve our lives in the emergency department and to assure high quality emergency care for our patients*. We must:

- Decrease regulatory burden. Earlier this year I testified on this topic before a congressional subcommittee. Physician wellness needs to include an improved work environment. As emergency physicians, we should be spending less time in front of computers and more helping our patients.
- Assure appropriate financial and societal support for emergency medicine. Whether this is through ACEP's quality efforts, such as CEDR, or policy efforts such as our lawsuit against Anthem in Georgia over their controversial emergency care policy.

We are caring, thoughtful, hard working professionals. We care about our patients and for our colleagues. ACEP and emergency medicine play a critical and ever-increasing role within the health care system. Together we *will* go far and make a difference.

I ask for your support and your vote as ACEP President-Elect. Thank you.

Jon Mark Hirshon, MD, PhD, MPH, FACEP
Cell: 410-271-4825
Email: jhirshon@acep.org

JON MARK HIRSHON

MD, PHD, MPH, FACEP

Leadership

Integrity

Passion

Dedication

Candidate for President-Elect

SELECTED LIST OF ACEP SERVICE

- **ACEP Board of Directors, 2014-2018**
- **Past President of Maryland ACEP**
- **Chair, National Report Card Task Force 2014**
- **Past Chair of ACEP's Public Health Committee**
- **Board Liaison to multiple National Committees and Sections, including:**
  - **Emergency Medicine Informatics**
  - **Clinical Policies**
  - **State Legislative**
  - **Reimbursement**
  - **National/Chapter Relations**
- **Testified before Congress on the national crisis related to psychiatric boarding**
- **Member of multiple ACEP Task Forces, including:**
  - **Epidemic Expert Panel**
  - **Freestanding Emergency Center Accreditation TF**
  - **ED Health Information Systems Safety TF**
- **ACEP International Ambassador to Egypt and Sudan**

Personal Statement:

There is an old African proverb- *If you want to go fast, go alone. If you want to go far, go together.* This proverb has been a guiding principle of my career; I consistently work to build bridges and break down barriers. Healthcare is rapidly changing in these times of economic and political turbulence. Specific challenges facing us and our patients include the shifting of the cost of medical care from insurance companies to patients and providers through increased co-pays, deductibles, inadequate physician networks and limited medical coverage. As Emergency Physicians, we are caring, thoughtful professionals. We work hard, and we play hard. We care about our patients and for our colleagues. ACEP and emergency medicine play a critical and ever-increasing role within the health care system. I will work together with our many partners to forcefully advocate for emergency medicine and to sustain and to grow the support for our important work. Working together we can, and we will, make a difference.

ACEP's mission is to promote the highest quality of emergency care and be the leading advocate for emergency physicians, our patients, and the public. This has been our mission during my time on the ACEP Board of Directors and for me personally in my other professional activities. It has been my honor and privilege to serve as your representative and voice on the ACEP Board of Directors for the past four years, to strive to achieve our mission, and for the vision of access to emergency care for all our patients in need- regardless of time of day, ability to pay, disease status or social circumstances. Over the past 25 years, I have been passionately dedicated to improving access to the highest quality emergency care. Whether at the bedside, in the board room, meeting with my Senator or standing in front of policy makers and the public, I continue to passionately, thoughtfully and tirelessly advocate for you, our profession, and our patients.

I ask for your vote for President-Elect in order to continue to serve as your advocate.

Background: Jon Mark Hirshon, MD, MPH, PhD, FACEP

- ***Professor,*** Department of Emergency Medicine and the Department of Epidemiology and Public Health at the University of Maryland School of Medicine.
- ***Mentor and Teacher,*** both domestically and internationally
- ***Senior Vice-Chairman,*** Institutional Review Board, U. of Maryland, Baltimore
- ***Federally funded researcher and teacher*** with specific interest in improving access to acute care and in developing emergency departments as sites for surveillance and hypothesis driven research in public health and emergency department operations
- ***Prolific Author*** of over 100 articles and chapters on emergency care topics, including placing emergency care on the global health agenda.
- Honored by his peers and the American College of Emergency Physicians as a "***Hero of Emergency Medicine***".

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2018 PRESIDENT-ELECT CANDIDATE WRITTEN QUESTIONS

William P. Jaquis, MD, FACEP

Question #1: **What is the most common public misperception about emergency physicians that you would like to dispel?**

A widely held misperception is that the Emergency Department (ED) is full of people that "don't need to be there." Physicians outside Emergency Medicine also seem to have that perception, in part because of their self-professed time they have spent in the ED. In addition, our own colleagues in the ED often speak loudly, in person and on social media, about their experiences with low acuity patients who they feel did not need to be seen in the ED. Finally, the media has become a conduit for misinformation on this concept, leading to bad policy and reimbursement decisions by legislators and insurance companies like Anthem.

While we can all identify those instances where we are taking care of patients who could have received care in a lower intensity setting, I believe we should consider that the ability to access acute care in another venue is dependent on several realities. First and foremost, we are the only site of care that is open at all times and to all people regardless of the ability to pay. Though this causes frustration at times for all of us, it is fundamental to our specialty that we serve as the safety net. As one of my colleagues described it, we are the wall off which the rest of medicine bounces. Second, the definition of "who needs to be there" is not dependent on our medical knowledge or on a retrospective look by a payer, but on the patient's perception (the prudent layperson) of whether a delay could cause her or him harm. State and federal laws have codified this, though it is frequently challenged by insurers. Third, in the three decades that I have been an emergency physician, the acuity and complexity of the patients I see in the ED has steadily increased. We might disagree on the number of patients who could receive care in another setting, but whatever that number is, it has definitely declined over the years. With the advent of longer hours for physicians' offices, after-hours and retail clinics, urgent care centers, and care delivery through tele health, many of the low acuity patients are no longer coming to us for care.

The downstream effects of this misperception are important. Allowing this line of thought to continue creates an atmosphere where we in the ED are not perceived as having significant value. Payment systems then become aligned to dissuade patients from using the ED for care. Patients are therefore forced to diagnose their own illness and to place a price tag on their symptoms, at times with significant adverse outcomes. We see patients who have waited too long to see us and who clearly need our services for evaluation and stabilization, and then we hear weeks later that the visit was determined retrospectively to be "unnecessary."

We have to correct this misperception and we have to create solutions – solutions that will create a more effective care system by care coordination, broader views of population health, and payment solutions that improve transparency. We must continue to work through our messaging, demonstrate our value and improve outcomes however possible.

Question #2: **As ACEP president, how would you help unify the house of emergency medicine? Are there any impediments that you see as particularly challenging?**

Our leadership has worked very hard in the last several years to identify opportunities to find common ground with other groups not only in emergency medicine but the bigger house of medicine. The approach to Medical Merit Badges, acute unscheduled sedation summit, and council on psychiatric emergencies are great examples of that effort. I was appreciative of being a part of a Wellness Summit at SAEM 2017, and have had an active role with groups both within EM and across the house of medicine on the approach to fair coverage and fair payment. Working with multiple other specialties in medicine on this significant concern, there are often differences in how we might approach this issue. What is common to all of those collaborations is that we found the places where we have a shared vision, put aside our differences that might exist in other areas, and worked toward goals that would provide better care for our patients and a more satisfying work environment for our physicians. With that background, however, the very recent (at the time of writing) challenge to one of our senior leaders and friend and our own sense of division, is very much top of mind.

We are more frequently in situations that require more meaningful conversations. As delineated in the book Crucial Conversations - stakes are high, opinions vary, and emotions run strong. We can choose to ignore the differences, continue to fight, or we can find the areas of common ground and principles of conduct that move us to a higher level of performance.

Those of you who attend ACEP's Council have seen how the process can work to a better outcome. We have representation from 53 chapters as well as other sections and organizations. The group has widely disparate ideas on many issues, yet we discuss and debate and move forward. In the high stress, high stakes time when emotions run high, there is a high necessity to listen. My leadership style is to listen to the opinions and thoughts of the experts we have in many areas of care and policy, using the expertise to move forwards with informed decisions.

Two impediments are top of mind for me – the nature of physicians to focus on the exceptions, and the current means of expression of our thoughts. From our first observation as medical students we are taught to look for the "zebras." We look at the work of others with a critical eye in an attempt to be sure our patients are getting the best care possible. While this works well as advocates for the individual patient, it sometimes falls short when we look to the greater good. Unifying the house requires us to refocus on the greater good. Certainly leaders across the house of medicine have learned that skill, and we must hone it at this time.

The second impediment is the potential for our opinions to rapidly be disseminated to a large audience. Access to information and conversation is immediate but does not always reflect what is accurate or affirming. Social media can be of great value in sharing experiences and providing information, but can also do considerable harm to people and issue when not clearly considered. When and where possible, we need to be on message about the significant work that all of you do, both in your clinical and your leadership practices.

Question #3: **What are the biggest internal and external threats to emergency medicine and how will you address them?**

Externally, the biggest threat is our current form of funding and paying for health care. The "system" is far from a coordinated entity but more a collection of stakeholders with their own interests exceeding the needs of the system as a whole. Those who fund and pay for the care are often deeply separated from the consumers of care, and the complicated approach to payments leaves us all confused. Consumers should have more transparency about what the cost to them of their care will be, but we are unable to give it to them because we have no idea across our delivery system how we will be paid, if at all. We have insurers who have hidden lists for which they will retrospectively deny payment, and every day it seems there is a new story or "study" that highlights "excessive" ED costs. In this setting it is incredibly difficult to provide timely care for patients, help them understand the costs of that care to them, and appropriately staff and reimburse our providers. EM is unique in this battle from our EMTALA mandate to see all patients regardless of ability (or intent) to pay. Addressing this issue will take all of us acting in many different venues. For our patients, we need to continue to advocate for access by requiring essential health services to be covered and paid according to prudent layperson laws. This also has and may continue to require legal action such as the current suit (July) against Anthem. We have some solutions that are improvements to the issue of fair coverage, and that message needs to continue through coalitions, the courts, social media and public relations.

Internally, our biggest threat is our inability in many situations to find a shared vision as a physician community. As the phrase goes, we have met the enemy and he is us. I cannot determine how many meetings I have attended where the physicians spent a great deal of time arguing with each other while the non-physician team stands by, leading to no directed action. Through many means in society as a whole, we are becoming more polarized rather than recognizing what is shared in the middle. This is true of EM at times as well. Do not misunderstand, I highly value the discourse of opposing views, as they often lead me and us to a better understanding of an issue. We must, however, make sure that in doing so, we do so with respect, and we understand there must be a forward direction. We can do so by continuing the dialogue on our important issues with civility, keeping our criticisms more private, and moving forward publically with a shared vision and praise.

We are well positioned to address the threats and the opportunities to EM. The leadership of the College – both physician and ACEP staff – are strong and well informed. The working relationships with Committees and Sections and Task Forces are constructive, utilizing the immense talent we have within the College. The Council leadership and the members of the Council have consistently shown their dedication to defining the important work we do. Our leaders have influence not only in the College, but within their groups, within other specialty societies, and leaders in the health systems. At the turn of our 50th year, we should recognize the tremendous growth and influence we have had not only in EM but in the entire health care system at a national level. Honoring that growth, we also remain vigilant, building our practice and our leaders for the next 50 years.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

William P. Jaquis, MD, FACEP

Contact Information

215 SE 8th Avenue #580, Fort Lauderdale, FL
Phone: 4103007242
E-Mail: Wjaquis@acep.org

Current and Past Professional Position(s)

Current: Senior Vice President, Alliance Operating Unit - Envision, East Florida Division
August 2017 – present

Attending Physician, Aventura Hospital
Aventura, FL
April 2018 – present

Prior: Chief, Emergency Medicine, Sinai Hospital of Baltimore
Baltimore, MD
April 2001 – June 2017

Medical Director, St. James Hospital
Chicago Heights, IL
1998-2001

Medical Director, Holy Cross Hospital
Chicago, IL
1994-1998

Attending Physician, Holy Cross Hospital
Chicago, IL
1992-1998

Attending Physician, Michael Reese Hospital
Chicago, IL
1992-1994

Education (include internships and residency information)

B.A., Cedarville University, Cedarville, OH 1980-1984
M.D., Medical College of Ohio, Toledo, OH 1985-1989
EM Residency, Case Western – Mt. Sinai, Cleveland, OH 1989-1992

Certifications

BCEM - ABEM

Professional Societies

Member, ACEP, Maryland Chapter
Member, AMA

National ACEP Activities – List your most significant accomplishments

Board of Directors 2012–2018
Vice President, 2016-2017 (Liaison to Bylaws, Annals of Emergency Medicine, EMRA, Young Physicians)
Secretary/Treasurer, 2015-2016 (Liaison to Audit, Finance Committees)

Liaison to
Committees
National/Chapter Relations 2016-2018
Awards 2015
Coding and Nomenclature 2013-2015
Reimbursement 2013-2015
Public Relations 2014-2015
Nominating 2014
EM Practice 2012-2013
Sections
Critical Care 2017-2018
EM Practice Management and Health Policy 2017-2018
Ultrasound 2012-2018
(Clinical Ultrasound Accreditation 2015-2018)
Palliative Medicine 2012-2015
Task Forces (includes those before Board)
Governance 2018
Joint Task Force on Reimbursement (EDPMA) 2015-2018
Alternative Payment Model 2015-2018
Clinical Ultrasound (ABEM) 2015-2018
End-of Life 2015-2016
Cost Effective Care 2012-2015
Sedation 2012-2015
Delivery System Reform 2011-2012
Episodes of Care/Integration 2010-2011
Chair – Advisory Group 2012-2015
Past Chair – EM Practice Committee 2010-2012

ACEP Chapter Activities – List your most significant accomplishments
MD Chapter 2001-current
Past-President, Vice President, Secretary, Treasurer
Two terms on Board of Directors
Appointed to Community Health Resources Commission

Practice Profile
Total hours devoted to emergency medicine practice per year: **~2200** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.
Direct Patient Care **20** % Research **0** % Teaching **20** % Administration **80** %
Other: **Work in residency program, patient care and clinical teaching are concurrent** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

As Senior Vice President for Envision, I lead the EM and HM programs for 14 hospitals in East Florida. Within those programs are three EM residency programs as well. These hospitals include small rural hospitals, community hospitals, urban teaching hospitals, and academic centers.

As as attending physician, I work at Aventura Hospital which is a community teaching hospital with an EM residency (among other teaching programs).

I am also have leadership over five free-standing emergency departments (hospital-based)

Expert Witness Experience
If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

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ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

William P. Jaquis, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Envision Health

Address: 18167 US Highway 19 N Suite 650

Clearwater, FL 33764

Position Held: Senior Vice President

Type of Organization: Physician practice management

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: ACEP

Address: 4950 Royal Lane

Irving TX

Type of Organization: Specialty society

Duration on the Board: 5 years

Organization: Maryland Chapter ACEP

Address:

Type of Organization: Specialty society

Duration on the Board: 6 years

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE

☒ If YES, Please Describe:

As above, I work for a physician practice management company as a Senior VP. My equity interest is far less than 1%

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:

As above, I work for a physician practice management company as a Senior VP. My equity interest is far less than 1%

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

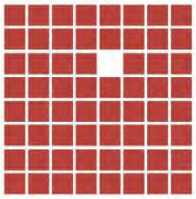
6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

William Jaquis Date July 18, 2018

1211 Cathedral Street
Baltimore, MD 21201-5585
410-727-2237
e-mail: info@mdacep.org
www.mdacep.org



Maryland Chapter
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

August 14, 2018

Members of the Council,

The Maryland Chapter of the American College of Emergency Physicians enthusiastically supports the candidacy of Dr. William Jaquis for President-Elect. We firmly and confidently believe that the leadership he has shown during the past 26 years on the local, state, and national levels have prepared him well to serve as the leader of ACEP. Time and time again, over many years, Bill has demonstrated that he has the great wisdom and savvy necessary to lead our organization forward. He has been a skillful spokesman who is able to get people to listen and act.

Bill's commitment begins at the local level. His 26 years of clinical work have included a leadership commitment for most of that time as well. For 16 years he served as the Chief of Emergency Services for LifeBridge Health, a growing health care network in the Baltimore area. In that role, he integrated the ED with comprehensive service lines and clinical initiatives, including education, trauma, stroke, and cardiac programs.

At the local chapter level, he has been an active participant with the Maryland team through his 17 years in Maryland. His input into our committee structure has continued throughout this time despite his many other activities. He actively served on our Education, Practice Management, EPIC Newsletter, and Public Policy Committees. He consistently demonstrates excellence and integrity in chapter service and advocacy; and he is always willing and ready to serve in any capacity asked of him. He served on our Board for two terms, and has held every officer position culminating in the Presidency for the years 2015-2016. During that time, he also extended his leadership to the Maryland community through other volunteer service. He was appointed by the Governor to be a Commissioner on the Community Health Resources Commission, looking for ways to direct state grant activities to the underserved people and communities in Maryland.

Maryland ACEP was also honored to select Bill as the "Physician of the Year 2013." His vision, leadership and contributions of time volunteering to enhance the profession of emergency medicine and improve patient care are extraordinary and inspiring. His career has been dedicated to delivery of the very finest quality of emergency care. He has

approached these goals through personal commitment to emergency medicine, advocacy for patients, and support of organizations and causes beyond himself.

Likely, you are more aware of the governance Bill has shown at the national level from committee member to committee Chair then to the Board of Directors. As a member of the Board, he has guided the work of multiple committees, sections, and task forces. He was elected by his peers to be the Secretary-Treasurer and currently the Vice President of ACEP. He continues to lead on many topics that are key to the continued ability of our members to practice effectively, including the issues of balance billing and payment models. His experience in Maryland has also given him experience on the integration of the ED into Population Health.

In summary, both personally and as the current President of Maryland ACEP, I strongly recommend that you consider electing Bill to be the next President-Elect of ACEP.

Respectfully,

Orlee Panitch

Orlee Panitch, MD, FACEP
Maryland ACEP President

William P. Jaquis, MD, FACEP

My anticipation always begins to build this time of year as we approach Council and the Scientific Assembly. For those six days, I generally find myself both exhausted and energized. The knowledge and energy that you will bring, along with the range of interests and ideas that you bring are invaluable. In addition, as with the last five times while I have been on the Board, the reconciliation of what we need to do, and the issues you need us to pursue keeps my focus as a Board leader fresh.

Every year brings challenges that we will meet together, but this year seems to have been filled with exceptional issues. While we memorialize the short 50-year history of our specialty and the leaders that brought us here, we also celebrate our rapid integration of our ideals into the delivery of health care. However, while the "system" could not likely express what our patients would do without emergency care, those who drive payment and policy have failed to appropriately recognize its value. Our patients are left not knowing where and how to get the care they need while considering the financial risk they might face. In many cases our diplomacy has failed, and extraordinary measures have been needed just to try to maintain the access patients have been given by law. Taking legal action against the federal government and against bad payer behavior is a poor way to use the resources in the system but has become a necessary step in trying to maintain access to care for our patients and fair payment for your exceptional work.

I have been fortunate to work with passionate Boards, leadership, and staff within ACEP on these key issues for six years now. I have also been fortunate to work along so many of you whose passion also helps me understand the unique issues that you face. Through these efforts, we can share the knowledge and develop plans that will make the delivery of medicine more effective. To look at a couple of examples, I look to the work I have been focused on as Board liaison to the ACEP/EDPMA Joint Task Force (JTF) on Reimbursement and the APM Task Force. On the JTF, we have shared resources across entities to address the tide of legislation that threatens the access to care through failed payment policy. On the APM TF we have discovered new ways of thinking about our unique value and the nature of reimbursement related to it.

At the heart of it all is the heart of emergency medicine. I believe the struggle we have with burnout and wellness represents the struggle I have when I see patients that you have as well. We can see the issues that face our patients. We know how to be more efficient and effective. We know how to lead and integrate teams of care, and we know the solutions that would help our communities have more productive, healthy lives. But our knowledge and our voices have been marginalized while others try to fill the gap in ineffective ways. I believe my role as a leader is to steadily find ways to bridge that gap, by listening, learning, and acting, building a shared vision of better care and better experience while being cost effective. I also believe the way to get there is to reengage physicians in finding solutions, realizing the value we bring to these priorities. I look forward to your support and your votes that will allow me to continue to lead. You stay classy San Diego.

WILLIAM JAQUIS, MD, FACEP

CANDIDATE
•
PRESIDENT ELECT

THE FUTURE IS NOW

Protect our Mission

Serve our Communities

Rediscover the Passion

Experienced Leader

- Vice President ACEP
- Secretary Treasurer ACEP
- Past President Maryland ACEP
- Board Liaison
  Reimbursement Task Force
  APM Task Force
- Past EM Practice Chair
- Chief of Service 16 years
- EM Clinician 25 years

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Board of Directors Candidates

acep Scientific Assembly SAN DIEGO, CA 18

ACEP 50 YEARS

American College of Emergency Physicians®
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2018 Board of Directors Candidates

L. Anthony Cirillo, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Kathleen J. Clem, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Francis L. Counselman, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

John T. Finnell, MD, FACEP, FACMI

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Jeffrey M. Goodloe, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Christopher S. Kang, MD, FACEP, FAWM

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Michael J. McCrea, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
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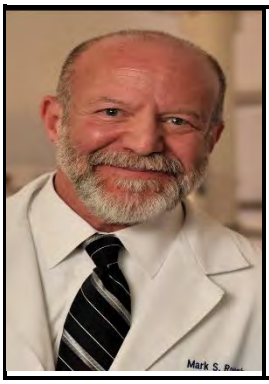

Mark S. Rosenberg, DO, MBA, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

Thomas J. Sugarman, MD, FACEP

- Written Questions
- Candidate Data Sheet
- Disclosure Statement
- Endorsement
- Campaign Message
- Campaign Flyer

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

L. Anthony Cirillo, MD, FACEP

Question #1: **Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

The simple answer to this question is "everywhere"! With advances in technology and the ability to provide and direct patient care remotely, emergency medicine will be practiced wherever there are patients who have acute illness or injury. As a specialty, emergency medicine is uniquely positioned to expand our day-to-day work from the physical confines of the emergency department to patients everywhere. Fundamentally, emergency medicine is *the* specialty equipped to rapidly assess a patient and to deploy the resources they need within the appropriate time frame. The practice of emergency medicine has evolved over the past 50 years to meet the needs of our patients and the healthcare system. We are the 24/7/365 healthcare safety net for the nation, filling the gap for the US healthcare system's inadequacies. While insurance companies and some policymakers characterize us as being "the expensive emergency department", patients and office-based providers choose us because they know that we are the experts in quickly and accurately evaluating acute illness and injury.

The opportunities to provide care remotely present both the greatest opportunity and the greatest challenge for the specialty of emergency medicine for the next 10 years. We must seize the opportunity to redefine paradigms of care based upon evolving technology that provides the ability to remotely "see" patients and to have access to data that previously accessible only when the patient "came" to the emergency department. However, because some patients won't physically come to the ED, we must reaffirm our standing within the house of medicine as the only specialists who are qualified to evaluate and treat patients presenting with acute illness and injury. Our training, through its rigorous and well-defined curriculum, enables us to expertly care for patients with undifferentiated illness and injury. This is emergency medicine's great differentiator - a truly unique fund of knowledge and the skill to make efficient and definitive management decisions abilities, inside or outside the physical confines of the emergency department.

As part of the evolution of the practice of emergency medicine, we will need to ensure that the laws, regulations, and policies that govern the care we provide adapt to the needs of our patients, and the practice of emergency medicine. Working in the advocacy arena over the past 25 years, I have had the opportunity to work at the federal, state, and local level to ensure that emergency physicians are recognized for the quality care we provide, and compensated appropriately for that care. As models of healthcare delivery evolve, ACEP will need to be vigilant and defend the specialty and practice of emergency medicine, regardless of where our patients are.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

My active involvement and leadership within ACEP began twenty-five years ago with my role as an EMRA Board member serving as the representative to ACEP, and the ACEP Board of Directors. I am incredibly fortunate to have had the opportunity to work with many amazing people within ACEP. Through my work on various committees and task forces, I have listened to, and learned from, emergency physicians who truly represent the breadth and depth of our specialty. In my time serving on, and chairing, the Membership, State Legislative/Regulatory, and Federal Government Affairs Committees I learned of the unique challenges faced by the various emergency medicine practices as they provide care to our patients. Personally, I have practiced clinically and administratively in a variety of emergency medicine settings and groups. During my career, I have worked as an academic faculty member at a residency training site, in a single coverage tiny community hospital ED, and pretty much every size ED in between. This variety of experiences helps me to be able to better understand and appreciate the unique perspectives of the emergency physicians who care for patients on a daily basis. During my time in service of ACEP, especially in the advocacy arena, I strived to become a better listener in order to be able to better represent our specialty in discussions within the house of medicine and with healthcare policy makers.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

Since its' creation 50 years ago, ACEP has been the organization that best represents the specialty of emergency medicine, and the physicians who are the experts in the specialty. In today's evolving U.S. healthcare system, there will be persistent and growing external pressures to provide emergency care that is high-quality and cost effective. It is emergency physicians who must remain the leaders and drivers of the practice and scope of emergency medicine. By virtue of our focused training and the unique body of knowledge that has defined emergency medicine as a specialty, emergency physicians are the true experts in the evaluation and management of acute illness and injury. As part of the evolution of healthcare delivery, there are other providers who today, together with the emergency physician, comprise the "emergency department team" caring for patients. Just as the emergency physician is the leader of the emergency department team, emergency physicians must remain the leaders of the specialty and practice of emergency medicine. As such, I believe that ACEP must remain the organization that represents emergency physicians, while also retaining its authoritative voice for the specialty and practice of emergency medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

L. Anthony Cirillo, MD, FACEP

Contact Information

91 Woodridge Drive
Saunderstown, RI 02874
Phone: 401-465-0806 (cell) / 401-294-2415 (home)
E-Mail: acirillo@usacs.com

Current and Past Professional Position(s)

Director of Health Policy & Legislative Advocacy, US Acute Care Solutions
Medical Director, Pequot Emergency Department, Groton, CT
Site Quality Director, US Acute Care Solutions (multiple sites)
Physician-in-Chief, Department of Emergency Medicine, Memorial Hospital of RI
Chief, Center for Emergency Preparedness & Response, Department of Health, State of Rhode Island

Education (include internships and residency information)

George Washington University Hospital, Washington, DC
Preliminary Year, Internal Medicine (1990-91)

UMASS Medical Center, Worcester, MA
Residency in Emergency Medicine (1991-94) / Chief Resident 1993-94

University of Vermont College of Medicine (M.D.) May 1990

Certifications

ABEM (1995, 2005, 2015)

Professional Societies

ACEP – RI Chapter, AMA, RI Medical Society

National ACEP Activities – List your most significant accomplishments

Chair, Federal Government Affairs Committee
Chair, State Legislative & Regulatory Committee
Chair, Membership Committee
Member, NEMPAC Board of Trustees
Member, Alternative Payment Model (APM) Task Force, Workgroup Chair
Member, Single Payer Task Force
Member, ACEP*Now* Editorial Board
Member, Communications Plan Task Force
Member, Core Curriculum Task Force
Member, Section Grant Task Force
Member, Board Nominating Committee

Member, Council Steering Committee
Member, Council Tellers & Credentials Committee

ACEP Chapter Activities – List your most significant accomplishments

Chapter President, 1998-1999
Councilor/Alternate Councilor 1998-Present

Practice Profile

Total hours devoted to emergency medicine practice per year: **2400** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **50** % Research **0** % Teaching **0** % Administration **50** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

For the past 14 years I have been employed by Emergency Medicine Physicians (EMP) and its successor company US Acute Care Solutions (USACS), which is a national emergency medicine group that is primarily physician owned. I have practiced clinically every year and continue to provide direct patient care on average of 100 hours per month. During my time at EMP/USACS I have worked at a variety of clinical sites in many states, providing care in a variety of clinical settings. Since joining EMP/USACS I have served as the Director of Health Policy & Legislative Advocacy at a national level, coordinating our advocacy efforts and educating physicians on the importance of advocacy to improve our healthcare system. In addition to my clinical responsibilities, I have also served as both a Medical Director capacity for one of our freestanding hospital affiliated emergency departments and as a Site Quality Director overseeing quality improvement activities at three of our emergency department sites.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases **Plaintiff Expert 8 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

L. Anthony Cirillo, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: US Acute Care Solutions, LLC

Address: 4535 Dressler Road, NW

Canton, OH 44718

Position Held: Director of Health Policy & Legislative Advocacy
Medical Director, Pequot Emergency Department

Type of Organization: Emergency Medicine / Hospitalist Multi-site Group

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: RI Chapter – American Heart Association

Address: 1 State Street, Suite 200

Providence, RI 02908

Type of Organization: Not-for-profit chapter of the American Heart Association

Duration on the Board: 1998-99

Organization: Safer Institute, LLC

Address: 31 Elbow Street

Providence, RI 02903

Type of Organization: For profit company providing digital personnel security and data services

Duration on the Board: October 2011 - Present

Organization: US Acute Care Solutions Political Action Committee (USACS PAC)

Address: 4535 Dressler Road, NW

Canton, OH 44718

Type of Organization: Company affiliated federally qualified political action committee

Duration on the Board: 2013 – Present (Chair of the Board)

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

√ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

√ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

√ NONE

☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

√ NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

√ NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

L. Anthony Cirillo, MD, FACEP Date July 12, 2018

American College of Emergency Physicians®

RHODE ISLAND CHAPTER

OFFICE
405 PROMENADE STREET, SUITE A
PROVIDENCE, RI 02908
TEL (401) 331-3207
FAX (401)751-8050
WWW.RIACEP.ORG
EMAIL MBIALEK@RIMED.ORG

Director
MARC BIALEK

John McManus, Jr., MD, MBA, FACEP
Speaker of the Council

Dear Dr. McManus,

On behalf of the Rhode Chapter of the American College of Emergency Physicians, it is my privilege and honor to provide this Letter of Endorsement in support of the candidacy of ***L. Anthony (Tony) Cirillo, MD, FACEP*** for the ACEP Board of Directors. Dr. Cirillo exemplifies the qualities and qualifications that ACEP desires for the Board of Directors. Dr. Cirillo has been a true leader and advocate in the state of Rhode Island and nationally, and is extremely motivated to serve our specialty.

I've known Dr. Cirillo a long time and first met him when he interviewed me for a job in 2001. Even then, he was advocating for my involvement in Emergency Medicine issues at the hospital, state, and national ACEP level. "You have got to get involved" and "You can make a difference" are what I remember from that interview. I'm sure others have similar stories as he continues to reach out and encourage "the next generation" to get involved.

As an example of the depth of Dr. Cirillo's contribution to Emergency Medicine on just one issue, take "Surprise" legislation. Several years ago, Dr. Cirillo identified this problem and has since been leading multi-year effort to pass reasonable legislation in Rhode Island, working with the Rhode Island Medical Society and in doing so, bringing other medical specialty societies to the battle. His experience and expertise have been leveraged to help other states directly, and indirectly by helping craft the ACEP position.

"Surprise" legislation is just one of Dr. Cirillo's interests. He has a breadth and depth of knowledge and experience in areas of particular relevance. Tony has been active in many other payment issues, such as MIPS, MACRA, alternative payment models, and single payer models. Tony also works on issues related to insurance practices like downcoding and denial of coverage. Importantly, he is also looking forward at cutting edge issues that are developing in providing emergency care outside of physical EDs – like telemedicine. His position is that even in these realms, Emergency Medicine must be steadfast that acute injuries and illness are the domain of our specialty.

In addition to the leadership in advocacy and mentoring described above, Dr. Cirillo has taken on other roles in Rhode Island including being a Past President of the Rhode Island Chapter of ACEP and a long time Chair of Rhode Island Medical Society's Political Action Committee.

Dr. Cirillo has been successful not only because of his knowledge but also because of his care toward personal relationships. Whether they be medical students or Senators, his genuine passion for getting the right thing done is obvious. This is clearly evident in his involvement at the ACEP Leadership and Advocacy conference where it's also apparent that he makes extra efforts to involve and help the "smaller" states who don't have the depth of resources, navigate the proceedings and understand the issues.

It is difficult to summarize such a long and varied career as Dr. Cirillo's in a page or two. Even though I've known Dr. Cirillo for a long time, I continue to discover and appreciate the multitude of contributions he has made to Emergency Medicine. He is clearly devoted to the betterment of Emergency Medicine as a specialty and is the type of colleague who ACEP will be proud to have leading us into the future.

Sincerely,

Catherine A. Cummings, MD, FACEP
President

cc: Mary Ellen Fletcher

L. Anthony Cirillo, MD, FACEP

Dear Fellow Councilors and ACEP Colleagues,

Thank you for your service to the Council, the College and the specialty of Emergency Medicine. It is my great honor and privilege to work with you on behalf of our patients, our physicians, and our specialty. At this time, I respectfully ask for your vote to represent you on the ACEP Board of Directors.

The healthcare landscape is evolving at an incredible pace. Changes in clinical medicine, technology, and the healthcare delivery system guarantee that the future practice of emergency medicine will be markedly different than it is today. While these changes present challenges to our specialty, they also present incredible opportunities for us to build a future of patient-focused, technology-enhanced, high-quality emergency care. Just as the founders of ACEP did 50 years ago, today's ACEP Board must be willing to envision and articulate the next generation of emergency medicine and be the leading advocates for the future of emergency healthcare. As a member of the ACEP Board, I will emphasize my vision of a **MAP** for the future of emergency medicine. I believe we must work diligently on behalf of current and future emergency physicians on ***Mentorship, Advocacy, and Policies*** that will ensure a viable and rewarding practice of emergency medicine for generations to come.

- ***Mentorship for the Future***

As ACEP celebrates its 50th anniversary there is a powerful lesson to be remembered. Those of us who are practicing emergency medicine today have an obligation to the future generations of emergency physicians. We are, in essence, the founders of the next 50 years of this specialty. The relationship between ACEP and EMRA, a profoundly effective resident organization, is a strong and productive one. As delivery models for emergency medicine evolve, ACEP must work collaboratively with all emergency medicine organizations to ensure that the education and training of emergency physicians parallels our workforce needs and the needs of our patients.

- ***Advocacy for the Specialty***

In the rapidly evolving healthcare system environment, ACEP must remain the leading voice advocating for our patients, our physicians, and our practice. Emergency medicine truly is the safety net of the U.S. healthcare system and this pivotal role must be broadcast continually to policymakers and healthcare leaders. We care for patients who seek our services because they are injured, ill, or afraid, and we turn no one away. Emergency departments are the social safety net of our nation and it is we who provide care to patients when the rest of society and the healthcare system can't, or won't, help them. Emergency physicians should be proud of the role we play in the healthcare system and society, and policymakers need to acknowledge and respect the invaluable role we play.

- ***Policy Development for the Practicing Physician***

Every day, there are new issues and challenges facing the specialty of emergency medicine. As ACEP addresses these issues and develops policy for the specialty, our guiding principle must be a focus on improving the ability of emergency physicians to care for our patients. The unpredictable and often chaotic nature of emergency medicine is challenging and difficult. ACEP must prioritize those issues that enhance our ability to care for patients and reduce the unnecessary distractions from patient care. Issues of fair reimbursement for the services we provide, reduction in administrative burdens and ensuring that emergency physicians remain the recognized leaders in the evaluation and management of acute illness and injury must be our priority as the leading physician organization in emergency medicine.

L. Anthony Cirillo, MD, FACEP
Candidate for the ACEP Board of Directors
Past President, Rhode Island Chapter

TONY CIRILLO, MD, FACEP

Candidate for the ACEP Board of Directors

Sponsored by the Rhode Island Chapter

ACEP Leadership

- Councilor / Alternate Councilor, 25 Years
- Federal Government Affairs Committee, Chair
- State Legislative & Regulatory Affairs Committee, Chair
- Membership Committee, Chair
- Alternative Payment Method Task Force, Workgroup Chair
- Healthcare Financing/Single Payer Task Force
- ACEP*Now* Editorial Advisory Board
- Council Steering / Tellers & Credentials Committees
- Board Nominating Committee

Advocacy for Emergency Medicine

- 2018 Recipient of the ACEP Rorrie Health Policy Award
- Emergency Medicine Action Fund, Board of Governors
- ACEP / EDPMA Balance Billing / OON Joint Task Force
- NEMPAC Board of Trustees
- EMRA / ACEP Health Policy Mentor

Active Clinical Practice

- Medical Director - Community Hospital based Freestanding ED
- Clinically Practicing 100 hours/month at 3 community hospital sites, 25-50k
- Previous academic appointments and faculty teaching positions

Dear Fellow Councilors and ACEP Colleagues,

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Mentorship for the Future

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Advocacy for the Specialty

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Policy Development for the Practicing Physician

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L. Anthony Cirillo, MD, FACEP

Candidate for the ACEP Board of Directors

Past President, Rhode Island Chapter

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Kathleen J. Clem, MD FACEP

Question #1: **Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

In 10 years Emergency Medicine will increasingly be at the center of US healthcare. People want their health care to be immediately accessible, connected electronically, easy to use, and yet have a human touch. No other specialty comes as close as Emergency Medicine does to meet this public demand. No other specialty is as integrated as Emergency Medicine. We practice at the interface of the inpatient and outpatient world, work with all specialties, and within and for our communities. Our residencies will become even more competitive. We will continue to provide access to emergency health care and we will be empowered to integrate care across the continuum. We will no longer simply generate discharge instructions, we will be empowered to get our patients access to the next appropriate level of care. We will continue to embrace evidence-based technology and be a leader in implementation.

Our electronic connectivity with the inpatient and outpatient worlds will enable us to navigate the system seamlessly to effect health care. When we admit patients, it will be a smooth process with warm-handoffs as the electronic medical record will automatically glean and format the information necessary for admission. We will continue to be the place for emergency care, and our expertise for emergency medicine will continue to be excellent.

My skill set includes clinical Emergency Medicine, academic leadership, and healthcare system leadership. All are crucial as we lead our specialty into the future. I recognize and understand the challenges facing our specialty. ACEP needs experienced leaders to lead through this critical time in health care. I have been an involved ACEP member since 1993 and have over 20 years of experience in community, academic, and now health system leadership. I will use my skills to keep Emergency Medicine's excellence within complex systems as we shape the future of our specialty.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

I work clinically in a high-volume community ED and teach EM residents. I have served as a medical director, tackled reimbursement issues for my group, tort reform at the state level, and understand that unnecessary requirements of our time and energy matter. I have worked to decrease documentation requirements that do not add to patient care.

As a past academic chair, I bring additional experience to navigate challenges to our specially and residency support
I also understand the challenges associated with addressing these issues.

As a current health system executive vice president and Chief Clinical Officer, overseeing 47 hospitals and over 1.5 million ED visits per year, I have led efforts for hospitals to be incentivized to rapidly admit patients, supported resources for timely consults, and worked to build bridges with other specialties, and am actively involved in improving electronical medical record use.

My experience as ACEP Steering Committee member, Committee Chair for Public Relations, Chair National Chapter Relations, AAWEP Chair, and Membership Committee Chair have provided key leadership opportunities and understanding of ACEP administration and positive change.

I value, seek out, and treasure opportunities to listen to physicians. The importance of listening-to-understand cannot be overstated. I would continue to seek these opportunities as a member of the BOD and collaborate with the board to incorporate the concerns and solutions offered by our members into the work we do in our state chapters and nationally to advance Emergency Medicine.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**
ACEP is THE umbrella organization for the house of emergency medicine. Collaboration with other Emergency Medicine organizations is a laudable ACEP goal. ACEP provides mentorship for the next generation of emergency physician. It is our professional home and the premier organization to provide guidance, support, mentoring and professional networking throughout our careers. ACEP is the best source for the ongoing career needs of emergency physicians.

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CANDIDATE DATA SHEET

Kathleen J. Clem, MD, FACEP

Contact Information

169 Vista Oak Drive, Longwood, Fl 32779
Phone: (919) 599-9660
E-Mail: kathleen.clem@ahss.org

Current and Past Professional Position(s)

HOSPITAL APPOINTMENTS
Loma Linda University Medical Center 1992-1998
Kaiser Permanente Riverside 1991- 1992 (during residency)
Riverside General Hospital 1992-1998 (per diem)
San Antonio Community Hospital – 1991-1998 (per diem)
Suburban Hospital, Maryland 1993-1998
(per diem to care for family member with terminal illness)
Duke University Medical Center 1998 – 2007
Loma Linda University Medical Center 2007-2016
Loma Linda University Children's Hospital 2016
Florida Hospital – 2017-present
Adventist Health System – 2018-present

CURRENT ACADEMIC APPOINTMENTS
Professor Emergency Medicine, University Central Florida, College of Medicine

PAST ACADEMIC APPOINTMENTS

1992 Instructor LLSOM- Department of Emergency Medicine
1994 Assistant Professor LLSOM – Department of Emergency Medicine
1999 Associate Professor Duke University SOM – Department of Surgery
2007 Professor Emergency Medicine and Pediatrics, LLU School of Medicine

LEADERSHIP POSITIONS
Chief, Division of Emergency Medicine, Department of Surgery, Duke University 1999-2007
Chair, Department of Emergency Medicine, Loma Linda University 2007-2016
Chief Medical Officer, Vice President, Florida Hospital East Orlando 2016-2017
Executive Vice President Chief Clinical Officer Adventist Health System 2018-present

Education (include internships and residency information)

EDUCATION AND TRAINING

ASN	Loma Linda University School of Nursing
BSN	Tennessee Technological University
1989	Loma Linda University School of Medicine
1989- 1992	Residency Loma Linda University- Emergency Medicine

MD 1989

Certifications

ABEM
1994 Emergency Medicine – initial
2004 Emergency Medicine – recertification
2013 Emergency Medicine – recertification

Professional Societies

ACEP
Florida Chapter
Vermont Chapter
SAEM

National ACEP Activities – List your most significant accomplishments

American College of Emergency Physicians (ACEP) Steering Committee 2016-2018
ACEP Well Being Committee – 2015-2016
Wellness Week Task Force **Chair** 2016
Association of Women Emergency Physicians (AAWEP) – **Chair** 2013-2015
American College of Emergency Physicians (ACEP) 1992-present

ACEP International Section Councilor 2000-2001
ACEP American Association of Women in Emergency Medicine 1992-present
ACEP Public Relations Committee member 2002-2008 **Chair** 2002-2004
ACEP Council Awards Committee 2008-2009
ACEP Membership Committee 2014-2016
Chair 2016-2017
ACEP Reference Committee Chair - 2014
ACEP National Chapter Relations Committee 2008-2015 **Chair** 2008-2010
ACEP Speakers Bureau Subcommittee – 2006
ACEP Geriatrics Subcommittee – 2006 - 2007
ACEP Candidate Forum Subcommittee 2005-2006
ACEP Council Steering Committee 2005-2007, 2017-present
ACEP Emergency Preparedness Steering Committee 2007
ACEP State Chapter Grants in Public Relations and Chapter
Grant Review for National/State Chapter Relations Committee 2004-to present

ACEP Chapter Activities – List your most significant accomplishments

North Carolina Chapter of ACEP - Councilor 2005-2008

North Carolina Chapter ACEP – Board Member 2001-2007

California Chapter ACEP Education Committee 1996-1998, 2008
Florida Chapter – Task Force to implement statewide implementation of EDIE and Opioid Task Force

Practice Profile

Total hours devoted to emergency medicine practice per year: **432** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **7** % Research **1** % Teaching **2** % Administration **80** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.) Group Employment – multi-hospital -community hospital with affiliated ACGME accredited EM residency.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 2 Cases **Plaintiff Expert 0 Cases**

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CANDIDATE DISCLOSURE STATEMENT

Kathleen J. Clem, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Adventist Health System
Address: 900 Hope Way
Altamonte Springs, FL 32714
Position Held: Executive Vice President/Chief Clinical Officer
Type of Organization: Health System

Employer: TeamHealth
Address: 265 Brookview Centre Way Suite 400
Knoxville, TN 37919
Position Held: Part-time attending physician
Type of Organization: CMG

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: SAEM - Board of Directors Member-at-Large 2013-2016
Address: 1111 East Touhy Ave. Suite 540
Des Plaines, IL 60018
Type of Organization: Emergency Academic Medicine Society
Duration on the Board: 3 years

Organization: Loma Linda University School of Medicine Alumni Association
Address: Loma Linda, California

Type of Organization: Alumni Association
Duration on the Board: 2 years

Organization: Loma Linda University Board of Directors

Address: Loma Linda California

Type of Organization: University

Duration on the Board: 3 years

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

X NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

X NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

X NONE

☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

X NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

X NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Kathleen J Clem, MD Date July 10, 2018

Florida College of Emergency Physicians

July 13, 2018

The Florida College of Emergency Physicians (FCEP) is extremely pleased to endorse the candidacy of Kathleen Clem, MD, FACEP, for a position on the American College of Emergency Physicians Board of Directors.

Over the past 25 years, Dr. Clem has dedicated her career to building up organizations and individuals. The notable number of "firsts" among her many accomplishments speak to a combination of superlative leadership skills and infectious passion. Examples include inaugural Division Chief of Emergency Medicine at Duke University, first female Division Chief within Surgery at Duke University, first female Chair of a Department at Loma Linda University School of Medicine, and founding president of the AAWEP's sister organization, the Academy for Women in Academic Emergency Medicine (AWAEM).

Reviewing her accomplishments, it should come as no surprise that Dr. Clem has established a reputation as a worthy role model for women in Emergency Medicine, and her award-winning service as Chair of the AAWEP Section is yet further evidence of her broad impact. Beyond her work with AAWEP, Dr. Clem's contributions to ACEP over the last two decades also include Chair roles for the Public Relations Committee, the Wellness Week Task Force, the Membership Committee, and the National Chapter Relations Committee. Additionally, her experience as Councilor for both the ACEP International Section and the North Carolina Chapter, her service on the North Carolina Chapter Board of Directors, as well as her extensive committee work all demonstrate an in-depth understanding of ACEP policies and priorities befitting a candidate for the Board of Directors.

Since taking the Chief Clinical Officer at Adventist Health, Dr. Clem has become very active in ensuring quality measures and patient satisfaction measures are in place at the multiple emergency departments under her jurisdiction with the hospital system. Dr. Clem is also participating in a Task Force working for the establishment of opioid addiction treatment centers. Dr. Clem is also working clinically and has developed great relationship with the EM residents at Florida Hospital East.

Dr. Clem's leadership, passion, and experience make her a uniquely qualified candidate for the ACEP Board of Directors, FCEP is very pleased to fully and enthusiastically endorse her candidacy.

Joel Stern

Joel Stern, MD, FACP
President, FCEP

Kathleen J. Clem, MD, FACEP

ACEP needs experienced leaders to guide us through this critical time in health care. I have been an involved ACEP member since 1992 and have over 20 years of experience as a leader for community and academic Emergency Medicine. I know how to work within and for complex systems as we shape the future of our specialty.

I have served as an ED medical director, tackled reimbursement issues, fought for tort reform at the state level, advocated for residency support, and I understand the burdens and obstacles to efficient use of our time and energy, whether you are a young physician just out of residency or in the middle of your career. I continue to work clinical shifts and teach EM residents. As a past academic chair, chief medical officer and now health system executive vice president, I bring additional experience in knowing how to work with others to obtain the resources we need to both give great care and enjoy our practice. I value, seek out, and treasure opportunities to listen to physicians.

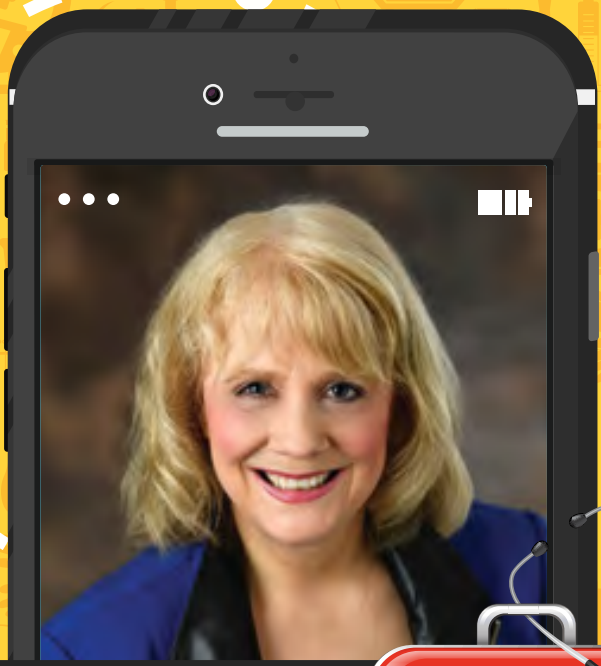
I have designed specific strategies to recruit and retain young physicians by defining designated chapter leadership positions for residents and specific leadership development tracks. Our youngest members need increased opportunities for mentorship and connectivity. I continue to nurture strong professional relationships and believe this is one of the best ways to insure ongoing success of our young EPs. As a past AAWEP Chair, I am the inaugural leader for the AAWEP Leadership Pipeline initiative and continue to serve as a mentor for women in EM.

We need to further leverage and build on the work that ACEP has initiated to address burnout and resiliency. I was Chair for the inaugural ACEP Wellness Week and I am proud of the programs we have put into place. ACEP must continue to address unnecessary stressors such as: nursing staff shortages, unreasonable documentation demands, unrealistic expectations for EDs to solve hospital throughput issues without administrative commitment/action, and inappropriate patient satisfaction demands. As a Department Chair, and health system leader, I am experienced in putting solutions into place – and getting them to stick!

I understand that when we can deliver the excellence that we expect of ourselves within a supportive system, the true joy of practice will be realized. I want to be at the forefront to promote our core values and continue to deliver the highest quality of care for our patients by serving as a member of the ACEP Board of Directors. I am ready to give back and I have the support and time to serve. Now is the right time for me to bring my skills and experience to the ACEP BOD and I am asking for your vote

Thank you!

Kathleen Clem, MD, FACEP



KATHLEEN J CLEM
MD, FACEP

ACEP Board of Directors Candidate
Endorsed by The Florida Chapter of Emergency Physicians

- Gets things done in our complex and changing healthcare environment
- Strong track record as a physician advocate and mentor
- Experienced leader within,
  - Academic Emergency Medicine
  - Community Emergency Medicine
  - System Health Care

I am proud to be an emergency physician and will work relentlessly on your behalf to make our specialty stronger. I am honored and grateful to have served ACEP throughout my career. My focus has been on ensuring that we have the resources we need to enjoy our practice and continue to give outstanding patient care. My experience has given me the skills essential to serve capably on the ACEP BOD as we lead our specialty into the future. It would be my privilege to advocate for you as a member of the ACEP BOD. I ask for your support. I will make your vote count.

Kathleen Clem, MD, FACEP

ACEP SERVICE HIGHLIGHTS

- Membership Committee Chair
- Diversity and Inclusion Task Force
- Wellness Week Task Force Chair
- International Section, SAEM, International Section Councilor
- AAWEP Chair
- Public Relations Committee Chair
- Council Awards Committee
- National Chapter Relations Committee Chair
- Speakers Bureau Subcommittee
- Spokespersons Network
- North Carolina (NCEP) Board member
- Emergency Preparedness Steering Committee
- Candidate Forum moderator
- ACEP Steering Committee member

CLINICAL EXPERIENCE/ LEADERSHIP

- 18 years leadership Level 1 trauma centers
- Community EDs- single and double coverage
- Community ED Directorships in CA and NC
- CMO at community hospital
- Current Executive VP/Chief Clinical Officer Advent Health System
- Current clinical practice community ED >120K/yr with EM residents

PROFESSIONAL SERVICE HIGHLIGHTS

- Works for hospitals to be incentivized to rapidly admit patients and support resources for timely consults
- Fights against inappropriate demands on physician time
- Experienced in reimbursement, tort reform, residency support
- Focus on diversity and inclusion
- Developed leadership pipeline for women via AAWEP
- Focus on physician wellness
- Developed structured opportunities for physician mentors

ACADEMIC LEADERSHIP

- Founding Chief- Division of Emergency Medicine -Duke University
- Emergency Medicine Department Chair- Loma Linda University (LLU)
- International EM Fellowship Director- LLU
- Administrative Fellowship Director- LLU
- National speaker for ACEP, SAEM, Joint Commission
- Women Executives in Science and Healthcare – Board of Directors
- Society for Academic Emergency Medicine – Board of Directors
- Professor of Emergency Medicine – LLU, University Central Florida

AWARDS

- Distinguished Faculty Award – Duke University
- ACEP Hero of Emergency Medicine
- SAEM Founders Award – Academy for Women in Academic Emergency Medicine (AWAEM)
- Outstanding Reviewer – Academic Emergency Medicine
- SAEM Global Emergency Medicine Academy International Collaboration
- SAEM Advancement of Women in Academic Emergency Medicine
- SAEM Outstanding Department
- Physician Leadership – LLU
- AAWEP Leadership
- SAEM Academy for Diversity and Inclusion in EM Service

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2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Francis L. Counselman, MD, CPE, FACEP

Question #1: **Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

Forecasting the future is no easy task. We know change is inevitable, and that successful organizations adapt to it- it is a constant and dynamic process. Having been practicing Emergency Medicine for the past 32 years, I have learned the importance of keeping a moral compass to guide me, while adapting to the surrounding environment. I have proven to be someone that can evolve with change and become a better physician and leader over time. I look forward to the challenges and opportunities the future will offer.

The good news is, 2028 will still need Emergency Medicine and emergency physicians. In fact, our role in the house of medicine will continue to expand, just as it has over the past decade. Artificial intelligence will play a very large role in the practice of medicine, and Emergency Medicine in 10 years. Historically, and even today, a physician subconsciously runs through their personal database after performing a history and physical examination, determining pretest probabilities and differential diagnoses. In ten years, we will have devices that will scour enormous, national databases, to assist us with testing and treatment decisions. We will have significantly better information on risk/benefit ratios regarding treatment and patient disposition decisions. We will be able to inform our patients much better regarding prognosis and what to expect. To be clear, this "new' information will not be correct 100% of the time, but much better than what we currently possess.

Laboratory testing and imaging study turn around times will be improved in the future, decreasing some of the current bottlenecks present in ED patient throughput. This will be one of those rare achievements that makes emergency physicians, patients and hospital administrators all happy.

I suspect we will see a shift in the type of patients we see in the ED, with a significant trend toward high acuity. Low acuity patients will have many more efficient and cheaper alternatives. Emergency physicians will get to treat the type of patients they specifically trained for- acute MIs, stroke, DKA, severe asthma attacks, penetrating trauma- the list is long.
As a physician and leader that has been practicing for over three decades, I know and have experienced significant change- I look forward to it because with it, there is always the opportunity to do things even better.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

Professionally, I'm a hybrid - equal mix community and academic EM physician. After Emergency Medicine residency graduation, I joined Emergency Physicians of Tidewater (EPT) - a private practice, democratic group of board-certified emergency physicians. In addition, I began serving as an Assistant Program Director of the EM residency program from which I graduated.

In 1990, I was appointed the Program Director of the EM residency. I served in this role for the next 20 years, and oversaw its growth and maturation. In many ways, it's the best job in all of EM. This job only deepened my commitment to quality EM education; it is part of my DNA.

When I started, EM was a division of the Department of Family Medicine at Eastern Virginia Medical School (EVMS). It was clear to me we should to be an academic department. I spent one year meeting with every department chair, explaining why we deserved such status. In 1992, we were granted academic departmental status, becoming the first in Virginia and only the 26th in the nation; I was appointed the inaugural chair and continue to serve today. This taught me how to effectively deal and negotiate with other departments, advocate for EM clinically and academically, and run a multimillion dollar enterprise.

For the past 20 years, I have served on the Board of Directors of EPT, helping lead our democratic practice group through the changing health care environment, demands from hospital administration, reimbursement issues, and all manner of other threats.

In 2008, I was asked to serve as the President of the Medical Staff of our 1100+ physician, two hospital system; the first emergency physician to do so. I gained invaluable experience and education in dealing closely with hospital administration, interacting with other clinical services, and overseeing the hospital transition to an electronic medical record. I now see EM through many different lenses, but always guided by the desire and passion to promote a healthy working environment for all emergency physicians.

Finally, I have served as President of two national EM organizations- the Association of Academic Chairs of Emergency Medicine and the American Board of Emergency Medicine. I have first-hand experience in serving large groups of emergency physicians- academic and community-by listening, advocating, and working hard on their behalf.

From all of my experiences, I am acutely aware of the challenges and opportunities offered by private practice and academic EM. While some make a hard distinction between the two, there is much more in common, than unique. Issues of fair reimbursement, coding and billing, appropriate staffing, LWBS, patient satisfaction, boarders, throughput metrics, and on-call availability are all important, regardless of your practice type. You have to be knowledgeable of all of these issues, and advocate for a working environment that is healthy, professionally rewarding, and satisfying for patients and emergency physicians. I have the passion and the experience to work hard on these issues on behalf of all of the ACEP membership. I hope you will support my nomination..

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

Every organization needs to take a hard look at itself and decide what is it's purpose; why do we exist ? Some organizations in Emergency Medicine have a very specialized purpose, and cannot, and should not, be placed under a large umbrella. A good example of this is the American Board of Emergency Medicine (ABEM). Their primary purpose is in setting the competency standards regarding board-certification and maintenance of certification. The Council of Residency Directors in Emergency Medicine (CORD-EM) is another example; it has a very specific and important role to play in EM residency education, and does not lend itself to being neatly folded under an umbrella

The American College of Emergency Physicians, while not as an umbrella, is never the less best suited to take the lead for our specialty, primarily due to its large and diverse membership base and its tremendous legislative advocacy work, at the national, state and local levels. I see more of a hub and spokes model, rather than an umbrella. ACEP would be at the center (hub), with other organizations working closely and collaboratively with ACEP, but also focusing on their nitch; be it research, board-certification, or EM residency training (the spokes). ACEP, and the various EM organizations should make every effort to work together on common issues, and avoid duplication of efforts at every opportunity. There is too much work that needs to be done on behalf of emergency physicians to waste time on inconsequential (in the big picture) turf issues, and strive to work together instead.

I have had the good fortune to hold leadership positions in many EM organizations- ACEP, ABEM, AACEM, and SAEM. Each has its particular strengths and focus. These organizations should continue to focus on their reason for existence. But at the same time, all organizations should work hand in hand with ACEP, ensuring a common understanding and an offer of assistance when needed. While there will certainly be differences of opinion on certain issues, it can almost always be worked out to a satisfactory conclusion when discussed and debated in a collegial atmosphere.

ACEP focuses on the practicing emergency physician- private practice, academic, employed, independent contractor, partner, locum tenens- which means just about everyone in the house of emergency medicine. If you practice our specialty, ACEP represents you, whether you are a member or not. As I have told my residents, fellow, and junior colleagues and anyone else); its not an either/or prospect when joining an EM organizations, its an "and" issue. You should belong to ACEP, and to…(you fill in the blank).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Francis L. Counselman, MD, CPE, FACEP

Contact Information

Department of Emergency Medicine, Rm 304 Raleigh Building, 600 Gresham Drive, Norfolk, Virginia 23507
Phone: 757-388-3397
E-Mail: counsefl@evms.edu

Current and Past Professional Position(s)

Founding Chairman, Department of Emergency Medicine, Eastern Virginia Medical School, 1992-present.
Program Director, Emergency Medicine residency, Eastern Virginia Medical School, 1990-2010.
Associate Program Director, Emergency Medicine residency, Eastern Virginia Medical School, 1986-1990.
Attending Physician, Emergency Physicians of Tidewater, 1986-present.
Editor-in-Chief, ***Emergency Medicine***, 2018-present.
Associate Editor-in-Chief, ***Emergency Medicine,*** 2006-2017.

Education (include internships and residency information)

Residency: Emergency Medicine, Eastern Virginia Medical School, 1984-1986.
Internship: Internal Medicine, Eastern Virginia Medical School, 1983-1984.

Medical Degree (M.D.), Eastern Virginia Medical School, 1983..

Certifications

American Board of Emergency Medicine: 2007-2020; 1997-2007;1987-1997.
Certified Physician Executive (CPE), 2010-present
Certificate in Business Management, Raymond A. Mason School of Business, College of William and Mary, 2016

Professional Societies

American College of Emergency Physicians, 1984-present.
Virginia College of Emergency Physicians, 1984-present.
American Board of Emergency Medicine, Diplomate, 1987-present
Society for Academic Emergency Medicine, 1990-present.
Council of Emergency Medicine Residency Directors, 1990-present.
Norfolk Academy of Medicine, 1990-present.
Association of Academic Chairs of Emergency Medicine, 1993-present.
Alpha Omega Alpha (AOA) Honor Medical Society, 1994-present.
Medical Society of Virginia, 1996-present.
American Association for Physician Leadership, 2009-present.

National ACEP Activities – List your most significant accomplishments

Received ACEP Award for Outstanding Contribution in Education, Oct 2017
Faculty, ACEP Teaching Fellowship, 2004-2016 (each year)

ACEP Academic Leader/Residency Visit Program, 2005-present
Chairman, Third Emergency Medicine Workforce Study, 2007-2009.
Membership Committee, 2001-2006
-Chairman, 2004-2006
Academic Affairs, 1996-2001
-Chairman, 1999-2001

ACEP Chapter Activities – List your most significant accomplishments

Board of Directors, 1989-1997
Secretary, 1993-1994
President-elect, 1994-1995
President, 1995-9996
Immediate Past-President, 1996-1997
Received the VA ACEP Heatwole Career Achievement Award, 2001
Education Committee, 1989-2000
-Chairman,1996-2000; 1993-1995
Councilor, 1990
Alternate Councilor, 1991-1995, 1997-1998

Practice Profile

Total hours devoted to emergency medicine practice per year: **2200** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **50** % Research **5** % Teaching **20** % Administration **25** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am employed by Emergency Physicians of Tidewater, a democratic private practice group of ABEM certified emergency physicians and advanced practice providers providing emergency services to five hospital EDs and two free standing EDs, with a combined patient volume of @ 360,000 annually.

I also serve as the Chairman of the Department of Emergency Medicine for Eastern Virginia Medical School, where I am fulltime, non-salaried.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 16 Cases **Plaintiff Expert 7 Cases**

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CANDIDATE DISCLOSURE STATEMENT

Francis L. Counselman, MD, CPE, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Emergency Physicians of Tidewater
Address: 4092 Foxwood Drive, Suite 101 Virginia Beach, Virginia 23462
Position Held: Board of Directors since 2000. Responsible for academic arm of group
Type of Organization: Private practice, democratic group of ABEM board-certified physicians (@ 65+) providing coverage for five hospital EDs and two free standing EDs.

Employer: Eastern Virginia Medical School
Address: 825 Fairfax Avenue, Norfolk ,Virginia 23507
Position Held: Chairman, Department of Emergency Medicine (since 1992. Full-time, nonsalaried)
Type of Organization: A public-private medical school

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: American Board of Emergency Medicine
Address: 3000 Coolidge Road, East Lansing, MI 48823-6319
Type of Organization: One of 24 medical specialty certification boards recognized by the American Board of Medical Specialties (ABMS).
Duration on the Board: 2008-2016

Organization: Educational Commission for Foreign Medical Graduates (ECFMG)
Address: 3624 Market Street, 4th floor, Philadelphia, PA 19104
Type of Organization: Private, nonprofit. The world leader in promoting quality healthcare.
Duration on the Board: 2017-2021

Organization: Virginia College of Emergency Physicians (VA ACEP)
Address: 2924 Emerywood Parkway, Suite 202, Richmond Virginia 23294
Type of Organization: State chapter of the American College of Emergency Physicians
Duration on the Board: 1989-1997

Organization: Eastern Virginia Medical School Alumni Association

Address: Office of Alumni Relations, 721 Fairfax Avenue, Suite 505, Norfolk, Virginia 23507

Type of Organization: Volunteer board to raise money for Eastern Virginia Medical School

Duration on the Board: Board of Trustees, 1996-2005

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE

☒ If YES, Please Describe: I serve as the Editor-in-Chief of ***Emergency Medicine,*** a peer-reviewed practice journal for emergency physicians.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Francis L Counselman MD, CPE, FACEP Date June 6, 2018

VIRGINIA COLLEGE OF EMERGENCY PHYSICIANS

Headquarters

2924 Emerywood Pkwy., Suite 202
Richmond, VA 23294

Tel: (804) 297-3170
Fax: (804) 747-5022
www.vacep.org

June 12, 2018

To the ACEP Nomination Committee:

The VACEP Board of Directors voted at our June 7, 2018 Board of Director meeting to endorse the nomination of Dr. Francis Counselman, MD, FACEP as a candidate for ACEP's Board of Directors.

Dr. Counselman served as VACEP's president from 1995-1996 following eight years on the Chapter's Board of Directors. He served as six years as VACEP's chair of our Education Committee.

Please let us know if you need anything else from us.

Sincerely,

Dr. Bruce Lo, MD, MBA, FACEP

VACEP President

Francis L. Counselman, MD, CPE, FACEP

I am very excited about running for the Board of Directors of the American College of Emergency Physicians (ACEP). I have been a member of ACEP since I was a resident, and would love to give back to the organization and members that have supported and encouraged me for the past three + decades.

I am a hybrid – I am both a community emergency physician (EP) and an academic EP. I am a member of a private practice, democratic group of board-certified emergency physicians; Emergency Physicians of Tidewater (EPT). I joined EPT right out of EM residency training and have been practicing with them full-time since July 1986. In addition, for the past 20+ years, I have served on EPT's Board of Directors, help leading our group forward. At the same time, I am volunteer faculty at Eastern Virginia Medical School (EVMS), where my appointment is "full-time, nonsalaried." At EVMS, I was able to lead the change from a division of the Department of Family and Community Medicine to our own academic department of Emergency Medicine. We were the first academic department of Emergency Medicine in Virginia, and only the 26th in the nation at that time (1992). I continue to serve in the role of Chairman today.

I work in the ED, seeing patients primarily and also supervising EM residents and medical students in the delivery of care. I work holidays, weekends, and evenings. In our democratic group, I work the same number of holiday and weekend shifts as the most junior partner. I know firsthand the challenges of practicing both community and academic emergency medicine.

I feel I have the experience, temperament, and leadership skills necessary to serve on the ACEP Board of Directors, and to help move the specialty forward. Over the years, I have served on committees, and in leadership positions, with ACEP, SAEM, and ABEM. I have chaired two important ACEP committees – Academic Affairs and Membership. As you well know, membership is the lifeblood of any organization, and we need to continue to meet the needs of our membership going forward. I served on the ACGME Residency Review Committee for Emergency Medicine (RRC-EM) for six years; I well understand and appreciate the policies and program requirements necessary for EM residency accreditation. I served on the Executive Committee (and eventually, President) of the Medical Staff of my hospital – Sentara Hospitals Norfolk. This includes two hospitals (Sentara Norfolk General Hospital, the areas only Level 1 Trauma Center and primary teaching hospital for EVMS, and Sentara Leigh Memorial Hospital). The medical staff includes over 1000 physicians, representing every specialty. During my year as President, I oversaw the transition to an electronic medical record and a Joint Commission visit – it was an exciting year.

I have also served on the Board of Directors of the American Board of Emergency Medicine (ABEM). I was actively involved in the negotiations with the American Board of Surgery and the American Board of Anesthesia resulting in allowing EM residency trained physicians to be eligible for critical care fellowships, and sitting for the critical care examinations. I was also very involved in the development and introduction of the eOral cases into the ABEM Oral Certifying Examination.

My various experiences have taught me the importance of listening, doing the right thing, not the easy thing, and the tremendous amount of work that a small group of dedicated individuals can accomplish. I am asking for your vote for the ACEP Board of Directors; I would like to work hard on your behalf. Thank you.

Francis L. Counselman, M.D., CPE, FACEP

Francis L. Counselman, MD, CPE, FACEP

Candidate, Board of Directors, American College of Emergency Physicians

The Virginia College of Emergency Physicians proudly endorses Dr. Francis Counselman for election to the ACEP Board of Directors. Francis has unflagging enthusiasm for our profession. His hard work and loyalty continues to contribute to the strength of emergency medicine in Virginia. Francis's expertise reflects the depth and breadth of his well-rounded experiences. His leadership and service to ABEM as well as to his home department and community demonstrate his commitment to advancing emergency medicine. We respectfully ask for your vote for Dr. Francis Counselman.

Sincerely,

Bruce Lo, MD, MBA, FACEP
President
Virginia College of Emergency Physicians

Virginia Service

- Virginia ACEP, Board of Directors, 1989-1997
- Virginia ACEP, President, 1995-1996

ACEP Service

- ACEP Award for Outstanding Contribution in Education, 2017
- ACEP Registry Review Workgroup, 2014
- ACEP Teaching Fellowship Faculty, 2004-2016
- ACEP Third Emergency Medicine Workforce Study Group, Chairman, 2007-2009
- ACEP Membership Committee, 2001-2006, Chairman, 2004-2006
- ACEP Academic Affairs Committee, 1996-2001, Chairman, 1999-2001

Other Service

- American Board of Emergency Medicine, Board of Directors, 2008-2016, President, 2014-2015
- Association of Academic Chairs of Emergency Medicine, President, 2002-2003

My promise to you is to work hard on behalf of the ACEP membership to advance our specialty. I respectfully request your support in this year's Board of Directors election.

Francis Counselman, MD, CPE, FACEP

ACEP BOARD OF DIRECTORS CANDIDATE 2018
FRANCIS L COUNSELMAN, MD, CPE, FACEP

Current Practice

- Full time EM practice (32 years)
- Board of Directors (20+ years)
  of Emergency Physicians of Tidewater
  -a 40 year old democratic practice group of board-certified EM physicians

Additional Leadership Experience

- President of Medical Staff, Sentara Hospitals Norfolk, 2008-2009 (two hospitals:1,000+ physicians)
- Program Director, EM Residency, Eastern Virginia Medical School, 1990-2010
- President, Norfolk Academy of Medicine, 1998-1999

Recognition

- Award for Outstanding Faculty Achievement, Eastern Virginia Medical School, 2016
- Mason Andrews Community Service Award, Sentara Hospitals Norfolk, 2014
- Heroes of Emergency Medicine, Virginia, American College of Emergency Physicians, 2008
- Parker J. Palmer “Courage to Teach” Award, Accreditation Council for Graduate Medical Education, 2005
- Residency Director of the Year Award, Emergency Medicine Residents’ Association, 2003

DEDICATION LEADERSHIP EXPERIENCE

Endorsed by the Virginia College of Emergency Physicians (VA ACEP) and the Association of Academic Chairs of Emergency Medicine (AACEM)

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ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

J.T. Finnell, MD, FACEP, FACMI

Question #1: **Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

Healthcare is entering a period of rapid change. Advancement of new technologies will fundamentally change how we practice medicine. Hospitals will become smaller as more healthcare will be done at home. Precision medicine where treatments will be based on genetic, environmental and lifestyle factors. Aging will become a treatable disease. Cars that drive themselves, drastically reducing rates of traumatic injuries. When was the last time you did a saphenous vein cutdown, or diagnostic peritoneal lavage? Advances in technology have already changed and will continue to change how we practice emergency medicine.

We should be working smarter, not harder. We should be building tools to help us manage the deluge of clinical data we must consume in order to make rational treatment decisions. In Indiana, we are already working on tools to help mine "Big Data". Similar to how Amazon will present you relevant buying decisions, why can't your EHR do the same? Patient's with chest pain have their last EKG, Cardiology notes, Stress and Cath reports (regardless of health system) available for review. We've discovered this saves over 5 minutes of chart review down to just seconds.

How we use knowledge is different today than when we were younger. A quarter-century ago, when we first started going online, we took it on faith that the web would make us smarter: more information would breed sharper thinking. However, what we've seen instead is that we often sacrifice our ability to turn information into knowledge. We get the data but lose the meaning.

In a recent study, a group of volunteers read 40 brief factual statements and then typed the statements into a computer. Half the people were told that the machine would save what they typed: the other half were told that the statements would be immediately erased. The Google effect was born. The Google effect, also called digital amnesia, is the tendency to forget information that can be found readily online by using Internet search engines such as Google. This is changing how we practice, and more importantly, how we certify emergency physicians. What information should an emergency physician "know" versus have the ability to "look up"?

As a child, and before technology, I remember my father during a party game would boldly state there are five state capitals where "city" is part of their name. There are actually only four, so no one could ever come up with the fifth. My father would claim it was Indiana, and Indiana City as the capital. No one would disagree.

Psychologist and philosopher William James said in an 1892 lecture, "the art of remembering is the art of thinking." Upgrading your devices will not solve the problem. We need to give our minds more room to think.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

How many of us recall growing up with "Emergency!" which debuted on NBC on January 15, 1972? What an awesome team. Firefighters Johnny Gage and Roy DeSoto working together with nurses (Dixie McCall) and emergency physicians Kelly Brackett, and Joe Early MD, FACS, **ACEP**. Yes, ACEP was listed in their credentials, founded only four years earlier, found its way into our hearts and living rooms.

ACEP continues to represent a family of physicians who share a commitment to improving the quality of emergency care. I've been a member of ACEP for over 30 years and have practiced in multiple settings. I've worked for both private and small groups, and currently serve as the program director of Clinical Informatics and as teaching faculty in the Indiana University

residency program. While we all wear many hats, I consider ACEP to be my home, and my informatics training to add unique value, which will truly complement the existing ACEP board.

Healthcare is entering a period of rapid change. Advancement of new technologies will fundamentally change how we practice medicine. Hospitals will become smaller as more healthcare will be done at home. Precision medicine where treatments will be based on genetic, environmental and lifestyle factors. Aging will become a treatable disease.

I'm well aware that the "promise of technology" with the advent of electronic records has presented new challenges. The burden of the electronic record has resulted in increased rates of physician burnout and spawned a new class of scribes. However, my particular set of skills helps to transform the realities of all emergency physicians. True transformation requires trusted data and sound analytics. We all work with problematic electronic records, order sets, and decision support that drive us crazy. However, I've built systems that truly reflect emergency medicine's best practices and our particular realities of care. I've led collaborative and creative teams to streamline our existing processes in order to enhance the efficiency of our department. I understand the nuances of data collection and measurement and can help our Board to insure the success of all of our practices.

As part of my extensive career I've been able to bridge the crucial gap between generations of physicians through the use of technology. We are all part of connected teams. Using tools like Slack, Trello, and Basecamp to bridge that divide. I want us to work smarter, not harder. We are currently working on tools to help mine "Big Data". When a patient presents to the ED with chest pain, why should we have to search for an old EKG, cardiology notes, or stress reports? These all should be readily available and instantly viewable.

Nomination to ACEP's board is an honor and a privilege. I would like the opportunity to bring the advances in emergency medicine that we have in Indiana to ACEP. I have the full support of my family, practice group, and state to serve you. I'm asking for your support and will bring your voice to lead our college into the future.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

As Mark Twain once said: "The difference between the right word and the almost right word is the difference between lightning and a lightning bug." I endorse the ACEP's Mission statement.

The ACEP Mission Statement. The American College of Emergency Physicians promotes the highest quality of emergency care and is the leading advocate for emergency physicians, their patients, and the public.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

John T. Finnell, MD, FACEP, FACMI

Contact Information

505 South 5th Street, Zionsville, IN 46077
Phone: 317-454-1089
E-Mail: jtfinnell@gmail.com

Current and Past Professional Position(s)

Fellowship Program Director, Clinical Informatics
President AMIA Academic Forum
Member AMIA Board of Directors
Member AMIA Education Committee
ABEM Senior Case Examiner Reviewer
ABEM Item Writer
ABEM Oral Examiner
ABEM Case Development Panel

Education (include internships and residency information)

B.S., Biology, University of Vermont	1983-1987
M.D., University of Vermont	1987-1991
Residency: Emergency Medicine, UCSF-Fresno	1991-1995
EMF/ACEP Teaching Fellowship, Dallas Tx	1997-1998
Evidence Based Medicine, McMaster University	2001
M.Sc., Clinical Research, Indiana University	2002-2004
Informatics Fellow, National Library of Medicine	2002-2005
M.D., University of Vermont	1991

Certifications

Diplomate, American Board of Emergency Medicine	1996-Present
Diplomate, American Board of Preventive Medicine in Clinical Informatics	2013-Present

Professional Societies

ACEP
Indiana ACEP
SAEM
AMA
AMIA (American Medical Informatics Association)
CCIPD (Clinical Informatics Program Directors)

National ACEP Activities – List your most significant accomplishments

Board of Directors Nominee	2016-Present
Council Steering Committee	2013-2015
Chairman Reference Committee	2014

Education Committee	2014-Present
Indiana Counselor	2010-Present
Tellers, Credentials Committee Member	2010-2013
State Leader 911 Network	2010-Present
Reference Committee Member	2010-2013
Clinical Policies Committee – Informatics Liaison	2004-2007
Academic Affairs Committee	1999-2003
Secretary Informatics Section	2002-2003

ACEP Chapter Activities – List your most significant accomplishments

Past-President INACEP	2014
President INACEP	2013-2014
Board of Directors	2009-Present

Practice Profile

Total hours devoted to emergency medicine practice per year: **1864** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **25** % Research **5** % Teaching **50** % Administration **20** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Eskenazi Health (formerly Wishard Memorial) is a county, level 1 trauma and burn center. It is one of the major teaching hospitals for central Indiana. The academic faculty are employed by Indiana Health, an affiliate of Indiana University.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

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CANDIDATE DISCLOSURE STATEMENT

John T. Finnell, MD, FACEP, FACMI

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Indiana University

Address: Bloomington, IN

Position Held: Emergency Medicine Attending Physician

Type of Organization: Health Care / Hospital

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: American Medical Informatics Association (AMIA)

Address: Bethesda, Maryland 20814

Type of Organization: Member Organization for Biomedical Informatics

Duration on the Board: 1 year

Organization: Outrun The Sun

Address: Indianapolis, IN

Type of Organization: Non-Profit, Melanoma Advocacy

Duration on the Board: 4 years

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☐ NONE

☒ If YES, Please Describe: Maria, my wife, is employed by Anthem/Medicaid.

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

John T. Finnell, MD July 16, 2018

Advancing Emergency Care

INDIANA CHAPTER
American College of Emergency Physicians
630 No. Rangeline Rd. Suite D, Carmel, IN 46032
Phone: (317) 846-2977 Fax: (317) 848-8015
Email: inacep@inacep.org

January 23, 2018

John G. McManus, Jr., MD, MBA, FACEP
Chair, Nominating Committee
P.O. Box 619911
Dallas, TX 75261-9911

Dear Dr. McManus,

The Indiana ACEP Chapter highly recommends John Thomas Finnell MD, FACEP as a candidate for the national ACEP Board of Directors. As you can see from his Curriculum Vitae, Dr. Finnell has not only spent many years in leadership positions with the Indiana Chapter, but has also been very involved with numerous national ACEP committees, as well as ABEM and the national ACEP Council.

His energy and continued commitment to ACEP's interests are outstanding and his leadership skills are impeccable. He has formal training in BioMedical Informatics, is board certified in Clinical Informatics and is the program director for the first EM based Clinical Informatics program in the country. This specific skill set would help ACEP realize its informatics goals with CEDR and other data initiatives.

The Indiana ACEP Board of Directors wholeheartedly supports John Thomas Finnell MD, FACEP for candidacy to the national ACEP Board of Directors.

Sincerely,

E. Nicholas Kestner

John T. Finnell, MD, FACEP, FACMI

Dear Colleagues,

It is an honor and privilege to have been selected to be a candidate for your Board of Directors.

As you review the qualities of each of the exceptional candidates, I'd like for you to consider some of my core values that will give you a sense of who am I am, and the type of Board member I will be, if elected.

Service. Service is the ability to put aside your needs for the greater good of the group. For physicians specializing in Emergency Medicine - our schedules are 365/24/7. We work nights, weekends, and holidays. We work during major sporting events (Super Bowl in Indy) that we'd rather be attending. I value the commitment I've made to our specialty and I will work tirelessly for you to ensure your needs are being met in order to make the best decisions in the interest of our specialty.

Health. Wellness matters. We must do things outside of our work lives to keep us whole. For me, I'm a runner. I find the time I use running helps to clear my head and helps me to prepare for the challenges that lie in the days/weeks ahead. I'm very fortunate that my family can join me on these activities so we can spend these precious hours together.

Innovation. I like to explore new ways to do things and I think outside of the box. I have been fortunate at Indiana University to have worked with other schools on campus and have been awarded patents based upon our work together. I find that innovation comes not from one person, but from a group of individuals who wish to make something unique and better. I promise to bring these talents to your board to help make your job and our specialty better.

Informatics. Looking at the composition of the current ACEP board, I can help fill a void. We all experience the challenges related to electronic medical records and rising rates of dissatisfaction and burn out. In Indiana, we create tools to allow us to become more efficient with our time to be more productive. The simple reality of a practicing emergency physicians life includes information technology. EMR, building order sets to reflect best practices, streamlining our existing processes to enhance efficiency, and understanding data measurement are skills that I possess.

I look forward to getting to know more of you. For those that do not yet know me – here are some words that others I work with have used to describe the type of person I am.

"Calm, caring, creative, collaborative, driven, engaged, enthusiastic, experienced, fair, focused, knowledgeable, honest, insightful, open minded, personable, relaxed, thoughtful."

I ask for the honor and privilege to serve you, and for your vote for the ACEP Board of Directors.

Sincerely,

JT

JOHN T. FINNELL MD, MSc, FACEP

• ACEP Board of Directors Candidate •

Today's reality of practicing emergency medicine includes Information Technology (EMRs, Order Sets, Clinical Data).

As an informatician and data scientist, I ask for your vote to help lead ACEP into our future.

WHO I AM:

- Associate Professor of Clinical Emergency Medicine
- Associate Professor of Informatics
- Current INACEP Board Member
- Fellowship director of the first EM Clinical Informatics fellowship
- 20+ Years practicing academic physician in a Level 1 Trauma Center in an Urban Environment

PROVEN LEADERSHIP:

- Department Chair Health Informatics, Indiana University
- Fellowship Program Director, Clinical Informatics

MY GOALS AS A BOARD MEMBER:

- Physician wellness (EHRs are a major burden)
- Enhance communication around our Advocacy Issues
- Innovative on-line communities for support / mentorship

LEADERSHIP **SERVICE** **DATA SCIENTIST**

Endorsed by Indiana ACEP & ACEP Informatics Section

JOHN T. FINNELL MD, MSc, FACEP

• ACEP Board of Directors Candidate •

National / Chapter Service:

- ACEP Council Steering Committee 2013 - 2015
- ACEP Chairman Reference Committee 2014
- ACEP Education Committee 2014 - Present
- ACEP Indiana Councillor 2010 - Present
- ACEP Tellers, Credentials Committee 2010-2013
- ACEP State Leader 911 Network - Present
- ACEP Reference Committee 2010-2013
- ACEP Clinical Policies Committee Informatics Liaison 2004 - 2007
- ACEP Academics Affairs Committee 1999 - 2003
- INACEP Past-President 2014
- INACEP President 2013 - 2014
- INACEP Board of Directors 2009 - Present

SERVICE:

- ABEM Oral Board Examiner
- ABEM Item Writing Committee
- ABEM Case Reviewer
- American Medical Informatics Association Board of Directors

LEADERSHIP **SERVICE** **DATA SCIENTIST**

Endorsed by Indiana ACEP & ACEP Informatics Section

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2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Jeffrey M. Goodloe, MD, FACEP

Question #1: **Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

Emergency medicine will become more valued for its role in resuscitating, stabilizing, and navigating higher acuity, unscheduled patients. Despite a continuing multitude of attempts to simplify healthcare in the United States, largely for cost containment, with some focused upon improving the patient care experience and/or clinical outcomes, developing integrated networks of care will heavily depend upon emergency physicians throughout all hours of the day.

If history is a sage predictor of future behavior, emergency medicine will retain its "front door to the hospital" status in traditional settings. Emergency medicine is also poised to continue to find developing markets in health care as patients understandably value ease of access, efficient diagnostic capabilities, and effective treatments. Whether within a traditional emergency department or in a developing capacity (e.g. multi-national telemedicine) the emergency physician will always embody the best in patient protection and advocacy.

ACEP is widely, and appropriately, held in regard for advancing not just the science of emergency care, but doing so within the strengths of our humanity, our passions for aiding others on often the worst days of their lives. No future technology in emergency medicine can fully succeed without these strengths, fostered best within the ACEP community.

My skills include being a careful student of history to learn the lessons well from days past to enable us to move with calculated safety and effectiveness into the future. My skills also include being an optimistic futurist, with an open mind, challenging the status quo, in finding answers to the current challenges, and always remaining poised for "the next big thing" that can't yet be anticipated.

Protecting the foundations and responsibilities of the patient-emergency physician relationship, avidly incorporating the perspectives of all generations of leaders in emergency medicine, and always serving with a "What if?" and "How can we?" mindset enables me to help lead ACEP and its members effectively into and through the coming decade.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

Speaking for emergency physicians translates specifically to advocating for emergency physicians. Effective advocacy for emergency physicians is built upon understanding and respecting us. *All* of us.

I'm celebrating 20 years since emergency medicine residency graduation. In my journey as an emergency physician, I've been taught by generalists, other specialists, non-EM residency trained/EM boarded faculty and EM residency trained/EM boarded faculty. These mentors, teachers, and colleagues are female and male, spiritual and not spiritual, and as diverse in interests as I could have ever imagined. I've found valuable medical and life lessons from them all.

I've worked at a rural/small suburban community hospital, with its 16 bed ED and with phone handsets duly worn, proving the frequency of transfers to "the big city" that most often involved more than one conversation (aka persuading, pleading, and/or praying). I've worked at an inner city tertiary referral hospital with an annual ED census soaring past 100,000 patients. I've also worked at larger suburban and even urban hospitals that many assumed were "nice little places to practice emergency medicine" while my partners and I routinely saw 4-5 patients/hour throughout 10+ hour shifts, many with acuities requiring invasive airway management, central lines pre-routine ultrasound guidance, and trauma/STEMI/stroke/sepsis teams that were all comprised of one emergency physician, 2 nurses (if we were lucky), and 1 respiratory therapist (maybe). For the past several years, I've been fortunate to share the benefits of those experiences, while still learning emergency medicine advances daily, as I teach fellows, residents, and medical students in the base hospital for an EM residency and conduct research in a historically medically underserved state.

Also, as an emergency physician, I've built upon my love for pre-hospital care that I discovered as a paramedic in college and medical school years. I've served in EMS for 30 years, 22 of those as a medical oversight physician, currently the clinical leader for over 4,000 credentialled professionals in the metropolitan Oklahoma City and Tulsa areas. I also find professional fulfillment in serving in special events medical planning and on-site coverage, including many NASCAR and IndyCar events as well as law enforcement tactical missions.

Each of these roles – bedside clinician, teacher, researcher, EMS medical oversight leader, special mission clinician - has an axis of being an emergency physician. Add in years of advocacy and service in state and national ACEP and I can't hardly believe what started as a hopeful vision has come to this fulfilling reality.

If you recognize yourself in any of the above, I can effectively help to speak for you. If you don't, I'm sincerely willing to listen so I can better understand and factor your perspectives.

Do we all have continual challenges? Yes. Can we find the answers *together*? Yes. Between our dates of birth and death, we all have a dash. Emergency physicians make positive differences with those dashes. Part of my positive difference is a sincere desire to serve you as a member of the ACEP Board of Directors, speaking for you.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a constituency?**

Neither. ACEP must respect the democracy of medicine itself. Just as other specialty societies respected the formation and now continual advancement of ACEP itself, ACEP must acknowledge and respect the rights and abilities of emergency physicians that form other organizations centered upon our specialty. Simultaneously, ACEP must commit to advocate for all emergency physicians, avoiding unnecessary fractionation among us…all of us.

No 37,000+ member organization can ever speak in unanimity, but sincere and careful adherence to ethics, respect for differences, and responsible, responsive leaders can, and I believe will continue to position ACEP as the leading voice of emergency medicine, for its physicians, and for its patients and communities we are privileged to collectively serve.

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CANDIDATE DATA SHEET

Jeffrey M. Goodloe, MD, FACEP

Contact Information

3720 E 99th PL, Tulsa, OK 74137 (Home)
Phone: 918-704-3164 (Cell); 918-298-0502 (Home)
E-Mail: jeffrey-goodloe@ouhsc.edu (Work/Public); jgoodloemd@aol.com (Personal/ACEP staff use)

Current and Past Professional Position(s)

Attending Emergency Physician – Hillcrest Medical Center Emergency Center – Tulsa, OK
Professor of Emergency Medicine; EMS Section Chief; Director, OK Center for Prehospital & Disaster Medicine
University of Oklahoma School of Community Medicine – Tulsa, OK
Medical Director, Medical Control Board, EMS System for Metropolitan Oklahoma City &Tulsa, OK
Medical Director, Oklahoma Highway Patrol
Medical Director, Tulsa Community College EMS Education Programs

Past Positions
Attending Emergency Physician – St. John Medical Center – Tulsa, OK
Attending Emergency Physician – Saint Francis Hospital Trauma Emergency Center – Tulsa, OK
Attending Emergency Physician – Medical Center of Plano – Plano, TX
Medical Director, Plano Fire Department – Plano, TX
Medical Director, Allen Fire Department – Allen, TX

Education (include internships and residency information)

EMS Fellowship – University of Texas Southwestern Medical Center at Dallas (1998-99)
Emergency Medicine Residency – Methodist Hospital of Indiana/Indiana Univ School of Medicine (1995-98)
Indianapolis, IN
The Medical School at University of Texas Health Science Center at San Antonio (1991-95)
Baylor University – Waco, TX (1987-91)

MD - 1995

Certifications

ABEM Emergency Medicine Initial Certification 1999, Recertification 2009, All MOC components met for 2019
ABEM EMS Medicine Initial Certification 2013, All MOC components current

Professional Societies

ACEP member since 1991 (medical student, resident, fellow, active, FACEP)
OCEP (Oklahoma College of Emergency Physicians – State ACEP Chapter)
NAEMSP
Prior memberships in Texas College of Emergency Physicians, Indiana ACEP Chapter, AMA, Oklahoma State Medical Association, Tulsa County Medical Society, SAEM

National ACEP Activities – List your most significant accomplishments

Member, Council Steering Committee, ACEP Council
Chair, Reference Committee, ACEP Council
Member, Reference Committee, ACEP Council

Councillor, Oklahoma College of Emergency Physicians
Councillor, EMRA
Chair, EMS Committee
Member, EMS Committee
Member, Internal & External Membership Committee Taskforces

ACEP Chapter Activities – List your most significant accomplishments

President, Oklahoma College of Emergency Physicians
Vice-President, Oklahoma College of Emergency Physicians
Councillor & Board Member, Oklahoma College of Emergency Physicians

Practice Profile

Total hours devoted to emergency medicine practice per year: **2750** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **50** % Research **2** % Teaching **10** % Administration **38*** %

Other: ***predominantly EMS medical oversight** ____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am employed full time by the University of Oklahoma School of Community Medicine. My roles are multiple, including serving as medical school faculty as a professor of emergency medicine and clinically as an attending faculty physician in the Hillcrest Medical Center Emergency Center (Comprehensive Stroke Center, full-service cardiovascular institute site – including ECMO and VAD surgeries, Level III Trauma Center, regional burn center for geographical areas of four states, Level III NICU) supervising residents in Emergency Medicine, Internal Medicine, Family Medicine, OB/GYN, fellows in Pediatric Emergency Medicine, and medical students. The University of Oklahoma Department of Emergency Medicine faculty currently partially staffs four emergency departments in Tulsa and Oklahoma City, employing a university academic group/private group collaborative structure. I currently am staff credentialed at Hillcrest Medical Center in Tulsa, the base hospital for the EM residency, though I have been staff credentialed in prior years at two other teaching hospitals in Tulsa. I also serve as the Medical Director for the EMS System for Metropolitan Oklahoma City and Tulsa, clinically leading over 4,000 credentialled EMS professionals working in an ambulance service, fire departments, law enforcement agencies, industrial emergency response teams or emergency communications centers. I further serve as a tactical emergency physician and Medical Director for the Oklahoma Highway Patrol, responding on emergency tactical missions across the entire state. Additional practice roles include special events medical support planning for metropolitan Oklahoma City and Tulsa, motorsports medical support (on-site track physician) for NASCAR and IndyCar events in Ft. Worth, Texas, and as an educational program medical director for EMT and Paramedic education at Tulsa Community College. I also frequently lecture at national educational meetings, such as the NAEMSP Annual Meeting, EMS State of the Science – A Gathering of Eagles, and Emergency Cardiovascular Care Update.

Expert Witness Experience (I am interpreting such as courtroom testimony – JG)

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 1 Cases **Plaintiff Expert 0 Cases**

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CANDIDATE DISCLOSURE STATEMENT

Jeffrey M. Goodloe, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: University of Oklahoma School of Community Medicine

Address: Department of Emergency Medicine, 1145 S Utica Ave, 6th Floor

Tulsa, OK 74104

Position Held: Professor; EMS Section Chief; Director – OK Ctr for Prehospital/Disaster Med

Type of Organization: Medical School

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: Oklahoma College of Emergency Physicians

Address: No physical office address for OCEP – Executive Director is Gabe Graham

gabegraham11@gmail.com

Type of Organization: State Chapter of ACEP

Duration on the Board: Since 2007 continuously and currently

Organization: Emergency Medical Services Authority

Address: 1111 Classen Blvd

Oklahoma City, OK 73103

Type of Organization: Public Utility Model Ambulance Service

Duration on the Board: Ex-officio as Medical Director since 2009 continuously and currently

Organization: Emergency Medicine Residents' Association

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Professional medical association

Duration on the Board: 1995-1998

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

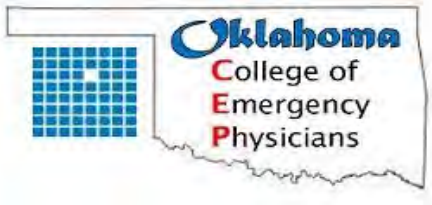
☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Jeffrey M. Goodloe, MD Date July 16, 2018



August 1, 2018

Re: Endorsement for Jeffrey M. Goodloe, MD, FACEP for the ACEP Board of Directors

Dear Councillors

On behalf of the Oklahoma College of Emergency Physicians, I am writing with an enthusiastic endorsement for our current President, Dr. Jeffrey M. Goodloe, to be elected to the ACEP Board of Directors.

Dr. Goodloe is already well known nationally within ACEP, starting prior to his EMRA presidency in the late 1990s and continuing since. He is an active councillor, with past service on the Council Steering Committee and Reference Committees, including chairing a 2012 Reference Committee. He is active in advocacy activities at the federal level, regularly attending ACEP's Leadership and Advocacy Conference, and well-known among Oklahoma's US Representative and Senators. He is an active promoter of our specialty's future in supporting the Emergency Medicine Foundation, recruiting members to the Wiegenstein Legacy Society. He is a voice trusted by ACEP leaders, including multiple ACEP presidents, evidenced in part by a two-year term as Chair of the EMS Committee.

Dr. Goodloe has effectively led the Oklahoma College of Emergency Physicians as a Board Member since 2007 and as President since 2016, helping lead a resurgence in activity and interest at our local level.

Dr. Goodloe moved to Tulsa in the Summer of 2007 and immediately volunteered for service in OCEP. He was promptly elected to our Board of Directors as a councillor, given his experience and expertise representing EMRA for several years in the ACEP Council and his activity within the Texas College of Emergency Physicians. He has represented us well throughout the years, helping our councillors understand the history behind many resolutions and the intricacies often involved when contemplating the full impacts of resolutions on ACEP. He is a consummate team player and leader, encouraging involvement of any OCEP member willing to serve and mentoring younger members. OCEP membership is growing in significant part due to his dynamic vision to make OCEP more effective, more tangible, and more fun!

Dr. Goodloe leads our federal legislative action arm, yet remains very active with our state legislative priorities, testifying at the Oklahoma State House. He formed a coalition of medical specialists, including emergency physicians, internists, stroke neurologists, and EMS professionals to oppose a problematically worded stroke care bill. This coalition was able to effectively then work with the American Stroke Association and Oklahoma legislators to ultimately craft a bill that truly strengthens stroke care capabilities for Oklahomans, from first medical contact by EMTs and paramedics to

Jeffrey M. Goodloe, MD, FACEP

Hello, fellow councillors, colleagues, and friends. I'm Jeffrey Goodloe and I'm honored and incredibly excited to be running for the ACEP Board of Directors.

Many we serve are disenchanted with government and industry leaders and/or pundits that opine about them. Truth can seemingly get defined by the holders of facts, whether real or manufactured. This is decidedly not a time to lose momentum in what we believe best advances our beloved specialty. We and our patients deserve good leaders. Energized leaders. Enthusiastic leaders. Ethical leaders. Servant leaders. Strong leaders. Vocal leaders.

Speaking for emergency physicians translates specifically to advocating for emergency physicians. Effective advocacy for emergency physicians is built upon understanding and respecting us. *All* of us.

I'm celebrating 20 years since emergency medicine residency graduation. In my journey as an emergency physician, I've been taught by generalists, other specialists, non-EM residency trained/EM boarded faculty and EM residency trained/EM boarded faculty. These mentors, teachers, and colleagues are female and male, spiritual and not spiritual, and as diverse in interests as I could have ever imagined. I've found valuable medical and life lessons from them all.

I've worked at a rural/small suburban community hospital, with its 16 bed ED and with phone handsets duly worn, proving the frequency of transfers to "the big city" that most often involved more than one conversation (aka persuading, pleading, and/or praying). I've worked at an inner-city tertiary referral hospital with an annual ED census soaring past 100,000 patients. I've also worked at larger suburban and even urban hospitals that many assumed were "nice little places to practice emergency medicine" while my partners and I routinely saw 4-5 patients/hour throughout 10+ hour shifts, many with acuities requiring invasive airway management, central lines pre-routine ultrasound guidance, and trauma/STEMI/stroke/sepsis teams that were all comprised of one emergency physician, 2 nurses (if we were lucky), and 1 respiratory therapist (maybe). For the past several years, I've been fortunate to share the benefits of those experiences, while still learning emergency medicine advances daily, as I teach fellows, residents, and medical students in the base hospital for an EM residency and conduct research in a historically medically underserved state.

Also, as an emergency physician, I've built upon my love for pre-hospital care that I discovered as a paramedic in college and medical school years. I've served in EMS for 30 years, 22 of those as a medical oversight physician, currently the clinical leader for over 4,000 credentialled professionals in the metropolitan Oklahoma City and Tulsa areas. I also find professional fulfillment in serving in special events medical planning and on-site coverage, including many NASCAR and IndyCar events as well as law enforcement tactical missions.

Each of these roles – bedside clinician, teacher, researcher, EMS medical oversight leader, special mission clinician - has an axis of being an emergency physician. Add in years of advocacy and service in state and national ACEP and I can't hardly believe what started as a hopeful vision has come to this fulfilling reality.

If you recognize yourself in any of the above, I can effectively help to speak for you. If you don't, I'm sincerely willing to listen so I can better understand and factor your perspectives.

Do we all have continual challenges? Yes. Can we find the answers *together*? Yes. Between our dates of birth and death, we all have a dash. Emergency physicians make positive differences with those dashes. Part of my positive difference is a sincere desire to serve you as a member of the ACEP Board of Directors, speaking for you.

JEFFREY M. GOODLOE, MD, FACEP

For ACEP Board of Directors

Accountable
service
Consensus
builder
Enthusiastic
commitment
Proven
leadership

Council Steering Committee Member
Council Reference Committee Chair
EMS Committee Chair
State Chapter President & Councillor
Past EMRA President & Councillor

Proudly endorsed by:

Oklahoma College of Emergency Physicians

Jeffrey M. Goodloe, MD, FACEP

1145 S. Utica Ave, Suite 600 | Tulsa, OK 74104 |918-704-3164 (Cell)

jeffrey-goodloe@ouhsc.edu

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2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Christopher S. Kang, MD, FACEP, FAWM

Question #1: **Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

Three years ago, I predicted that the next decade would mark a dynamic and historic time of opportunity for our College as emergency medicine transitioned from fighting for acceptance by the members of the House of Medicine, to being recognized as one of their leaders. That transition is now underway. As a newly emerged leader at a time when healthcare has become increasingly complex, subject to greater scrutiny, and factionalized, our College must undertake new challenges and responsibilities, engage its internal and external critics, and respect competing priorities with fewer resources. It is essential that the College continue to have experienced, strategic, and visionary leaders.

For 25 years, I have practiced in a variety of settings around the world, from austere environments and the back of ground and air ambulances, public health to mass casualty events, and in rural facilities and modern medical centers. As Medical Project Director for an ACEP grant, I visited and evaluated the disaster preparedness of dozens of hospitals and agencies across the country. Over the past three years, I have represented the College at state and national meetings with other professional, industry, and government organizations. Trust and respect have been earned, individual and specialty relationships developed, and the foundations for future collaboration fortified. I would like to continue to build upon these advancements.

As a military officer, I became proficient with strategic planning and management – assessing the context of a situation, setting common objectives, identifying resources, foreseeing contingencies, and adjusting plans in response to changing priorities and conditions. As research director, I objectively studied proposals, reviewed current literature, and critically evaluated data. As a result, I can rapidly interpret and effectively employ those analyses.

As President, I led the Washington Chapter as it transitioned from a small to medium chapter and its emergence as a leading resource for the College for several critical initiatives, including repudiating psychiatric boarding, curtailing opioid use and deaths, improving patient care coordination, and advocating for user-oriented clinical information sharing technologies. Also, programs for resident physician liaisons and past state leaders were started, greater engagement with state emergency nursing and medical associations fostered, and the recruitment and mentorship of future chapter leaders expanded. I have continued to seek out and serve as advisor and mentor to several generations of College members at the section, committee, chapter, and national levels. Cultivating tomorrow's emergency medicine leaders is just as important as confronting today's issues.

These skills and track record make me uniquely qualified to continue to lead the College's efforts to better serve our patients, members, and profession and to successfully sustain its role as the leader of emergency medicine and the House of Medicine.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

My continued service on the Board of Directors would advance the College's ability to speak for all emergency physicians because of my affinity and ability to see from and appreciate diverse perspectives that stem from my personal background and professional career and which are evidenced by my College service.

I spent my childhood in Asia, North America, and Europe, where I was sometimes a member of the majority, sometimes the minority. Since medical school, I have observed and practiced a wide range of medicine in various settings across the country and around the world, including Asia, Central America, and the Middle East. I welcome and respect different values, cultures, and clinical practices.

Professionally, my career reflects the diversity of the practice models of emergency medicine. I work at a federally-operated medical center and for an independent group in a community hospital. I also serve on the faculty of an accredited emergency

medicine residency and emergency medicine physician assistant fellowship program. My responsibilities have included advisor, curriculum development, didactic and simulation instruction, research director, faculty development, and liaison to other departments and hospitals. Both jobs provide me first-hand experience with different patient populations, levels and generations of emergency medicine providers, healthcare systems, and employment and reimbursement models.

Within the College, I have solicited the counsel of past leaders and advised resident physicians, junior members, and committee and chapter leaders. I have assisted the composition, presentation, and adoption of numerous Council resolutions, some of which involved emerging and contentious issues. Over the past three years, I have visited multiple chapters and sought out and served as a liaison to numerous College sections to learn more about and foster your interests. I have also represented the College at state and national meetings with other professional, industry, and government organizations. Trust and respect have been earned, individual and specialty relationships forged, and the foundations for future collaboration cultivated. Continued appreciation for and inclusion of you will enhance patient care and rapport, fortify membership identity and contentment, and promote the growth and maturation of our specialty.

As a result of my unique background and career, I can and will continue to represent and advocate for emergency physicians and their clinical practices, interests, and priorities to advance quality emergency care and the evolution of our profession.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

Our College should and must continue to represent, advocate for, and lead one constituency – emergency medicine.

Our College will achieve this mission by doing three things,
1. Remain devoted to advancing quality emergency patient care – patients first should always be our foremost professional responsibility;

2. Continue to have the mechanisms and resources to represent, promote, and inspire emergency physicians' interests, practices, and advocacy – they are essential to the growth, evolution, and success of our specialty; and,

3. Conduct itself and lead with fidelity, integrity, and sincerity – although sibling rivalries will occasionally arise with various emergency medicine members and organizations because of contrasting priorities, trust and respect will be earned by and successful collaboration within and outside of emergency medicine will ensue for our College and emergency medicine family.

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CANDIDATE DATA SHEET

Christopher S. Kang, MD, FACEP, FAWM

Contact Information

2184 Bob's Hollow Lane, DuPont, WA 98327
Phone: (253) 964-1445
E-Mail: Christopher.s.kang@gmail.com

Current and Past Professional Position(s)

Current Employment
1. Department of Emergency Medicine, Madigan Army Medical Center, Tacoma, WA (2001-Present)
   Faculty, Emergency Medicine Residency, Madigan Army Medical Center
2. Olympia Emergency Services, PLLC, Providence St. Peter Hospital, Olympia, WA (2007-Present)

Past Employment
1. Mt. Rainier Emergency Physicians, PLLC, Good Samaritan Hospital, Puyallup, WA (2004-2005)
2. Emergency Medical Services, 121st General Hospital, Yongsan, Seoul, Republic of Korea (2000-2001)

Academic Appointments
1. Assistant Professor, Adjunct, Uniformed Services University of the Health Sciences (2008-Present)
2. Assistant Professor, Clinical, University of Washington (2006-Present)
3. Assistant Professor, Physician Assistant Program, Baylor University (2008-Present)
4. Clinical Instructor, University of Washington (2002-2006)

Additional Emergency Medicine-Related Positions and Responsibilities
1. Peer Manuscript Reviewer, Annals of Emergency Medicine (2013-Present)
2. Disaster Clinical Advisory Council, Northwest Healthcare Response Network (2013-Present)
3. Peer Manuscript Reviewer, Journal of Wilderness and Environmental Medicine (2008-Present)
4. Peer Manuscript Reviewer/Section Co-Editor, Western Journal of Emergency Medicine (2007-Present)

Additional Professional Positions and Responsibilities
1. Institutional Review Board, Madigan Army Medical Center (2006-Present)
2. Research Director, Emergency Medicine Residency Program, Madigan Army Medical Center (2006-2015)
3. U.S. Army Safety Center Accident Investigation Board, Iraq (2004)
4. Field Surgeon, 2-3 Stryker Brigade Combat Team, Iraq (2003-2004)
5. Flight Surgeon/Emergency Treatment Physician, Joint Task Force Bravo, Honduras (2002)
6. Patient Safety Committee, Madigan Army Medical Center (2001-2003)
7. Instructor, ACLS (2001-Present)
8. Instructor, PALS (2001-Present)
9. Battalion Surgeon and Flight Surgeon, 52nd Medical Battalion, Republic of Korea (2000-2001)

Education (include internships and residency information)

Residency: Emergency Medicine, Northwestern University (1996-2000)
Medical School: Northwestern University (1992-1996)
Undergraduate: Northwestern University (1989-1992)

Doctorate of Medicine, Northwestern University (1996)

Certifications

Emergency Medicine, American Board of Emergency Medicine (2001, Recertification 2011)
Fellow, Academy of Wilderness Medicine (2009)

Professional Societies

American College of Emergency Physicians (1993-Present)
- Washington Chapter
- Government Services Chapter
- Prior Chapter – Illinois
- Sections – Disaster Medicine, EM Locum Tenens, EM Research, Pain Management, Wilderness Medicine
- Prior Sections – EM Informatics, Forensics

American Academy of Emergency Medicine (2018)
Society for Academic Emergency Medicine (2012-Present)
American Medical Association (2014-Present)
Washington State Medical Association (2007-Present)
Wilderness Medical Society (2002-Present), Fellow in Academy of Wilderness Medicine (FAWM)
U.S. Army Society of Flight Surgeons (2000-Present)

National ACEP Activities – List your most significant accomplishments

Board of Directors (2015-Present)
- Liaison - Disaster Preparedness and Response Committee (2015-Present)
- Liaison - Ethics Committee (2016-Present)
- Liaison - American College of Surgeons, Committee on Trauma (2016-Present)
- Chair, Workgroup for EM Workforce Initiative
- 50th Anniversary Task Force
- Section Liaison - Air Medical Transport, Disaster Medicine, Event Medicine, Undersea and Hyperbaric Medicine, Wilderness Medicine

Council Steering Committee (2013-2014)
Council Reference Committee (2012)
Chair, Disaster Preparedness and Response Committee (2013-2015)
National Chapter Relations Committee (2014-2015)
Secretary and Chair Elect, Disaster Medicine Section (2011-2015)
Survey Team Member and Project Medical Director, ACEP-DHS-FEMA Community Healthcare Disaster Preparedness Assessment Grant Project (2006-2012)
Advisor, Emergency Medicine Basic Research Skills Course (2009-Present)
EMF – Wiegenstein Legacy Society, 1972 Club
NEMPAC – Give a Shift Donor 5+ Years
911 Legislative Network
InnovatED Code Black (2013-2015)
Emergency Medicine Practice Research Network

ACEP Chapter Activities – List your most significant accomplishments

Washington Chapter
- Treasurer, President Elect, President (2013), Immediate Past President
- Board of Directors (2010-Present)
- Councillor (2010-2015)
- Education Committee (2008-Present), Chair (2011-2012)

Practice Profile

Total hours devoted to emergency medicine practice per year: **1948** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **50** % Research **10** % Teaching **35** % Administration **5** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

1. Department of Emergency Medicine, Madigan Army Medical Center, Tacoma, WA
   Federal Government Employee, Civilian
   Military Medical Center - Level II State Trauma Center, State Cardiac Center, State Stroke Center
   Direct Patient Care, Faculty for Emergency Medicine Residency and Emergency Medicine Physician Assistant Fellowship Programs
2. Providence St. Peter Hospital, Olympia, WA
   Part-Time Employee, Non-Partner of Independent Group
   Community Hospital – Level III State Trauma Center, State Cardiac Center, State Stroke Center
   Direct Patient Care

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Christopher S. Kang, MD, FACEP, FAWM

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Department of the Army, Madigan Army Medical Center

Address: 9040 Fitzsimmons Boulevard

Tacoma, WA 98431

Position Held: Attending Physician

Type of Organization: Federal Government

Employer: Olympia Emergency Services, PLLC

Address: 413 Lilly Rd NE – Providence St. Peter Hospital

Olympia, WA 98506

Position Held: Attending Physician

Type of Organization: Independent Emergency Medicine Group

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: Washington Chapter, American College of Emergency Physicians

Address: 2001 6th Avenue, Ste 2700

Seattle, WA 98121

Type of Organization: Non-Profit Professional Medical Organization, Emergency Medicine

Duration on the Board: 2010-Present

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Christopher S. Kang, MD, FACEP, FAWM Date 9 July 2018

WASHINGTON CHAPTER American College of Emergency Physicians
ADVANCING EMERGENCY CARE

Aug. 6, 2018

Dear Members,

Please accept the Washington Chapter of the American College of Emergency Physicians' wholehearted endorsement of the candidacy of Christopher Kang, MD, FACEP for re-election to the American College of Emergency Physicians' National Board of Directors.

The state of Washington has been fortunate to have Chris as a leader for many years. Dr. Kang has made a career of serving his country in the Army for many years, including serving as residency research director at Madigan Army Medical Center, in addition to deployments all over the world. He has extensive experience in pre-hospital care, aviation medicine, disaster and emergency preparedness, wilderness medicine, and research. As member of Washington ACEP, Chris has truly done it all. Chris has lead state legislative efforts on opiate policy, psychiatric boarding, and reimbursement. While serving as chapter president, he organized the state chapter effort to host ACEP13, which was a very successful conference. He created our resident liaison program, and has mentored many Washington ACEP members to successful roles at the state and national level. Beyond his accomplishments, two qualities defined Chris Kang: he is an incredibly effective leader who gets things done, and he does it with the utmost humility, the ultimate team player who would rather promote others than get the credit himself.

Since his election to the national board of ACEP, Chris Kang has continued to be an important voice for emergency medicine. When the Ebola epidemic hit, Chris assisted with the publication of an article on Ebola in the *Annals of EM*. He is currently working on the Playbook for Social Media in the College. Because Chris is such an effective communicator, he serves in multiple liaison roles for the Board of Directors. He was also previously Chair of the Disaster Preparedness and Response Committee. Chris is an exemplary role model, who will help mold the next generation of leaders within ACEP.

The Washington Chapter is proud of the leadership that Chris Kang has brought to the Board of Directors. I hope that all ACEP members will give him the strongest consideration in re-election to the ACEP Board of Directors.

Sincerely,

Liam Yore, MD, FACEP
Washington ACEP President

Christopher S. Kang, MD, FACEP, FAWM

Dear Colleagues,

It is a privilege to have been selected to be a candidate for your Board of Directors.

As you assess each candidate, please consider the following four attributes that may attest to the type of Board member I will be if elected that may not be gleaned from the written responses, data sheets, and disclosure statements.

Awareness. Having been a history major, I incorporate lessons from past events and counsel from senior leaders. Because of my travels, I welcome and respect different values and points of view. Ingrained from my military service, I constantly seek to know and learn about what is and will be happening around me. As a result, I analyze issues from several perspectives and timelines to make decisions in the best interest of the College.

Strategic. I strive to plan ahead. However, when unfamiliar with an issue, I diligently do my homework, consult more knowledgeable peers, and organize the resources at hand. Then, I assess multiple scenarios and their impacts to determine the optimal timing and strategy for success.

Accountability. I treat everyone with respect and in the manner I want to be treated. I will not ask others to complete a task without sufficient guidance and resources, and that I have not done or would not do myself. If successful, the team members receive the credit, praise, and opportunity to grow. If not successful, it is my responsibility.

Character: For those who do not know me, please talk with anyone with whom I have worked. Ask them to describe me, how and why I did my work, and about my successes and mistakes. It is my hope that integrity, service to others, mentor, and steadfast loyalty to the College and its members are among the words mentioned.

As we celebrate our College's 50th anniversary, it is essential for us to appreciate those who have led us to this milestone and what has been achieve thus far. It is equally as important to recognize the increasingly complex issues and challenges ahead as well as those who will lead our College into the next 50 years.

If the above resonates with you and exemplifies the type of Board of Director member you want and that our College and specialty needs, please entrust me with your vote and the opportunity to serve, work with, and represent you.

Sincerely,

Christopher S. Kang, MD, FACEP, FAWM

As we celebrate our 50th anniversary and leadership within the House of Medicine, our College needs continued visionary leadership that:

- Cultivates the innovation and priorities of the next generation while also respecting the work and wisdom of our founders;
- Promotes the occupational and professional well-being of its members;
- Fosters broader member engagement and leadership at local and national levels;
- Empowers and collaborates with chapters and other organizations with the challenges we face;
- Restores the autonomy and prestige of our profession.

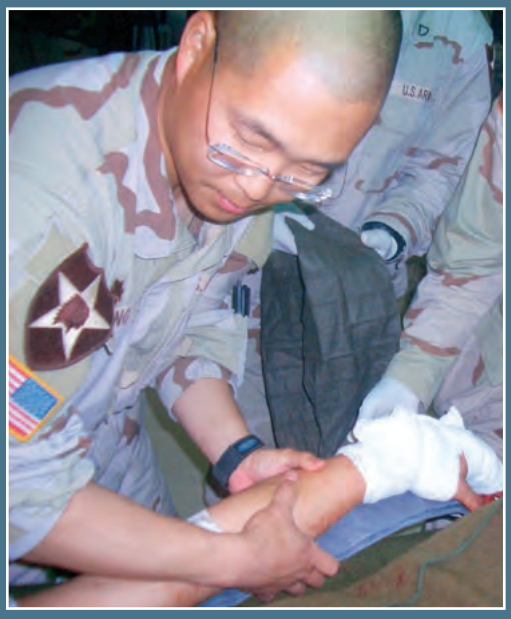
I will be that leader.

Christopher Kang, MD, FACEP, FAWM

Leadership: Dynamic • Veteran • Servant

For Re-election to 2018 ACEP Board of Directors

Past Service:



- Board of Directors
- Washington Chapter President
- Council Steering Commitee
- Chair, Disaster and Preparedness Committee
- National Chapter Relations Committee
- Council Reference Committee

- Liaison, Ethics Committee
- Liaison, Multiple Sections
- Wiegenstein Legacy Society
- Medical Director, ACEP/DHS Grant
- Residency Research Director
- Multiple Academic Faculty Appointments

Christopher Kang, MD, FACEP, FAWM

For Re-election to 2018 ACEP Board of Directors

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Michael J. McCrea, MD, FACEP

Question #1: **Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

There will always be external challenges to emergency medicine: new federal and state regulations, practice care guidelines written by other specialties that affect us in the ED. Yet whenever this happens, we do what we do best: prepare as best we can for the unknown and be ready to act against whatever may come. Issues will arise for which we may be unprepared, or even could not have predicted. Sometimes those issues will be something on which I am a context expert but oftentimes not. I have learned through my time with state and national ACEP, our residency program, and in my involvement on multiple hospital committees, how important it is to ask for more information when you need it. I have demonstrated that I will put in the work to help guide action. In such times leadership and careful deliberation are of utmost importance before action.

During my second term as Ohio ACEP President, such an unforeseen and unprecedented event occurred: the contract change involving the Akron Summa EM residency. Never before had a residency program been so affected by a group contract change, ultimately resulting in the loss of ACGME accreditation and closure of the program. There were calls for Ohio ACEP to act swiftly, to do "something," but we did not know what that should be. To ensure that our Board could make an informed decision, I spent hours listening to our members from both groups, the chief residents of the Summa program, and many past leaders and mentors within the Ohio Chapter. I felt mounting pressure that we must speak out, but for whom, and what should we say?

What I learned most from the experience is that sometimes patience and restraint are more important than being heard first. Other organizations released statements before Ohio ACEP, for which I was criticized. And yet, taking an extra half-day, not rushing a response, proved the most prudent course in the end. For our Chapter statement embodied the message of who we were: a Chapter that represents all practicing emergency physicians, residents, and patients. This is the skill set I believe I have to help keep ACEP in the forefront: deliberation, thought, hard work, and never forgetting that we serve our patients and communities.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

My voice is your voice. I have worked in an eight-bed critical access ED. I have worked in a sixty-bed urban tertiary care center. I have been a community medical director of a single coverage rural ED. I am an assistant program director supervising forty-two EM residents. I have been a democratic partner, an independent contractor, and an employee of a contract medical group. Although I am core faculty for our residency, I still work in the community without residents at a single coverage ED within our health system. Currently I am a teacher and mentor to residents and medical students, but I have never forgotten my roots in the community, fresh out of residency, just trying to get through the rack. I bring this varied and shared experience to my leadership

This diverse background of practice experiences allowed me to speak and advocate for EM physicians in Ohio during my two terms as Ohio ACEP President. Having worked in nearly all practice environments provided me with first hand insight into the issues that face emergency physicians. When I met with legislators or government officials, my personal experience gave real credibility to our message as I spoke for emergency physicians in Washington, D.C. or in our state capitol. I have testified before the Ohio House of Representatives on multiple occasions and I have developed personal relationships with the state and national officials from my district. Those relationships began at ACEP's Leadership and Advocacy Conference and Ohio ACEP's Advocacy Day. I have learned and seen firsthand the value of our advocacy. Although Ohio ACEP is widely known for our education courses, it is advocacy that ranks number one in importance to our chapter members every year on the chapter member survey.

Yet we must not forget that ACEP speaks for EM residents in training and medical students as well as the practicing physician. During my tenure on the Ohio Chapter Board, we separated our resident assembly from our annual member meeting into a standalone event to emphasize the importance of resident members in our Chapter. This year I authored a bylaws amendment for our Chapter to designate one Ohio councillor seat for a resident. It passed unanimously at our annual meeting. For the past four years I have chaired a new event, the Midwest Medical Student Symposium, for medical students interested in EM. Our medical student membership has grown as a result. Working daily with residents and medical students allows me to respond to these members' needs as well.

Our members want voices that listen to their needs, speak for them, and advocate for our profession and our patients. My experiences have refined my voice and demonstrated that I can speak confidently for all current and future emergency physicians as a member of the ACEP Board of Directors.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

This seemed like a simple question for me. I had always felt the same way going back to residency: that emergency medicine should only be practiced by residency trained, board certified emergency physicians. However perspective, maturity, and most of all, recent events in the College have caused me to re-examine exactly this question.

While struggling with this issue, I sought guidance from our College "Mission, Vision, and Values" and ACEP's definitions of "Emergency Medicine" and an "Emergency Physician." I'm pretty sure that I had read them before, but only now have I truly thought about these guiding principles for what ACEP is, who we are, and whom we represent. If you haven't read them recently or, gasp, ever, please do so. If you're feeling really adventurous, read the College Bylaws' section on membership too. One of my friends just yelled "nerd alert," but I'm on the Bylaws Committee, so I think I'm obligated to plug the Bylaws whenever I can. Joking aside, without knowing our defining principles and guiding policies, how can we possibly have an informed conversation on the topic as important as "Who does ACEP represent?"

When a non-EM boarded physician works in an ED, she or he does not introduce herself or himself as "I'm the NOT emergency physician today but I'll be taking care of you anyway." The bright red, all-capital-letter, "EMERGENCY" sign out front does not rotate to something else when a non-EM boarded physician is working. Regardless who is working: be it a residency-trained, board-certified Emergency physician; a physician boarded in something else; or in some states, a non-physician advanced practice provider, patients have the expectation and right that they will receive "the highest quality of emergency care." When we travel to Washington, D.C. each spring for ACEP's Leadership and Advocacy conference, we never couch our legislative agenda with the following caveat: "but we only want this legislation to apply to EM-boarded docs who pay ACEP dues."

Until recently, I had never thought of it this way. We advocate for everyone who works in an emergency department, whether they are members of ACEP, someone who is eligible for ACEP membership but for whatever reason has chosen not to join or renew, or a provider who is not eligible. Anyone who sees patients "dedicated to the diagnosis and treatment of unforeseen illness or injury" benefits from the tireless work and advocacy done by the College, from our clinical policies and policy statements, to committee and Board white papers that help guide all facets of emergency medicine.

I have worked with non-EM trained physicians in the community. As a community medical director, I never could have filled our schedule in our rural ED without them. They cared for patients in the same rooms with the same problems as I did. I took their sign-outs and they took mine. I came to realize how could I not see them as emergency physicians, albeit our different backgrounds and paths?

And yet, on the opposite end of the spectrum, I am an assistant residency director for forty-two residents and future board-certified emergency physicians. I unequivocally believe that dedicated training in emergency medicine following the Core Content model is important and must be valued. Residency training and board certification in emergency medicine are the ideal and highest achievement in our specialty.

So if I cannot reconcile these two conflicting issues for myself, how can ACEP? Is it quixotic to think that someday all patients seen in an ED will be cared for by an EM-boarded physician? Probably, but such a goal does not mean it should not be an ideal for which we continue to strive even if we never achieve it. However, until that day, and that may never come, I now believe that ACEP must find a way to represent all physicians who care for patients in an ED. I don't have that solution yet, but I look forward the possibility of helping ACEP accomplish this goal.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Michael J. McCrea, MD, FACEP

Contact Information

13100 Five Point Rd
Perrysburg, OH 43551

Phone: 614-975-5370
E-Mail: mmccrea2@gmail.com

Current and Past Professional Position(s)

Mercy Emergency Care Services, Team Health
Lucas County Emergency Physicians, Inc., Premier Physician Services
Attending Physician and Core Faculty, September 2009 - Present

Emergency Professionals of Ohio, Inc., Team Health
Staff Physician, July 2017 - Present

Wood County Emergency Physicians, Inc., Premier Physician Services
Medical Director, March 2013 – June 2014

Mid-Ohio Emergency Physicians, LLP
Staff Physician, August 2009 – May 2010

Richland County Emergency Physicians, Inc., Premier Health Care Services
Assistant Medical Director and Staff Physician, December 2008 – August 2009

Emergency Medicine Physicians of Richland County, Ltd.
Staff Physician, November 2006 – December 2008

Education (include internships and residency information)

The Ohio State University Medical Center
Emergency Medicine Residency 2004 – 2007

Medical College of Ohio at Toledo
M.D. 2000 – 2004

Ohio Wesleyan University
B.A. Biochemistry 1996 – 2000

Certifications

American Board of Emergency Medicine
Initial certification 2008, renewed 2017

Professional Societies

American College of Emergency Physicians
Ohio ACEP
American Academy of Emergency Medicine
Council of Residency Directors
American Medical Association
Ohio State Medical Association

National ACEP Activities – List your most significant accomplishments

Council Steering Committee, 2016-17
Bylaws Committee, 2015 – current
State Legislative and Regulatory Committee, 2012 – current
Council Horizon Award recipient, 2014
Council Tellers, Election, and Credentials Committee, 2013-16
Council Reference Committee, 2012
ACEP Teaching Fellowship alumnus 2010-11 class

ACEP Chapter Activities – List your most significant accomplishments

Ohio Chapter President, 2015-16, 2016-17
Ohio Chapter Immediate Past President, 2017-18
Ohio Chapter President Elect, 2013-14, 2014-15
Ohio Chapter Secretary, 2011-12, 2012-13
Ohio Chapter Board of Directors, 2011 – current
Chair, Midwest Medical Student Symposium, 2016 – current
Councillor, 2011 – current
Course Co-Director, Oral Board Review Course, 2012-17
Faculty, Emergency Medicine Review Course, 2011 – current

Practice Profile

Total hours devoted to emergency medicine practice per year: **1920** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **60** % Research **<1** % Teaching **40** % Administration **0** %

Other: _____ ____%

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

Employee, Mercy Emergency Care Services, TEAM Health, staffing a single site tertiary care urban community teaching hospital.

Core faculty and assistant program director, Mercy Health - St. Vincent Medical Center Emergency Medicine Residency for forty-two EM residents

Moonlight at a single coverage rural ED within Mercy Health system as an independent contractor

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert 0 Cases **Plaintiff Expert 0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Michael J. McCrea, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Mercy Emergency Care Services, Inc. Team Health
Address: 2213 Cherry St
Toledo, OH 43608
Position Held: Attending physician
Type of Organization: Employee model

Employer: Emergency Professionals of Ohio, Inc, Team Health
Address: 7123 Pearl Rd
Middleburg Heights, OH 44130
Position Held: Staff physician
Type of Organization: Independent contractor model

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: Ohio Chapter ACEP
Address: 3510 Snouffer Rd
Columbus, OH 43235
Type of Organization: Professional medical association
Duration on the Board: 2011 - current

Organization: Ohio State Emergency Medicine Alumni Society
Address: 791 Prior Hall, 376 W 10th Ave
Columbus, OH 43210
Type of Organization: Alumni society for Ohio State emergency medicine graduates
Duration on the Board: 2017 – current

Organization: University of Toledo College of Medicine Alumni Affiliate

Address: 2801 W Bancroft St, MS 301

Toledo, OH 43606

Type of Organization: Alumni society for MCO/UT medical school graduates

Duration on the Board: 2014 - current

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☒ NONE
☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☒ NONE
☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☒ NONE
☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Michael James McCrea, MD, FACEP Date 6/14/18

Ohio ACEP
American College of Emergency Physicians
Advocacy | Education | Leadership

The Board of Directors of the Ohio Chapter, American College of Emergency Physicians is proud to endorse our friend and colleague, Michael J. McCrea, MD, FACEP for election to the ACEP Board of Directors.

The Ohio Chapter has benefited immeasurably from Dr. McCrea's participation on our committees and Board of Directors (2010-present). He has served on Chapter committees, including Government Affairs and Education, and served the Chapter two terms as President (2015-2017), where his strategic focus and leadership was deeply appreciated. While extremely active with the Chapter's educational programs as a contributing faculty member, his ability to testify and speak to legislators has also been of great value to the Chapter. He is a compelling and powerful advocate for his profession. Dr. McCrea has also represented the Chapter as a Councillor annually since 2011, after a year as an Alternate Councillor with the Ohio ACEP Leadership Development Academy. Dr. McCrea was awarded, by Ohio ACEP, the 2017 *Bill Hall Award for Service,* the chapter's highest honor for service with distinction.

Dr. McCrea has additionally always demonstrated the highest level of commitment to Emergency Medicine and the College. He has shared without hesitation his expertise on committees of the College, including the Bylaws Committee and the State Legislative-Regulatory Committee. His leadership in the College has been recognized by appointments to the Council Reference Committee; Tellers, Election, and Credentials Committee; and Council Steering Committee. His engagement and effectiveness at Council was further recognized in 2014 when he received the Council Horizon Award. His commitment to Council and mentoring future leaders led him to develop for the Chapter "The First-Timers Guide to Council," a guide for encouraging ACEP service. A skillful listener, communicator, and leader, he has demonstrated at every turn his commitment to the cause and mission of emergency medicine and is well prepared to serve as a member of the ACEP Board of Directors.

The Ohio Chapter ACEP proudly endorses Michael J. McCrea, MD, FACEP for election to the ACEP Board of Directors.

Sincerely,

John Queen, MD, FACEP
Chapter President

3510 Snouffer Road, Suite 100, Columbus, Ohio 43235
Phone: (614) 792-6506 | TollFree: 1 (888) 642-2374 | Fax: (614) 792-6508
www.ohacep.org

Michael J. McCrea, MD, FACEP

Fellow Councillors:

Fifteen years ago I chose emergency medicine to be my career. As a medical student, I could not have foreseen that teaching residents and my work with ACEP advocating for our patients and our specialty would become my two professional passions. Today I am asking you to elect me to your ACEP Board of Directors.

It was through education that I became involved with Ohio ACEP but also where I first learned that I have a passion and skill for advocacy. My varied practice experience provides me insight into issues affecting all emergency physicians. During my two terms as Ohio Chapter President, I helped to defeat an out-of-network billing issue and have advocated recently for a bill that has already passed the Ohio House to extend our state's "I'm sorry" liability statute.

Through my commitment to our Chapter I have mentored future leaders. I created an insider's guide for first-timers to Council and LAC. As Chapter President I sought to better engage and address our practicing members concerns and created a membership committee. I also focused on future members by assisting in the development of a standalone Resident Assembly. I have chaired the Midwest Medical Student Symposium since it's inception.

I am unafraid to ask difficult or unpopular questions during debate. In fact, we need fresh ideas, innovation, and debate to move good solutions forward. I facilitate the conversation during meetings to ensure that differing viewpoints are heard. My leadership commitment is to moderate the conversation towards consensus for the betterment of our members.

We face real threats to the prudent layperson standard from multiple insurers across the country, non-evidence based metrics and regulations, and ever-mounting bureaucratic obstacles leading to burnout. We need to stand strong together, unified as emergency physicians celebrating our 50th anniversary as the American College of Emergency Physicians. We must always remind ourselves that we serve our members for the benefit of our specialty and our patients.

I know from my proven leadership, my passion for advocacy, and my commitment to membership, that I can help find solutions to these issues and whatever may come. I would be honored to serve you on the ACEP Board of Directors.

I look forward to seeing you in San Diego.

Michael McCrea, MD, FACEP
mmccrea2@gmail.com
614-975-5370

MICHAEL McCREA, MD, FACEP

FOR ACEP BOARD OF DIRECTORS

SERVICE TO ACEP

ACEP & COUNCIL

- Steering Committee
- Bylaws Committee
- Recipient, Council Horizon Award
- State Legislative and Regulatory Committee
- Tellers, Election, and Credentials Committee
- Reference Committee
- Alumnus, ACEP Teaching Fellowship

OHIO CHAPTER ACEP

- Two-term Chapter President
- Board of Directors
- Recipient, Bill Hall Award for Service to Ohio ACEP
- Medical Education Advisory Committee
- Government Affairs Committee
- Course Faculty
  - Co-Director and Examiner, Oral Board Review Course
  - Instructor, Written Board Review Courses
  - Instructor, LLSA Review Course
- Chapter Editor
  - *Dr. Carol Rivers' Written Board Review Materials*
  - *Dr. Carol Rivers' Oral Board Review Materials*
- Graduate, Leadership Development Academy
- ACEP Councillor

PROFESSIONAL

- Assistant Program Director and Simulation Education Director, Mercy St. Vincent Medical Center EM Residency
- Rural ED Medical Director
- Community Trauma Center ED Assistant Medical Director

PROUDLY ENDORSED BY:

Ohio ACEP
American College of Emergency Physicians
Advocacy | Education | Leadership

PROVEN LEADERSHIP. EFFECTIVE ADVOCACY. COMMITMENT TO MEMBERSHIP.

American College of Emergency Physicians®
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2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Mark S. Rosenberg, DO, MBA, FACEP

Question #1: **Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

Emergency medicine is not going away. Not during my lifetime and not during yours. One thing for sure, there will be changes. During the years ahead, the impact of legislators, insurers, lobbyists, and changing demographics will continue as well as the paradigm shift from a medical model to a population health model of medicine. Emergency medicine will continue to expand diverse delivery options such as mobile care units, telemedicine, free standing mental health emergency centers, and urgent care centers to name a few. Some changes may be based on new diseases, viruses, or epidemics. New inventions such as self-driving cars may increase the number of car accidents or decrease them. New medications may change the infectious disease landscape. New treatments for addiction, cardiovascular disease, stroke, and cancer may change delivery systems. Value-based payment models and bundled payment strategies are already changing reimbursements. Recent numbers show that Emergency Department (ED) visits are decreasing nationwide and the use of advanced practice providers is on the rise. In the future, it is possible that we will have all of the emergency physicians necessary to fill all of ED slots. A workforce analysis is critical as it may affect how our residency programs function, possibly necessitating changes in emergency medicine curriculums. It is impossible to know all of the changes that will happen.

So, the question is how will my skill set place ACEP successfully in the forefront over the next decade. My career has been a lifelong process of learning. It has been a process of learning to negotiate with different departments within a hospital, expanding to community partners and government leaders. Emergency medicine has been my first and only love from my first rotation years ago. Throughout my career, I have worked in a variety of different environments including academics, private emergency department practice, inner city, and suburban settings. I have been president and CEO of a large, national emergency medicine practice management company as well as the sole owner of a small emergency department group. I am currently an employed physician at St Joseph's Health where I am Chairman of Emergency Medicine and Chief Innovations Officer.

I understand the national landscape from being on the ACEP board for the past three years. I understand the state landscape from being active in New Jersey ACEP for more than a decade. This can be an exciting time for us as we need innovation, and that's what I do. Over the past decade I have started several programs in the ED including palliative care, Geriatric Emergency Departments and the Alternative to Opioids (ALTO) program which is on its way to becoming national legislation and was already passed by the House of Representatives. All of these programs provide necessary resources for emergency physicians to help provide better patient care and better outcomes. Creating these programs helps to address the evolving needs of our populations but also requires collaboration with community leaders, senators, congressmen, and other government representatives. This type of collaboration keeps ACEP at the legislative table as a leading voice for emergency care.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

In the very beginning, my mentor told me to join ACEP for life and that is exactly what I did. I have been a member ever since 1979. I have served on the council, committees, and task forces and was elected to the ACEP Board in 2015.

During my career I have had the opportunity to work in small community hospitals as well as large medical centers. I have experience working with large, national companies as well as small groups. I have had the privilege of owning my emergency medicine practice management company as well. Currently, I am employed as Chairman of Emergency Medicine and Chief Innovations Officer in a teaching hospital with an emergency medicine residency program. Emergency medicine residents are mirrors of our profession. They question the status quo, verbalize obstacles and barriers, and communicate opportunities to improve our practice. We have the opportunity to listen, discuss, collaborate, and innovate throughout our department, hospital, and community. We learn from each other.

Through my work with ACEP as well as my work within my hospital community, I have found myself collaborating with senators and congressman on issues of importance to emergency physicians such as out of network billing, access to care and population health issues. I have found that I am not shy and have a love affair with the microphone. I have learned not to talk for the sake of talking but to have a goal and know what needs to be said. I have been successful most recently with legislation for an alternative to opioid (ALTO) program in my home state of New Jersey and is now on its way to becoming national legislation. The ALTO program is an example of our discipline adapting to the needs of our communities. We remain that safety net across the country.

I remember where I started. I remember staying up all night wondering what I could have done differently when I have lost a patient. At this point in my career, I am up all night wondering what I can do for our college and how best can I serve. I believe I enhance ACEP's ability to speak for all emergency physicians because of my diverse practice experiences, my activities with ACEP, and my genuine love and respect for our profession. Thank you.
.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

The question of whether ACEP should be an umbrella organization or to represent a particular constituency requires serious discussion. However, time is of the essence. Over the years Emergency Medicine has become divided and that is just the nature of our specialty as it matures and grows. I think we all realize that as emergency physicians we have more in common than not. Our specialty started with us as a unified college and ACEP has become the largest EM professional organization with more than 37,000 members, even as a many of our members belong to multiple EM organizations.

I believe the House of EM is stronger as one unified voice on issues of vital importance. To that end, I recommend that an EM Council be created to include representatives from each emergency medicine organization and foundation. This council's mission would be to find the common ground and identify areas that divide EM. This forum would allow for the leadership, and collaboration necessary to debate concerns of today such as protecting EM as an essential health care benefit or the prudent layperson standard. Ultimately, the EM Council would be the sounding platform for the house of EM in which we need to survive the harsh practice environment and allow us to speak with one voice and one message.

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ADVANCING EMERGENCY CARE

CANDIDATE DATA SHEET

Mark S. Rosenberg, DO, MBA, FACEP

Contact Information

38 North Ridge Road Denville, NJ 07834
Phone: 9732240570
E-Mail: mrosenberg@acep.org

Current and Past Professional Position(s)

CURRENT POSITIONS

Chairman, Emergency Medicine – 2008-Currently
Chief Innovation Officer (CINO) – 2017-Currently
Associate Professor Emergency Medicine
St Joseph's Health, Paterson NJ

Board of Directors - American College of Emergency Physicians (**ACEP**)
Board of Directors - Emergency Medicine Foundation (**EMF**)
Pain Management Task Force - U.S Department of Health & Human Services (**HHS**)
Pain Task Force - Institute of Healthcare Improvement (**IHI**)

PAST POSITIONS

Chief Population Health - – St Joseph's Health Paterson NJ
Chief, Geriatric Emergency Medicine 2009 to 2015 – St Joseph's Health Paterson NJ
Chief, Palliative Medicine 2010 to 2015 – St Joseph's Health Paterson NJ
President and CEO, Evergreen Emergency Solutions, Contract Management Group, FL and NJ – 2004 - 2008
President PhyAmerica Physician Services, Contract Management Group, Ft Lauderdale, FL – 1997 - 2004
Vice President of Medical Affairs, Coastal Physician Services – 1995 – 1997
Chief, Emergency Services, The Germantown Hospital and Medical Center, Philadelphia, PA – 1993 - 1997
Director of Emergency Services, Roxborough Memorial Hospital, Philadelphia, PA – 1987 - 1993
Director of Emergency Services, Metropolitan Hospital - Parkview Division, Philadelphia PA – 1982 – 1986

Education (include internships and residency information)

Masters, Business Administration in Medical Management
St. Joseph's University
Philadelphia, Pennsylvania 19131
1990 to 1995

Internship and Residency, Emergency Medicine
Metropolitan Hospital
201 8th Street
Philadelphia, PA
1978-1980

Doctor of Osteopathic Medicine
Philadelphia College of Osteopathic Medicine
Philadelphia, PA 19131
1974 to 1978

Certifications

Board Certified Emergency Medicine (AOBEM-AOA)
Certificate No. 161, Feb. 29, 1988

Board Certified Emergency Medicine (ABEM-ABMS)
December 6, 1995; September 2004, October 2013

Board Certified Hospice and Palliative Medicine (ABIM)
December 31, 2010

Professional Societies

American Academy of Hospice and Palliative Medicine
American College Emergency Physicians
American Geriatric Society
American Osteopathic Association
American Medical Association
American College Osteopathic Emergency Physicians
New Jersey Chapter of the American College Emergency Physicians
Society of Academic Emergency Medicine

National ACEP Activities – List your most significant accomplishments

ACEP Board of Directors - Current
Multiple activities as BOD Member
Emergency Medicine Foundation Board of Directors – Current
HHS Pain Management Task Force – Representing ACEP
IHI Opioid Task Force – Representing ACEP
Past Chairman, ACEP Section of Geriatric Emergency Medicine 10/2011-2013
Past Chairman and Founder, ACEP Section of Palliative Medicine 10/2012-10/2014
ACEP Councilor 2011-2017
ACEP Disaster Committee 2013-2015
ACEP Ethics Committee 2014-2016
ACEP NOW – Editorial and Advisory Board 2014-Present
ACEP Practice Management Committee 2014-2016
ACEP Steering Committee 2013-2015

ACEP Chapter Activities – List your most significant accomplishments

NJ-ACEP President 7/2015-6/2016

Practice Profile

Total hours devoted to emergency medicine practice per year: **>2080** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **5** % Research **5** % Teaching **20** % Administration **70** %

Other: _____ ____ %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

I am Chairman of Emergency Medicine as a hospital employee and Manage two emergency departments. The larger is a bust inner city teaching hospital that sees 170,000 visits per year. The second is a community hospital Emergency Department seeing 30,000 visits/year

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert	**Cases**	**Plaintiff Expert**	**Cases**

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CANDIDATE DISCLOSURE STATEMENT

Mark S. Rosenberg, DO, MBA, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: St Joseph's Health

Address: 703 Main Street

Paterson NJ 07503

Position Held: Chairman, Emergency Medicine and Chief Innovations Officer

Type of Organization: Healthcare

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: ACEP

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Emergency Medicine Membership Organization

Duration on the Board: 3 Years

Organization: D2i formally EMBI

Address: 110 Cornelia Street

Boonton, NJ 07005

Type of Organization: Data Analytics

Duration on the Board: 4 Years

Organization: EMF, Emergency Medicine Foundation

Address: 4950 W. Royal Lane

Irving, TX 75063

Type of Organization: Research Foundation

Duration on the Board: 1 year

Organization: New Jersey Hospital Association Health Research Educational Trust

Address: 760 Alexander Road

Princeton NJ

Type of Organization: Education and Research Funding

Duration on the Board: 9/2014- Currently

Organization: American College of Osteopathic Emergency Medicine

Address: 142 E Ontario Street Suite 1500

Chicago IL 60611

Type of Organization: Professional Membership Organization

Duration on the Board: 2012-2014

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

X NONE

☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

X NONE

☐ If YES, Please Describe:

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

X NONE

☐ If YES, Please Describe:

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

X NONE

☐ If YES, Please Describe:

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

X NO

☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Mark Rosenberg Date 7/1/18

NEW JERSEY CHAPTER
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

August 7, 2018

John G. McManus, Jr., MD, MBA, FACEP
Chair, Nominating Committee
4950 W. Royal Ln
Irving, TX 75063

Dear Dr. McManus:

The New Jersey Chapter of the American College of Emergency Physicians (NJ-ACEP) would like to provide our support once again to Mark Rosenberg, DO, MBA, FACEP, FAAHPM for the national ACEP Board of Directors. Our Chapter wholeheartedly endorses Mark's candidacy because we know that his continued presence on the Board will immeasurably benefit our college for years to come. He has created a significant impact in emergency medicine with his vision in the areas of pain management, geriatrics, palliative medicine, and most importantly the role of the emergency department as a major hub in future healthcare systems.

Mark's career spans 39+ years ranging from bedside ED physician to administrator to business owner. His intuition has served him well in terms of understanding the need to constantly evaluate and test new processes in the delivery of emergency care. Mark's vast experience has allowed him to forge ahead with pilot programs, innovations, and creative solutions utilizing existing resources as well as identifying new solutions and strategies. Currently, Mark is the Chairman of Emergency Medicine at St. Joseph's University Medical Center in Paterson, NJ. This large teaching hospital is home to one of the busiest emergency departments in the country with over 170,000 visits. At St. Joe's, Mark started one of the nation's first comprehensive Geriatric Emergency Departments and also developed an ED based Palliative Medicine program called 'Life Sustaining Management and Alternatives'. He serves as faculty for their EM residency and was instrumental in three new fellowship offerings: EM Neuro Stroke Fellowship, Acute Pain Fellowship and a Mental Health and Addiction Fellowship. In 2016, he helped develop The Alternatives to Opioids (ALTO) program at St. Joe's, to address the issue of variation and over-prescribing. In 2018 the ALTO program was written in to House and Senate legislative bill. He testified in congress supporting this bill and it has passed the House. It is anticipated this will be signed into law this summer or fall.

Mark has a sophisticated, broad based and profound understanding of the complex nature of our specialty and its relationship to all of medicine. He is a nationally

recognized leader and has authored many articles and textbook chapters. In addition, he has lectured internationally in Geriatric Emergency Medicine, Palliative Medicine, and Opioid reduction strategies.

Mark has been an ACEP member since 1979 and has embraced service to ACEP with gusto and determination over the last few years. He is Past-President of the Geriatrics and Palliative Medicine Sections, both of which he founded. Through those sections he has helped guide not only ACEP's positions on these important matters but also many members with similar interests.

He is active in our state chapter, serving as President from 2015-2016. He continues to provide guidance by attending quarterly Board meetings as a Past President in a non-voting capacity. He is an effective communicator at both the state and national levels, testifying before the New Jersey state legislature on Out-of-Network legislation in 2016, to most recently testifying before Congress in March regarding the need to combat the nation's opioid crisis.

His strongest qualities are his innovative management style (highly collaborative), a desire and willingness to innovate to improve care, and a passion for our specialty. I have been happy to see him expand into the areas of national leadership and academics and look forward to seeing what the future holds for him.

I welcome the opportunity to talk with you at any time to discuss our enthusiastic support of Dr. Mark Rosenberg to serve a second term on the ACEP Board of Directors. Our proud chapter stands behind him as he seeks to advance the advocacy of emergency medicine through our vital organization.

Sincerely,

Marjory Langer

Marjory Langer, MD, FACEP
President, New Jersey Chapter

Mark S. Rosenberg, DO, MBA, FACEP

To my fellow Councillors:

The purpose of this letter to the council is to give you a brief glimpse of who I am as a person and board member. To let you know what my successes have been on the ACEP board these past three years and what my thoughts are for the future. I have learned a tremendous amount about the board, the college, and the challenges of chapters and practices across the country. I have worked tirelessly on advocacy efforts at the local, state, and national level. As an EMF Board member, I work to promote the mission and support the research that improves our patients' care.

I have been a member of ACEP for over 39 years. I have acquired a unique set of skills throughout my career that offers leadership, advocacy, innovation, financial/business, and graduate medical education expertise. Currently, I serve as Chairman of Emergency Medicine and Chief Innovations Officer of one of the largest EDs in the country seeing over 170,000 visits annually. In that role I have developed a dual accredited AOA and ACGME program, which now has 24 residents and includes several fellowship programs: Acute Pain management, Administration, Mental Health and Addiction, and ED Neuro-Stroke.

As a board member, besides being liaison to many committees, sections and task forces, I have also had the great opportunity to develop several programs and projects.

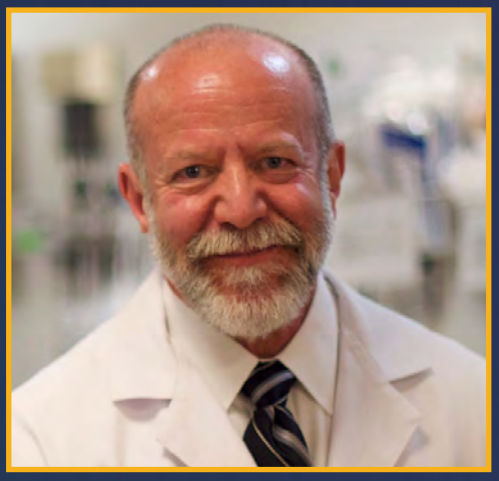
- **Palliative Medicine in the ED**: After successfully starting the Palliative Medicine section, this palliative initiative was chosen as part of ACEP's Choosing Wisely Campaign. The pilot program, Life Sustaining Management and Alternatives (LSMA), went on to achieve nation recognition.
- **Geriatric Emergency Department (GED) and Accreditation Development**: I had the opportunity to open our nations first *ED run* GED in 2009 and was instrumental in the development of the GED Guidelines in 2012. As a board member, I worked with ACEP to develop the GED Accreditation Program in 2017. Several healthcare systems and hospitals have been accredited and many are in the accreditation process. This is a great initiative for our patients, their families, and for emergency physicians as more resources are brought to the ED to better care for this group of patients.
- **Alternatives to Opioids Program (ALTO)**: I started the first ED Acute Pain Fellowship. The following year, 2016, I developed the national acclaimed ALTO program. Partnering with ACEP accelerated the success of this program. ALTO is now the leading prevention strategy for the opioid epidemic. The program not only provides evidenced-based opioid reduction strategies but also provides Medical Assisted Treatment and a warm handoff to hospital and community resources. Together with ACEP, ALTO was introduced into congressional bills that have passed the house and hopefully will become law before the end of the year.
- **Mental Health and Addiction Fellowship**: In 2018, in conjunction with ACEP, I developed a mental health and addiction fellowship. The goal of the program is to develop simple evidence-based protocols for managing this challenging set of patients that present to our EDs across the country. These protocols will assist emergency physicians in providing exceptional evidence-based care, make it easier to manage patients, and decrease psych holding.

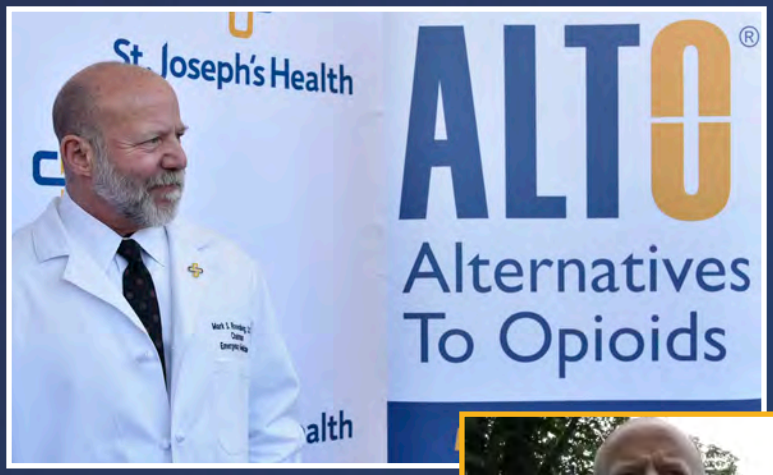
I believe I possess the necessary qualifications and work experience to be re-elected to the ACEP Board of Directors. I ask you for your vote to the ACEP Board of Directors, so that I may continue to advocate for our membership as well as identify innovations for Ease of Best Practice as well as our future success as a college.

Sincerely
Mark Rosenberg
mrosenberg@acep.org

Mark Rosenberg, DO, MBA, FACEP, FAAHPM

Candidate, Board of Directors (Incumbent)





ACEP Leadership

- Board of Directors, ACEP
- Board of Directors, EMF
- Board of Governors, Geriatric Emergency Department Accreditation Program
- ACEP Governance Task Force
- Transition of Care Task Force

Clinical Leadership

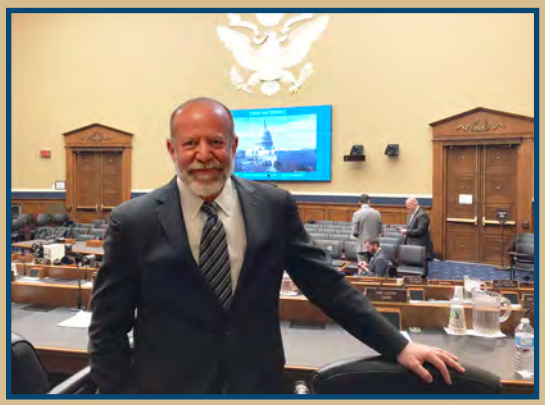
- Chairman, Emergency Medicine, St. Joseph's Health
  - The nation's third busiest Emergency Department 170,000 visits/year
- Chief Innovation Officer (CINO)
- Associate Professor Emergency Medicine
- Fellowship Program Development
  - Acute Pain Management
  - Mental Health and Addiction

Innovator

- Founded and developed the Alternatives to Opioids Program (ALTO®) in 2016. This is a multimodal, multidisciplinary acute pain management program and provides treatment for addiction and dependency with MAT and Peer Counselors.
- Developed the Geriatric Emergency Department at St. Joseph's University Medical Center, one of first departments in the country – and the only one in New Jersey to achieve accreditation from the American College of Emergency Physicians - ACEP.
- Developed Emergency Department Palliative Care Program called, Life Sustaining Management and Alternatives (LSMA)

National Appointments

- U.S. Department of Health & Human Services (**HHS**) - Pain Management Task Force
- Institute for Healthcare Improvement (**IHI**) – Opioid Best Practice Task Force
- Center of Disease Control (**CDC**) – Opioid Prescribing Estimate Project
- Board of Directors - Emergency Medicine Foundation (**EMF**)
- Board of Directors American College of Emergency Physicians (**ACEP**)



American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018 BOARD OF DIRECTORS CANDIDATE WRITTEN QUESTIONS

Thomas J. Sugarman, MD, FACEP

Question #1: **Where do you expect emergency medicine to be in 10 years and how will your skill set place ACEP in the forefront?**

I believe EM will continue to flourish because we meet so many different needs of our communities. The question is how will the health care system value emergency care? It is clear that payers – and our patients – will continue to push to reduce the overall cost of health care in the US. In order to ensure our patients and our communities have affordable access to high quality care, true physician leadership will be paramount. EPs are expert at making decisions to save lives. As a College we must use our skills collaboratively to save the health care system. ACEP is the perfect organization to bring together the diverse interests and stakeholders in emergency medicine to fulfill this vision.

ACEP members working collaboratively in the section and committee structure have produced great improvements in care delivery. Through these efforts, ACEP supports high quality care with clinical policies, non-clinical policies, education, and physician wellness. I have been an active member of the Emergency Practice Committee and the State Legislative/Regulatory Committee. In addition, I was appointed to serve on four ACEP task forces: sedation, mobile integrated healthcare/community paramedicine, contract transitions and the ACEP/EDPMA joint task force on reimbursement issues. When I was president of California ACEP, we initiated a public health improvement program, which continues today. During my presidential year, the first 2 initiatives, statewide dissemination of safe prescribing guidelines and a toolkit to facilitate implementation of the PECARN pediatric head CT guidelines, were rolled out. As a BOD member, I will continue to work to facilitate and shorten the time needed for every practice to adopt best practices that will improve both patients' lives and EPs' practices. Providing better more coordinated care is key to increasing and proving the value of EM.

Over the next decade, I expect there will be more and more pressure to control the cost of medical care with attempts to control costs by simply cutting. For profit driven insurance companies, the easy solution seems to be to just pay less. However, physicians know that without adequate reimbursement, access to care will suffer. EPs can lead the way towards developing a more rational health care system. In the era of cost containment, EPs should be adequately reimbursed for providing services that reduce avoidable healthcare costs.

The battles over surprise bills, out of network coverage and denying coverage for retrospectively determined "non-emergencies" will continue. California had a particularly absurd bill this year, AB 3087, which literally fixed prices for commercially insured patients at a multiple of Medicare for physicians and hospitals. Of course the bill did nothing to ensure Medicaid (Medi-Cal) or non-funded patients' care would be adequately reimbursed. Fortunately, California ACEP, the California Medical Association, the California Hospital Association and other stakeholders killed the bill, but not before it passed out of committee. This episode should be a wake up call to others across the country. Just as HMO implementation and balance billing bans in California portended these problems in other states, I believe price fixing and cost cutting efforts will occur again – not just in California, but also in many other states.

ACEP, as the voice of EPs, must continue to be at the forefront of political advocacy. I believe our best strategy will be to work with our patients, their employers, like-minded medical specialties, and healthcare innovators. In the current environment, it's not just politics that will be local – so will the best solutions for our practices. I believe we need grassroots effort in every community, every state chapter, with our national organization helping us promote best practices and tactics more widely with policy makers. My skills developed during my time on the BOD and as president of California ACEP, president of my county medical association and BOD member for both EMAF and NEMPAC, and alternate director for PFC will allow me to bring valuable perspectives to the ACEP BOD as we navigate these challenges.

Question #2: **Describe how your election to the Board would enhance ACEP's ability to speak for all emergency physicians.**

ACEP is the preeminent organization advocating on behalf of emergency physicians and our patients. Since completing my EM residency in 1992, I have averaged at least 10 shifts a month as a pit doctor, practicing in 3 states and in multiple practice settings. I primarily practice at small, but busy, suburban hospital (60,000 visits/year). My group, Vituity, (formerly CEP America) is a democratic partnership and 100% physician owned with no investor ownership. We share best practices and solutions across our multiple sites, spanning the breadth of EM. Vituity exists to offer doctors the opportunity for a fulfilling medical practice, delivering care the way we want our families to receive care. My personal practice experiences include rural hospitals, urban hospitals, teaching hospitals, for profit, non-profit and government owned hospitals. As an actively practicing pit doc, I understand the challenges facing EPs and our patients.

During my years in California ACEP and ACEP leadership, I learned that listening and understanding various perspectives is key to influencing positive change. ACEP BOD members must not only understand the needs and goals of all EPs, but also the views of patients, other specialties, government officials, payers, hospitals and other stakeholders in the medical system. We must educate and innovate for our patients and communities to enjoy high quality emergency care that is both available and affordable. Patients deserve to feel secure when seeking care for perceived emergencies without fear of dire economic consequences. They also deserve better tools to access the right care at the right time, with the right follow-up for post-stabilization care. Without stabilizing reimbursement, improving practice enjoyment and increasing resources for EM training, there will not be enough high-qualified EPs to deliver emergency care. ACEP, on behalf of EPs, must thread the needle by improving the value of the care EPs provide and ensuring that EM practices are sustainable. As an example, working with the EMS committee, California ACEP and the mobile integrated healthcare/community paramedicine task force, we were able to modernize ACEP's policy on community paramedicine. The new policy allows for care to be delivered in appropriate settings without undermining access to emergency care and EMTALA.

I will represent you and make decisions on the board from a paradigm of improving patient care and ensuring access to quality care. ACEP must mitigate EP practice hurdles such as administrative hassles, excessive time documenting in EHRs and unreasonable MOC requirements so EPs can focus on clinical care. I remain convinced that the best paradigm to advocate for improvements to our EM practices is to view the situation from the patients' perspectives. What is good for our patients and the community will be good for emergency medicine and emergency physicians.

I humbly ask for your vote so that I may represent you on the BOD. Thank you.

Question #3: **Should ACEP be an umbrella organization for the house of emergency medicine encompassing other EM organizations or should ACEP represent a particular constituency?**

The American College of Emergency Physicians is an organization representing emergency physicians. I believe that ABEM or AOBEM certification is the gold standard for EPs. I agree with our current membership policies that require EM residency or fellowship completion to join ACEP. However the reality is that there are many providers caring for emergency patients that are not board certified EPs. Our education interests, practice challenges and, most importantly, our patients are the same. Since the best way to advocate for EPs, is to advocate for emergency patients, ACEP should strive to provide services including education, practice support and advocacy (where there is alignment) for the broader community of physicians (and advanced providers) caring for emergency patients. That said, ACEP must be very careful to never undermine the concept that residency/fellowship training and board certification is the gold standard. ACEP will be more effective if we appreciate the perceptions of our patients, legislators and all emergency providers.

The more inclusive the EM house that ACEP represents, educates and supports, the more effective ACEP will be representing the best interests of EPs. ACEP should improve collaboration with other organizations representing EPs such as AAEM, ACOEP and SAEM. If I am elected to the ACEP BOD I will continue to work towards reconciliation with AAEM (of which I am a member). AAEM represents an important constituency of ACEP members, but the vast majority of goals and aspirations of both organizations are shared by all EPs.

The challenges facing us are great. EM practice is growing more complex. Reimbursement pressures are increasing. Too many of us are losing the sense of joy and fulfillment in our personal and professional lives. Rather than fighting within the house of EM or between specialties, we must work collegially to improve our practices and the care we deliver. As a united voice we will be more effective at convincing policy makers to make patient centered decisions that target high quality, high value care rather than sticker price. EP job satisfaction and fulfillment will improve when our practices allow us to focus on providing high quality care. The most effective way to improve emergency medicine is to unite to achieve our common goals.

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CANDIDATE DATA SHEET

Thomas J. Sugarman, MD, FACEP

Contact Information

1569 Solano Avenue, #463, Berkeley, CA 94707
Phone: 510-219-7261
E-Mail: tjsugarman@gmail.com

Current and Past Professional Position(s)

Current:

Emergency Physician (2001) and Chair of Emergency Services (2013), Sutter Delta Medical Center (FT)

Senior Director Government Affairs, Vituity (formerly CEP America) (2016) (PT)

Urgent Care Physician, East Bay Physicians Medical Group (2014) (PT)

Past:

Emergency Physician, Alameda Hospital (2003-2015) (PT)

Fire Brigade Emergency Physician for Vituity, California and Illinois hospitals (FT)

Emergency Physician, Illinois, Kentucky and California hospitals for Team Health (and precursors) (1992-3 and 1995-2001) (FT and PT)

Emergency Physician St Mary Medical Center and San Pedro Peninsula Hospital (1993-1994) (FT)

Clinical Faculty, Harbor UCLA Department of Emergency Medicine (1993-5) (PT)

Education (include internships and residency information)

Harbor UCLA Emergency Medicine Residency and Internship, 1989-1992

MD with Honors, University of Illinois at Chicago, 1989

Certifications

ABEM certified 1994, recertified 2004 and 2014

Professional Societies

ACEP

California ACEP

AAEM

CalAAEM

AMA

CMA (California Medical Association)—member Council on Legislation, 2010-current

ACCMA (Alameda Contra Costa Medical Association)—President, Nov 2017-Nov 2018, BOT, 2014-current.

National ACEP Activities – List your most significant accomplishments

ACEP Councillor, 2007-current, Alternate, 2006

Emergency Practice Committee member, 2010-current

State Legislative/Regulatory Committee, 2016-current

ACEP Sedation Task Force, 2013-2016

Mobile Integrated Healthcare/Paramedicine Task Force, 2016-2017

Contract Transitions Task Force, 2017

Joint ACEP/EDPMA Task Force on Reimbursement, 2017-current

NEMPAC BOD member, 2017-current

Emergency Medicine Action Fund BOD member, 2018-current

Invited speaker at ACEP Leadership and Advocacy Conference: "Taking the Lead: Essential Skills to Becoming a Highly Effective Chapter Leader," 2014

ACEP Chapter Activities – List your most significant accomplishments

California ACEP:

President, 2013-2014, BOD, 2006-2015

Chair Government Affairs Committee, 2013

Walter T. Edwards Meritorious Service Award, 2015

Chapter Service Award, 2012

Practice Profile

Total hours devoted to emergency medicine practice per year: **2400** Total Hours/Year

Individual % breakdown the following areas of practice. Total = 100%.

Direct Patient Care **55** % Research **0** % Teaching **0** % Administration **10** %

Other: **Advocacy** **35** %

Describe current emergency medicine practice. (e.g. type of employment, type of facility, single or multi-hospital group, etc.)

My clinical practice is at suburban non-profit community hospital. Our ED sees 60,000 pt/year and the hospital has 145 beds. My group, Vituity, is a multi-state, multi specialty, but predominantly emergency medicine physician partnership. All physicians (working the required hours) become full partners with equal ownership after 4 years. We own our billing company and practice management company and we have no outside investors.

Expert Witness Experience

If you have served as a paid expert witness in a medical liability or malpractice case in the last ten years, provide the approximate number of plaintiff and defense cases in which you have provided expert witness testimony.

Defense Expert **1** **Cases** **Plaintiff Expert** **0 Cases**

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CANDIDATE DISCLOSURE STATEMENT

Thomas J. Sugarman, MD, FACEP

1. Employment – *List current employers with addresses, position held and type of organization.*

Employer: Vituity

Address: 2100 Powell St #900, Emeryville, CA 94608

Position Held: Emergency Physician and Senior Director of Government Affairs

Type of Organization: Physician partnership

Employer: East Bay Physicians Medical Group

Address: 3687 Mt Diablo Blvd, Lafayette, CA 94549

Position Held: Urgent Care Physician

Type of Organization: Physician group contracting with Sutter East Bay Medical Foundation

2. Board of Directors Positions Held – *List organizations and addresses for which you have served as a board member. Include type of organization and duration of term on the board.*

Organization: California ACEP

Address: 1121 L St #407, Sacramento, CA 95814

Type of Organization: State Chapter of ACEP

Duration on the Board: 2006-2015

Organization: Alameda Contra Costa County Medical Association

Address: 6230 Claremont Ave, Oakland, CA 94618

Type of Organization: County component society of California Medical Association

Duration on the Board: 2014-current

Organization: NEMPAC

Address: 2121 K Street, NW, Suite 325, Washington, DC 20037

Type of Organization: Political action committee

Duration on the Board: 2017-current

Organization: EMAF

Address: 2121 K Street, NW, Suite 325, Washington, DC 20037

Type of Organization: Advocacy fund promoting emergency medicine

Duration on the Board: 2018-current

Organization: Physicians for Fair Coverage

Address: 8400 Westpark Drive, 2nd Floor McLean, VA 22102

Type of Organization: Advocacy organization focusing on surprise insurance gaps/billing

Duration on the Board: Alternate BOD member 2018-current

I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination.

☒ NONE
☐ If YES, Please Describe:

3. Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) a an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.

☐ NONE
☒ If YES, Please Describe:

I am a physician partner with < 1% equity interest with Vituity. Vituity's legal name is CEP America. I am the Senior Director of Government Affairs. Vituity has a quality clinical data registry and offers physician (and other providers) CME.

4. Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.

☐ NONE
☒ If YES, Please Describe:

I am a physician partner with < 1% equity interest with Vituity. I am the Senior Director of Government Affairs. Vituity has a quality clinical data registry and offers physician (and other providers) CME. Vituity owns a billing company and a practice management company. Vituity physicians, including me, are members of The Mutual Risk Retention Group which provides professional liability insurance to both Vituity and non-Vituity physicians.

5. Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.

☐ NONE
☒ If YES, Please Describe:

I am a member of AAEM, California Medical Association and AMA. I am President of Alameda Contra Costa Medical Association (term ends November 2018).

6. Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

☒ NO
☐ If YES, Please Describe:

I certify that the above is true and accurate to the best of my knowledge:

Thomas J. Sugarman Date July 15, 2018

CALIFORNIA ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

1121 L Street, Ste 407
Sacramento, CA 95814

PH 916.325.5455
FX 916.325.5459
TF 800.735.2237
E-Mail info@californiaacep.org

www.californiaacep.org

August 15, 2018

Dear Colleagues:

The California Chapter is pleased to give its enthusiastic endorsement to Thomas J. Sugarman, MD, FACEP for ACEP Board of Directors and strongly urges your support of his candidacy.

Dr. Sugarman's career demonstrates his steadfast commitment to emergency medicine and his relentless pursuit to make a difference in the lives of his fellow pit doctors and the patients they care for.

Dr. Sugarman is a Past President of the Chapter, and has served our Chapter with incredible enthusiasm and dedication in a variety of leadership roles for more than a decade. His numerous accomplishments, many years of service, and diversity of clinical experience ranging from Base Station EMS Medical Director, to International Medical Corps volunteer physician, to Sepsis Champion at his community ED, will bring a broad and knowledgeable perspective to the Board. He truly understands the challenges emergency physicians face in all practice settings and has dedicated his career to removing those practice barriers.

Dr. Sugarman is a tireless and enthusiastic advocate for emergency physicians, with several decades of commitment at every level of organized medicine. In addition to being a Past President of the Chapter, Dr. Sugarman is currently serving as President of his local medical society and as a delegate to the California Medical Association House of Delegates. For nearly a decade he has served as a representative to the Medical Association's Council on Legislation, where he has ensured that the positions taken adequately represent the uniqueness of our specialty. He is also the Co-Chair of the East Bay Safe Prescribing Coalition and has testified before the California Medical Board on behalf of the Chapter, helping ensure safe prescribing efforts are tailored toward the unique needs of the ED.

Dr. Sugarman's advocacy leadership is always focused on improving the practice of emergency physicians. For example, his work includes regulatory efforts on procedural sedation and legislation relating to psychiatric holds. He also initiated and led efforts to create PECARN and safe prescribing tools for emergency physician use at the bedside.

At the Chapter, group, and national level, Dr. Sugarman has been involved in fair payment issues for many years. During and after his service on the Chapter's Board, he testified before legislators in support of fair payment for emergency physicians. He also serves on ACEP's State Legislation and Regulatory Committee and is currently the Senior Director of Government Affairs for Vituity.

Dr. Sugarman's dedication to emergency medicine and unique skill set embodies precisely the kind of person we need leading and serving us on the ACEP Board of Directors. Our Chapter has been witness to his ability to inform and influence legislators, lobbyists, and regulators one day and turn around the following day to treat and care for patients. Dr. Sugarman has received numerous awards acknowledging his contributions to emergency medicine, including the Chapter's highest award, the Walter T. Edwards Meritorious Service Award, for a career's worth of exceptional contributions to the Chapter.

Dr. Sugarman is a tireless and enthusiastic advocate for emergency physicians. His expertise, experience, and desire to serve the College will prove invaluable to the Board of Directors. The California Chapter is extremely proud to endorse and respectfully request your support of Dr. Tom Sugarman for the Board of Directors.

Respectfully,

AIMEE MOULIN, MD, FACEP

President

Thomas J. Sugarman, MD, FACEP

Fellow Councillors:

I am honored to be nominated for the ACEP board, the preeminent organization representing EP's. I spend the majority of my professional time practicing clinically, and I love it. I am acutely aware of the increasing pressures we all face at the bedside. My passions to deliver excellent care and improve our specialty drive my advocacy and leadership endeavors. **As a board member, my main goal for the College will be enabling EPs to focus on patient care**. **By reducing on-shift hassles and ensuring EPs are fairly compensated, EM will be more fulfilling and sustainable. My vision is that collaboration, innovation and redesign— facilitated and supported by ACEP—will make our system of care healthier for everyone.**

Advocacy

At LAC, Surgeon General Jerome Adams told us that "advocacy is looking beyond the problem in front of you...it's figuring out how to prevent the problem. It's more than clinical excellence." ACEP allows EPs to harness the collective power of a united voice to benefit our patients. As an example, I led California ACEP's effort to improve the ability of EPs to place mental health holds resulting in decreased ED boarding and less EP frustration.

Clinical Practice Support

ACEP should strive to shorten the time and expense needed to adopt clinical enhancements that increase the value of EM. During my presidency, California ACEP developed safe opioid prescribing and PECARN pediatric head trauma CT toolkits. Tools included sample letters to medical staff, scripting for patient/parent discussions, and clinician pocket cards. Facilitating best practice implementation and mitigating burdensome regulations reduce burnout risks and improve care.

Reimbursement

We all know that EPs provide efficient, timely, life-saving care. But we must do a better job *communicating* the value of EM. Given the higher cost of care in America, financial pressure on the acute care system will increase. Accountable physicians must guard against cost containment efforts that threaten quality or access and member wellness. Emergency care must be a covered benefit without unaffordable patient financial risk. ACEP needs to promote price transparency by facilities and outcomes research that demonstrate our true value to both public and private insurers.

Workforce

ACEP members comprise less than two thirds of the ED workforce. Many physicians practicing in underserved EDs do not qualify for College membership. Many rural and metropolitan ED's utilize advanced providers to meet local demand for emergency care. ACEP should formally review and consider the differences between physician and advanced provider skills, experience, and roles in healthcare.

MOC guarantees the public that ABEM Diplomates are expert EPs, but we need ongoing efforts to ensure MOC is not overly burdensome.

Medical students, residents and newer graduates deserve relief from debt burdens hindering their ability to practice in the community of their choosing.

As an organization representing member EPs, ACEP must ensure its programs and policies serve members in multiple settings (rural, suburban, urban, academic, non-academic) and group structures (partners, employed, independent contracting). The College should play a leading role

in developing telemedicine and other care delivery modalities, such as mobile integrated healthcare, to close the performance gaps in many communities. Multiple challenges face the ACEP board to fulfill our primary mission.

Councillors:

My College service on committees and task forces, presidency of California ACEP and my county medical association demonstrate my long-term passion and ability to collaborate, innovate and co-develop practical solutions to real-world problems. As a BOD member, I will continue advocating to empower EPs to focus on patient care. I humbly ask for your vote to represent current and future ACEP members.

Sincerely,

Thomas J. Sugarman, MD, FACEP
Thomas.Sugarman@Vituity.com 510-219-7261

- Active Clinician
- Advocacy expertise
- Reduce on-shift hassles
- Ensure sustainable and fulfilling EM practices
- California ACEP endorsed

Thomas J. Sugarman, MD, FACEP
for
ACEP Board of Directors

My vision is that collaboration, innovation and redesign—facilitated and supported by ACEP—will make our system of care healthier for everyone. As a clinician, I understand the pressures on the practicing emergency physician. As a board member, my main goal for the College will be enabling emergency physicians to focus on providing patient care. By reducing on-shift hassles and ensuring EPs are fairly compensated, EM will be more fulfilling and sustainable.

- Actively practicing in California, past practices in Illinois and Kentucky
- Practice experiences range from tertiary care to rural hospitals, both academic and non academic
- I have worked as a partner, independent contractor and employee in various group structures. Currently practicing as a partner in Vituity (formerly CEP America), a democratic, 100% physician owned partnership
- Chairman of Emergency Services at Sutter Delta Medical Center
- Senior Director of Government Affairs, Vituity (formerly CEP America)

Selected Experience and Service

ACEP

- Councillor, 2007-current, Alternate, 2006
- Emergency Practice Committee member, 2010-current, Contractual Relationships Subcommittee Chair
- State Legislative/Regulatory Committee, 2016-current, Advocacy Objective Subcommittee Chair
- ACEP Sedation Task Force, 2013-2016
- Mobile Integrated Healthcare/Paramedicine Task Force, 2016-2017
- Contract Transitions Task Force, 2017
- Joint ACEP/EDPMA Task Force on Reimbursement, 2017-current
- NEMPAC BOD member, 2017-current
- Emergency Medicine Action Fund BOD member, 2018-current
- **Invited speaker, ACEP 2014 Leadership and Advocacy Conference: "Taking the Lead: Essential Skills to Becoming a Highly Effective Chapter Leader"**

California ACEP

- Lobbied successfully for expansion of 'temporary mental health hold" in CA resulting in less EP frustration and decreased mental health boarding
- **During Presidency (2013-2014)—led California ACEP's development of implementation toolkits for Safe Prescribing and for PECARN CT guidelines for minor pediatric head injuries**
- Advocated successfully to improve PDMP use and availability without onerous requirements for EPs
- **Awarded Walter T. Edwards Meritorious Service Award, 2015**

Physicians for Fair Coverage

- Alternate BOD member, 2018-current

California Medical Association

- Council on Legislation and House of Delegates—active member
- **Collaborated with multiple specialties to modernize CMA policy to support a fair payment standard with arbitration for out of network services**

Alameda Contra Costa County Medical Association

- President, 2017-2018
- Co-chair East Bay Safe Prescribing Coalition—physician, hospital, pharmacist, community and government coalition –**achieved 50% decrease in Alameda County opioid related mortality, significantly fewer high MME prescriptions and co-prescribing, increased MAT use**

I am the right candidate to serve ACEP members on the BOD because I am a clinician with an in depth understanding of the impact of healthcare policy on our practices. I have frontline experience protecting patient and physician interests. I always keep in mind that Emergency Medicine's value is created by the individual physician providing bedside care. I humbly ask for your vote to represent current and future ACEP members.

ACEP HONORS 2018 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

The 2018 American College of Emergency Physicians Awards Program honors leadership and excellence.

The program provides an opportunity to recognize all members for significant professional contributions as well as service to the College. All members of ACEP are eligible to participate in one or more of the College's award programs.

John G. Wiegenstein Leadership Award

Nicholas J. Jouriles, MD, FACEP

Presented to a current or past national ACEP leader for outstanding contribution to the College. The award honors the late John G. Wiegenstein, MD, a founding member and the first president of ACEP.

James D. Mills Outstanding Contribution to Emergency Medicine Award

Thom A Mayer, MD, FACEP

Presented to an active, life, or honorary member for significant contributions to emergency medicine. The award honors the late James D. Mills Jr., MD, second president of the College.

Colin C. Rorrie, Jr., PhD Award for Excellence in Health Policy

L. Anthony Cirillo, MD, FACEP

Presented to a member who has made a significant contribution to achieving the College's health policy objectives, or who has demonstrated outstanding skills, talent and commitment as an administrative or political leader. The award is named after Colin C. Rorrie, Jr., PhD, who served as ACEP's Executive Director from 1982 to 2003.

Judith E. Tintinalli Award for Outstanding Contribution in Education

Corey M. Slovis, MD, FACEP

Recognizes a member who has made a significant contribution to the educational aspects of emergency medicine.

ACEP HONORS 2018 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Award for Outstanding Contribution in Research

Lynne D. Richardson, MD, FACEP

Presented to a member who has made a significant contribution to research in emergency medicine.

Award for Outstanding Contribution in EMS

David E. Persse, MD, FACEP

Presented to an individual who has made an outstanding contribution of national significance or application in Emergency Medical Services. The award is not limited to ACEP members.

Council Meritorious Service Award

James C. Mitchiner, MD, MPH, FACEP

Recognizes consistent contributions to the growth and maturation of the ACEP Council.

John A. Rupke Legacy Award

David E. Wilcox, MD, FACEP

Presented to a current College member for outstanding lifetime contributions to the College. The award honors John A. Rupke, MD, one of the initial founding members of the College.

ACEP HONORS 2018 LEADERSHIP & EXCELLENCE AWARD RECIPIENTS

Community Emergency Medicine Excellence Award

Sergio Hernandez, MD, FACEP

Recognizes individuals who have made a significant contribution in advancing emergency care and/or health care within the community in which they practice.

Policy Pioneer Award

Anne Zink, MD, FACEP

Recognizes early and mid-career members who have made outstanding contributions to the College's health policy and advocacy initiatives.

Disaster Medical Sciences Award

Gregory R. Ciottone, MD, FACEP, FFSEM

The Disaster Medical Sciences Award recognizes individuals who have made outstanding contributions of national/international significance or impact to the field of disaster medicine.

Honorary Membership Award

Marjorie A. Geist, RN, PhD, CAE

Presented to individuals who have rendered outstanding service to the College or the medical profession.

Honorary Membership Award

Barbara Tomar, MPH

Presented to individuals who have rendered outstanding service to the College or the medical profession.

2018 ACEP COUNCIL AWARDS

Council Service Milestone Award

(Staff will identify all who qualify)

Purpose: To commemorate accumulated years of service as a Councillor or Alternate Councillor.

Award: The Award is a pin indicating years of service given at 5-year service intervals.

Criteria: Any member who has served as a Councillor or Alternate councillor. Recipients will be automatically recognized by ACEP staff via the Councillor database.

Presentation: The award is given to individuals at council registration. Recipients will be briefly recognized at the Council luncheon.

Council Meritorious Service Award

James C. Mitchiner, MD, MPH, FACEP

Purpose: Presented to a member of the College who has served as a councillor for at least three years and who, in that capacity has made consistent contributions to the growth and maturation of the ACEP Council.

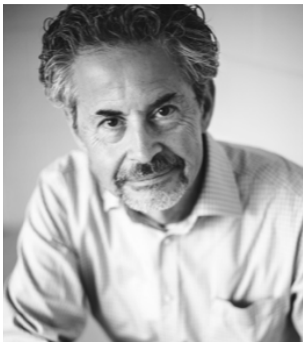
Criteria: The nominee must be an active, life or honorary member of the College, and must have served as a councillor for at least three years. he nominee's contributions to the Council should include, but are not limited to, one or more of the following: Steering Committee membership; reference committee participation; participation on other Council committees; resolution development and debate; longevity as a councillor; or service as a Council officer.

Council Horizon Award

Lisa J. Maurer, MD, FACEP

Purpose: Presented to an individual within the first five years of council service who demonstrates outstanding contributions and participation in Council activities. The award is given as needed, not necessarily annually.

Criteria: The nominee should have made an outstanding contribution to the Council of important resolutions, significant contributions to Council discussions, etc.



Council Curmudgeon Award

Charles F. Pattavina, MD, FACEP

Purpose: To recognize, in a lighthearted way, deserving Council participants that have contributed to the Annual meeting in a unique, eccentric, humorous, or cleverly astute manner.

Criteria: The Curmudgeon Award will be presented to current or former Council participants (ie, Councillor or Alternate Councillor, President, Speaker, ACEP staff, etc.) that have embodied the essence of the description above.

2018 ACEP COUNCIL AWARDS

Council Champion in Diversity & Inclusion Award

Aisha T Liferidge, MD, MPH, FACEP

Purpose: The award celebrates and promotes diversity of experience and thought, the merit of inclusivity, and the value of equity. It is presented to a councillor, group of councillors, or component body that has demonstrated a sustained commitment to fostering a diversity of contributions and an environment of inclusivity that directly enhances the work of the Council and provides excellence to ACEP.

Criteria: The nominee should exemplify service to the College through the promotion of diversity and inclusion. The nominee must demonstrate evidence of having a commitment to the promotion of a diverse leadership and/or membership and/or initiatives related to diversity and inclusion through mentorship, programmatic activities, professional development, and other contributions specifically purposed to promote the mission, support the policies, and enhance the work of the Council and the specialty of emergency medicine.

American College of Emergency Physicians
WASHINGTON CHAPTER
ADVANCING EMERGENCY CARE

Council Teamwork Award

Washington Chapter

Purpose: Presented to a component body or group of councillors to recognize outstanding contributions and participation in Council activities.

Criteria: Contributions to be recognized may include development of important resolutions, significant contributions to Council discussions, etc.

2017-18
Annual Report

Academic Affairs Committee

Chair: Chad Kessler, MD, MHPE, MD, FACEP
Board Liaison: Gillian R. Schmitz, MD, FACEP
Staff Liaison: Sandra Schneider, MD, FACEP

1. Continue collaboration with ACOEP and EMRA to develop educational material for medical students about the transition of the AOA/ACGME single accreditation system for emergency medicine residency training.

Outcome: Updated information will be added to the ACEP website.

2. Continue collaboration with EMRA to:
   - Develop strategies to increase medical student and resident diversity and inclusion based on the member survey results.

Outcome: This is an ongoing objective and will continue in 2018-19.

   - Complete development of a leadership/business curriculum for medical students and residents.

Outcome: Work is in progress and will continue in 2018-19.

3. Continue collaboration with EMRA and the Well-Being Committee to identify and/or develop resources for residents and medical students to address resiliency and coping mechanisms. (Academic Affairs is the lead committee.)

Outcome: This is an ongoing objective and will continue in 2018-19.

4. Continue collaboration with CORD, SAEM, and the Education Committee Simulation Subcommittee to develop mock cases on incorporating simulation to assist residents in preparing for oral board certification exams.

Outcome: The subcommittee revised the e-Oral cases and provided feedback to CORD.

5. Continue working with the Pediatric Emergency Medicine Committee to develop resources to encourage emergency medicine residents to enter pediatric emergency medicine and improve competency of training. (Pediatric Emergency Medicine is the lead committee.)

Outcome: The committee assisted with several projects (SAEM Consensus Conference, podcasts, mentorship, speakers database, etc.) and provided input as needed.

6. Develop and provide resources that highlight the benefits of residency programs to the institution.

Outcome: Work is in progress and will continue in 2018-19. The subcommittee is developing a survey for program directors and chairs to identify knowledge deficits and will then develop a manuscript that outlines how to deliver and define value.

7. Continue to work with ACEP website staff to reorganize academic-related information on the ACEP website.

Outcome: The committee provided feedback to the ACEP web development staff with the most relevant and high yield pages and resources. ACEP's updated website launched in May 2018.

8. Review and update academic affairs related information (papers, medical student slides, and other written material and resources) on the ACEP website. Collaborate with the Research Committee on research resources.

Outcome: The committee provided feedback to the ACEP web development staff with the most relevant and high yield pages and resources. ACEP's updated website launched in May 2018.

9. Solicit nominations and recommend recipients for the:
   - national faculty and junior faculty teaching awards (nominations are approved by the Board)
   - excellence in bedside teaching award (nominations are approved by the Board)
   - national outstanding medical student award (nominations approved by the Board)
   - local medical student awards (nominations approved by the Academic Affairs Committee

Outcome: The committee recommended four individuals for the National EM Faculty Teaching award, four individuals for the National EM Junior Faculty Teaching Award, one for the Bedside Teaching Award, four National Outstanding Medical Student awardees, and two honorable mentions. The Board approved the recommendations in June 2018.

10. Review and recommend journal articles, texts, practice guidelines, and important advances relating to ABEM's Lifelong Learning Self-Assessment (LLSA) and emergency medicine practice.

Outcome: Completed and LLSA articles were sent to ABEM.

12. Review the following policies per the Policy Sunset Review process:
    - Emergency Medicine Training, Competency, and Professional Practice Principles
      Outcome: The policy statement was reaffirmed by the Board in June 2018.

    - Emergency Medicine Workforce
      Outcome: The policy statement was reaffirmed by the Board in February 2018.

    - Financing of Graduate Medical Education in Emergency Medicine
      Outcome: The Board approved the revised policy statement in June 2018

    - Resident Training for Practice in Non-Urban Areas
      Outcome: The Board approved the revised policy statement in June 2018.

13. Develop the following information papers:
    - Documentation by medical students on electronic health records. Collaborate with content experts from the Reimbursement Committee to incorporate billing strategies. (Academic Affairs is the lead committee.)
      Outcome: Completed and added to the reimbursement area of the ACEP website as an FAQ.

    - Benefits of the academic partnership between the VA and a residency program.
      Outcome: This objective is in progress and will continue in 2018-19.

    - Transparency in how emergency medicine programs are funded and describe alternative methodologies for funding.
      Outcome: This objective is in progress and will continue in 2018-19.

14. Identify aspects of an academic practice that lead to low burnout rates and greater career satisfaction.

Outcome: The committee drafted a survey that will be administered to practicing emergency physicians. The committee will analyze the survey results to identify variables that indicate a healthy work environment.

15. Provide resources on best practices to transition faculty when the group loses its ED contract.

Outcome: Completed and resources are available on the ACEP website.

2017-18
Annual Report

Audit Committee

Chair: Josh Moskovitz, MD, FACEP
Board Liaison: Stephen H. Anderson, MD, FACEP, Secretary-Treasurer
Staff Liaison: Layla Powers, MBA

1. Oversee the audit function of the College as stated in the Audit Committee charter.

Outcome: The committee reviewed the audited financial statements with the auditors from BKD. The committee reviewed the IRS form 990 and it was reviewed by the Board in October 2017, before the filing deadline of November 15, 2017.

2. Complete and implement the Disaster Plan and Business Continuity Plan (Cyber Security Assessment).

Outcome: Two cyber security consulting firms submitted proposals for assistance with strengthening ACEP's cybersecurity posture. The selected vendor performed a penetration test and results were presented to the committee in February 2018. A two-phased approach was developed to assess the cybersecurity posture of the Clinical Emergency Data Registry (CEDR) platform. The first phase consisted of web application assessment of the CEDR dashboard. The second phase will review the documentation from FIGmd's ongoing HITRUST certification process. Testing was completed at the end of June 2018 and the final report is pending. Funds for additional cyber security assessment efforts are included in the FY 2018-19 budget.

2017-18
Annual Report

Awards Committee

Chair: John J. Rogers, MD, CPE, FACEP, President-Elect
Board Liaison: President-Elect
Staff Liaison: Sonja Montgomery, CAE

1. Recommend 2018 award recipients.

Outcome: The Board approved the committee's recommendations in May 2018 and selected the following award recipients:

John G. Wiegenstein Leadership Award
Nicholas J. Jouriles, MD, FACEP

James D. Mills Outstanding Contribution to Emergency Medicine Award
Thom A. Mayer, MD, FACEP

Outstanding Contribution in Education Award
Corey M. Slovis, MD, FACEP

Outstanding Contribution in Research Award
Lynne D. Richardson, MD, FACEP

Outstanding Contribution in EMS Award
David E. Persse, MD, FACEP

Colin C. Rorrie, Jr. Award for Excellence in Health Policy
L. Anthony Cirillo, MD, FACEP

John A. Rupke Legacy Award
David E. Wilcox, MD, FACEP

Honorary Membership Award
Marjorie Geist, RN, PhD, CAE and Barbara M. Tomar, MPH

2017-18
Annual Report

Bylaws Committee

Chair : Richard N. Bradley, MD, FACEP
Board Liaison: Vidor E. Friedman, MD, FACEP, Vice President
Staff Liaison: Leslie Moore, JD

1. Provide ongoing review of national Bylaws to identify areas where revision may be appropriate and submit recommendations to the Board of Directors.

Outcome: No revisions to the current Bylaws were identified.

2. Continue implementation of the revised *Chapter Bylaws Review Plan*.

Outcome: The committee continued to utilize the revised *Chapter Bylaws Review Plan* and contacted chapter representatives to discuss the suggestions to the chapter's Bylaws.

3. Review and revise the chapter bylaws review and approval process to ensure effectiveness and efficiency. Reassess communications with chapters and educate committee members on best practices to accomplish their assigned tasks.

Outcome: The committee utilized a standard review plan and members were assigned for reporting on the status of chapter bylaws reviews.

4. Review proposed 2018 Bylaws resolutions to determine if there are conflicts with other portions of the Bylaws. Provide comments to the resolution authors as needed.

Outcome: The committee reviewed one Bylaws amendment, one College Manual amendment, and two Council Standing Rules amendments that were submitted for the 2018 Council. No conflicts with other portions of the Bylaws, College Manual, or Council Standing Rules were identified.

5. Review 2017 Bylaws amendments adopted by the Council and the Board for potential Bylaws Committee action.

Outcome: The 2017 Bylaws amendments were reviewed. No conflicts with other sections of the Bylaws or revisions were identified.

6. Complete revisions to the *Guidelines for Bylaws* and *Model Chapter Bylaws* and submit to the Board of Directors for approval.

Outcome: A subcommittee was assigned and significant progress was made. This objective will continue in 2018-19.

7. Identify ways to increase interest and participation in serving on the Bylaws Committee.

Outcome: Work has begun on this objective and will continue in 2018-19.

2017-18
Annual Report

Bylaws Interpretation Committee

Chair: Elected by Committee Members
Board Liaison: Vidor E. Friedman, MD, FACEP, Vice President
Staff Liaison: Leslie Moore, JD

Note: The committee is assigned as needed for definitive interpretation of Articles VIII – Council, IX – Board of Directors, X – Officers/Executive Director, XI – Committees, and XIII – Amendments, of the ACEP Bylaws.

2017-18
Annual Report

Clinical Emergency Data Registry Committee

Chair: Stephen K. Epstein, MD, FACEP
Board Liaison: James J. Augustine, MD, FACEP
Staff Liaison: Pawan Goyal, MD

Registry Oversight Steering Committee
1. Develop an oversight body and platform for CEDR.

Outcome: A Quality Measures Strategy Summit was held at ACEP in February 2018. The three-year strategic priorities and roadmap were presented to Board. Regular Steering Committee meetings were held and guidance was provided as needed.

Research and Publications Subcommittee
1. Review, adjudicate, and recommend responses to data requests.
2. Review responses to inquiries that address questions regarding accuracy of data.
3. Advise registry vendor on internal audit and validation procedures.
4. Advise registry vendor on external audit and validation procedures.
5. Advise, design, publish, and disseminate registry research results.
6. Advise on registry analytics.

Outcome: The Standard Operating Procedure (SOP) for Research Governance was updated. A grant from the National Institute on Drug Abuse was awards to ACEP and CEDR will be used as a platform for targeted opioid data collection.

Measure Development and Validation Subcommittee
1. Develop, specify, maintain, and recommend quality measures to protect and enhance emergency care.
2. Consider development of measures in the following priority areas:
    a. EMS related measures, such as offloading (Collaborate with the EMS Committee.)
    b. Opioid Management (Collaborate with the Pain Management Section.)
    c. Healthcare disparities (Collaborate with the Diversity & Inclusion Task Force.)
    d. Pediatrics (Collaborate with the Pediatric Emergency Medicine Committee.)
    e. Geriatric Care (Collaborate with the Geriatric Emergency Medicine Section.)
3. Review data reports from the data registry vendor for face validation.
4. Provide input and advice to the data registry vendor, Quality Measures Technical Expert Panel, and the ACEP Board of Directors regarding administrative data, claims-based data, clinical and EHR data sets, data sources, data definitions, and data standards.
5. Develop and publish the process for future measure development.
6. Provide input and participate in the 2018 EDBA Performance Measures Summit.
7. Identify, develop, and maintain improvement of activities.

Outcome: Three-year priorities were established for new measure concepts. Five new measures are in the process of development through a PCPI contract. The Measure Owner Process was established for the top 10 domains and two owners were selected for each domain. Training is in development for these volunteer leaders. The MACRA Measure Grant application was submitted to CMS for funding measures lifecycle and infrastructure.

Education & Learning Collaborative Subcommittee
1. Develop Maintenance of Certification (MOC) Part II and Part IV activities regarding registry implementation, registry metrics, quality improvement collaborative, and registry research results in conjunction with the Education Continuing Competency Subcommittee (Education Continuing Competency Subcommittee is the lead subcommittee.)
2. Develop integration with the E-QUAL network. (E-QUAL is the lead.)
3. Develop educational tools to address the changes in the Quality Payment Program (MIPS, MACRA).
4. Develop ongoing professional practice improvement activities.
5. Develop, validate, and provide dashboard training materials and contents.

Outcome: The MOC Part IV interface was completed in the fall of 2017. The list of Improvement Activities was approved and published in 2017. ACEP provided several recommendations to CMS for additional Improvement Activities and all

were accepted for 2018. The new CEDR portal has Improvement Activities integrated. Requirements are being defined for alignment of CEDR metrics with EQUAL. A webinar is held bi-monthly and at major conferences to educate emergency physicians on MIPS and MACRA. The committee has worked with the Quality & Patient Safety Committee to define requirements to OPPE through process improvement. The committee is currently designing a survey to establish baseline practices. Videos, FAQs, and dashboard demos are available to assist members. The committee will work on "Help" menus and user manuals in 2018-19.

Member Outreach, Recruitment, & Marketing Subcommittee

1. Review the marketing materials for hospital return on investment information and revise as necessary.
2. Engage clinical data registry participants and participating groups and advise on outreach efforts.
3. Provide guidance to the CEDR newsletter.

Outcome: The CEDR newsletter is published quarterly. An information paper on Hospital ROI and a three-year strategic plan were developed.

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Clinical Policies Committee

Co-Chair: Michael D. Brown, MD, FACEP
Co-Chair: Stephen J. Wolf, MD, FACEP
Board Liaison: Jon Mark Hirshon, MD, PhD, MPH, FACEP
Staff Liaison: Rhonda Whitson, RHIA, Travis Schulz, MLS, AHIP

1. Continue to monitor clinical policies developed by other organizations, abstract information pertinent to emergency medicine, post the abstraction on the ACEP website, and communicate the information to members through ACEP communications.

Outcome:
- An abstract of the Brief Resolved Unexplained Events and Evaluation of Lower-Risk Infants guideline from the American Academy of Pediatrics was published in *ACEP Now* in January 2018 and is available on the ACEP Web site.
- An abstract of the American College of Physicians' guideline on management of low back pain was submitted for *ACEP Now* in May 2018.
- Highlights of the American Heart Association/American Stroke Association 2018 guidelines related to endovascular therapies in ischemic stroke was submitted for *ACEP Now* in May 2018.
- Highlights of the American Academy of Neurology guideline about reducing brain injury with cooling after cardiopulmonary resuscitation was published in *ACEP Now* in May 2018 and is available on the ACEP website.

2. Review and comment on other organizations' guidelines under development or for which endorsement has been requested, post the endorsement information on the ACEP website, and communicate the information to members through ACEP communications.

Outcome: Comments were provided by members on guidelines from the following organizations:
- American Academy of Otolaryngology – Head and Neck Surgery (sudden hearing loss, epistaxis)
- American Academy of Pediatrics (procedural sedation and analgesia of children)
- American College of Occupational and Environmental Medicine (opioids, TBI)
- American Heart Association/American Stroke Association (acute ischemic stroke)
- American Society of Hematology (anticoagulation, VTE diagnosis, pediatric VTE)
- CapView – LVO Stroke Care Model White Paper
- Centers for Disease Control and Prevention (pediatric mild traumatic brain injury)
- Infectious Diseases Society of America (influenza)
- International Liaison Committee on Resuscitation (ILCOR) (recommendations for antiarrhythmic drugs – adults and pediatrics)

The following guidelines were endorsed by ACEP and information shared with the membership on the ACEP website:
- None.

3. Provide recommendations for appointments to outside entities requesting member representation on guideline development panels.

Outcome: Recommendations were provided and approved for new appointments of members to the following outside guideline groups:
- American Academy of Otolaryngology-Head and Neck Surgery
- ACC ACTION Registry Steering Committee
- ACC/AHA Guideline for the Management of Chest Pain
- American College of Radiology Appropriateness Criteria Neck Pain
- American Dental Association guideline on antibiotic therapeutics; and ADA general Council on Scientific Affairs
- American Heart Association – National Cardiac Arrest Collaborative
- Brain Trauma Foundation – Severe traumatic brain injury algorithm
- The Joint Commission – National Patient Safety Goal on anticoagulation therapy

Member representation related to guidelines continued to the following organizations:

- American College of Cardiology/American Heart Association
- American Heart Association – ACLS Subcommittee and Emergency Cardiovascular Care Committee
- American Heart Association 3 CPR
- American Society of Anesthesiology
- Brain Attack Coalition
- Brain Trauma Foundation
- Centers for Disease Control and Prevention
- Infectious Diseases Society of America
- Surviving Sepsis Campaign.

4. Continue updating or modification of current clinical policies as necessary:
   a. Acute blunt abdominal trauma
   Outcome: Subcommittee assignments were made and the work will continue in 2018-19.

   b. Acute heart failure syndromes
   Outcome: The critical questions were drafted by the subcommittee and are in the review stage by various ACEP committees. The work will continue in 2018-19.

   c. Appendicitis
   Outcome: The subcommittee drafted critical questions that were sent to the Quality & Patient Safety Committee, E-QUAL, and the Board of Directors for review. The questions were finalized by the committee and the work will continue in 2018-19.

   d. Asymptomatic elevated blood pressure
   Outcome: Subcommittee assignments were made and the work will continue in 2018-19.

   e. Community-acquired pneumonia
   Outcome: The selected literature was graded by the methodologists. The subcommittee is in the early stages of drafting the clinical policy and the work will continue in 2018-19.

   f. Headache
   Outcome: The subcommittee is in the process of drafting the clinical policy and the work will continue in 2018-19.

   g. Mild traumatic brain injury
   Outcome: The draft critical questions were finalized and the work will continue in 2018-19.

   h. Opioids (Include elements of Amended Resolution 35-15: Create clinical practice guidelines for treatment of patients presenting to the ED in opioid or benzodiazepine withdrawal; and create a practice resource to educate emergency providers about the science of opioid and benzodiazepine addiction.)
   Outcome: The critical questions were finalized, initial literature searches done, and literature obtained. Selection of pertinent literature was done for initial searches. Additional searches are being worked on. Asymptomatic elevated blood pressure – Subcommittee assignments were made.

   i. Procedural sedation
   Outcome: Subcommittee assignments were made and the work will continue in 2018-19.

   j. Seizures
   Outcome: Subcommittee assignments were made and the work will continue in 2018-19.

Additionally, the development of the clinical policy on Acute Venous Thromboembolic Disease continued was completed in 2017-2018. The draft clinical policy went through internal and external review and was approved by the ACEP Board in February 2018. It was endorsed by the Emergency Nurses Association and published in *Annals of Emergency Medicine* online in May 2018. An Executive Summary was developed and published in *Annals* print in June 2018 and an article about the policy was published in the July 2018 issue of *ACEP Now*. eCME is now in development.

The development of the clinical policy on Non-ST-Elevation Acute Coronary Syndromes was completed in 2017-2018. The draft clinical policy went through internal and external review, was finalized, approved by the ACEP Board in June 2018, and is being considered for endorsement by the Emergency Nurses Association. It was posted to the ACEP Web site and is scheduled to be published in *Annals of Emergency Medicine* online in November 2018. An Executive Summary was developed and will publish in *Annals* print in November 2018. An article about the policy is being prepared for *ACEP Now*. eCME is being developed on the policy for the ACEP Web site.

5. Serve as a resource and continue working with the Quality & Patient Safety Committee to identify performance measures in new and revised clinical policies. (Quality & Patient Safety is the lead committee.)

Outcome: The Quality & Patient Safety Committee is asked to provide input to the clinical policy development process during the question and review stages. A member of the Quality and Patient Safety Committee Serves as a Liaison to the Clinical Policies Committee and participates in the committee meetings and conference calls.

6. Review the following policies per the Policy Sunset Review process.
   - Opposition to Routine Abscess Culturing. Obtain input from the State Legislative/Regulatory Committee on state legislative requirements for this policy. (Clinical Policies is the lead committee.)
     Outcome: The committee worked with the State Legislative/Regulatory Committee and the revised policy was approved by the Board in February 2018.

   - Rapid-Sequence Intubation
     Outcome: The Board of Directors reaffirmed the policy statement in February 2018.

7. Review Referred Resolution 38(17) Non-Fatal Strangulation and provide a recommendation to the Board regarding further work on the resolution.

Outcome: An initial literature review was conducted and the committee agreed there is not enough evidence to develop a clinical policy on the topic. The committee will provide a recommendation to the Board in September 2018 regarding possible other work, such as educational materials or program.

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Coding & Nomenclature Advisory Committee

Chair: David Friedenson, MD, FACEP
Board Liaison: Jon Mark Hirshon, MD, PhD, MPH, FACEP
Staff Liaison: David McKenzie, CAE

1. Identify and analyze Medicare, Medicaid, and private payer claims processing policies that deviate from CPT principles and/or documentation guidelines and recommend strategic solutions. Track payer issues such as denials, rates, appeals, and pay for performance. Monitor the Recovery Audit Contractor (RAC), and other audit activities, and react appropriately to issues affecting emergency medicine.

Outcome: The committee identified and provided analysis on at least eight private payer claims processing policies that were found to have deviated from standard CPT principles and/or documentation guidelines and recommended actions including reaching out to payers for clarification, adjustment, and/or reconsideration of policies deemed harmful to emergency medicine reimbursement. Work Group 1 continued to track Medicare and Medicaid RACs for issues related to recovery of improperly paid claims as well as contractual agreements.

2. Track ICD-10 implementation and continue to provide educational material on ICD-10 for members to aid in their reimbursement. Collaborate with content experts from the Quality & Performance Committee to ensure ACEP measures use appropriate ICD-10-CM/PCS mapping assignments. Continue to monitor the impact of ICD-10 implementation, evaluate the effect on reimbursement, and modify educational materials as needed.

Outcome: The committee continued to review downcoding policies by payers as well as lists of diagnosis codes unfairly used to lower reimbursement or deny payment to emergency physicians. The committee reviewed policies and other issues from nearly every major commercial insurer and five state Medicaid/Managed Medicaid programs.

3. Continue to advocate nationally for emergency medicine issues through the AMA CPT process and through possible CMS development of physician or facility documentation guidelines. Monitor efforts for transparency and claims processing edits. Explore development of an ED-specific code, such as using alternative payment models (APMs), for care coordination or transition to the post-acute setting.

Outcome: A code change proposal was submitted to the AMA CPT Panel in early 2017 for potential new codes for opioid counseling; however, the proposal was ultimately unsuccessful at the September 2017 meeting. The committee will continue to consider new and/or a revised proposal for the CPT Panel. New code proposals were considered, including lumbar puncture under fluoroscopy, as well as commenting on other specialty societies new or revised code change proposals. There is also continued discussion on how to address extended stays in the ED for behavioral health.

4. Identify and develop educational materials such as articles, webinars, and Frequently Asked Questions (FAQs) to provide members with up-to-date information that will facilitate an effective balance between optimal coding and compliance.

Outcome: The committee updated 16 FAQs and published new *ACEP Now* articles on students, APPs, and residents in the ED. The ACEP website has been updated to reflect the changes. Updated FAQs included rejected codes by payers, observation in a facility, APCs, RAC audits, utilization reviews, orthopedic fracture care, and telehealth.

5. Develop a strategy to seek reimbursement for counseling on safe opiate use, reversal agent instruction, and drug abuse counseling for patients as directed in Resolution 28(16) Reimbursement for Opioid Counseling.

Outcome: The CPT code change proposal describing reimbursement for counseling on safe opiate use, reversal agent instruction, and drug abuse counseling for patients was ultimately not accepted by the CPT Panel at the September 2017 meeting. The committee will consider a revised proposal in addition to exploring strategies for reimbursement for these services.

6. Investigate clinical classification software and determine what diagnosis groupings will be used.

Outcome: The committee investigated the use of CCS and determined the use of diagnosis groupings related to emergency medicine. The committee will continue to examine diagnosis groupings to determine how they could affect emergency physician reimbursement.

7. Investigate the creation of "K codes" to collect information for use in fighting down-coding and show value of ED services and make a recommendation for implementation.

Outcome: The committee investigated the potential use of K-codes on the CMS Form 1500 and is currently deciding on potential solutions to recommend for future implementation.

8. Explore developing codes for alternative payment models, including community paramedicine and mobile integrated health care

Outcome: The committee assigned Work Group 3 to study potential alternative payment models with the possibility of developing a proposal for new codes for community paramedicine and mobile integrated health care in the future.

9. Collaborate with the EMS Committee and other committees as appropriate to explore the development of CPT codes for community paramedicine and mobile integrated health care. (Coding & Nomenclature Advisory is the lead committee.)

Outcome: The committee is reviewing potential new code proposals for community paramedicine and mobile integrated health care and will collaborate with the EMS Committee and other committees as appropriate. Work on this objective will continue in 2018-19.

Compensation Committee

Chair: Marco Coppola, DO, FACEP
Board Liaison: None
Staff Liaison: Layla Powers, MBA

1. Establish stipends for Board members, Board officers, and Council officers.

Outcome: The committee recommended a 10% increase for all Board member and officer positions effective November 1, 2017 through October 31, 2018.

2. Monitor compensation trends for the Board of Directors and officers of other medical specialties to ensure ACEP members are compensated appropriately.

Outcome: The committee reviewed stipends from other medical specialties.

3. Analyze results of the Board compensation study. Provide recommendations to the Board for compensation and other incentives that are sufficient to attract members from all practice types to seek nomination to the Board of Directors.

Outcome: The committee reviewed the Governance Assessment report from Nelson Strategic Consulting and recommended that additional increases should not be considered until the Board addresses the key recommendations in the report. A governance subcommittee was formed to review the recommendations in the report. The committee will review the subcommittee report to assist in developing their recommendations for 2018-19 stipends.

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Disaster Preparedness & Response Committee

Chair : Ira R. Nemeth, MD, FACEP
Board Liaison: Christopher S. Kang, MD, FACEP
Staff Liaison: Pat Elmes

1. Continue to utilize identified national and international organizations active in disaster medical preparedness and response to assure appropriate liaisons and channels of communication with ACEP and seek opportunities to increase collaboration and member participation.

Outcome: The committee developed a guiding document that is being considered as a letter to the editor to be submitted to related emergency medicine and disaster emergency medicine publications. Four new liaison relationships were added: Team Rubicon, American Red Cross, National Wildfire Coordinating Group, and Federal Emergency Management Agency.

2. Collaborate with the Disaster Medicine Section to refine the Mass Casualty Medical Operations Management Course. Collaborate with the Pediatric Emergency Medicine Committee to include pediatric disaster education. (Disaster Preparedness & Response is the lead committee.)

Outcome: Past objectives and slides from the Mass Casualty Operations Course at *ACEP17* were compiled. The committee assessed the course and recommended adding a pediatric component to each section. The comments were submitted to the course director for implementation at the 2018 course. Work on this objective will continue in 2018-19.

3. Implement the Disaster Medical Sciences Award.

Outcome: Nominations were reviewed and the Board approved the recipient in April 2018.

4. Monitor the national disaster medicine environment for federal regulations, new guidelines, standards, and technologies that potentially significantly impact disaster medicine and provide recommendations to the Board as needed.

Outcome: The work group provided input to ACEP leadership on several legislative matters including the Pandemic and All-Hazards Preparedness Act (PAHPA) Reauthorization, the Mission Zero Military/Civilian Trauma Act of 2018, and changes to Section 1135 of the Social Security Act [42 U.S.C. 1320b-5] regarding freestanding emergency care facilities in disasters. The work group also reported on several technology innovations in disaster medicine including the First Responder Network by FirstNet Services and disaster response applications for Drone technology.

5. Serve as a resource and provide input to the Education Committee to explore online and other EMS, disaster, and other related training for emergency physicians. (Education is the lead committee.)

Outcome: Input was provided as requested. The committees are exploring an online format for disaster related courses for ACEP19. The committee is also compiling and reviewing a list of disaster medical education opportunities.

6. Collaborate with fellowship directors and explore development of a Disaster Medicine board certification.

Outcome: The work group met at *ACEP17* and discussed goals for this coming year. A writing group was established for the SAEM application and curriculum for the disaster medicine fellowship approval program. The work group also maintained a list of current and new disaster fellowships throughout the country. Another meeting will be held at *ACEP18* to discuss plans for next year.

7. Review the following policies per the Policy Sunset Review process:
   - Disaster Medical Services

   Outcome: The Board approved the revised policy statement in June 2018.

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Education Committee

Chair: Matthew Bitner, MD, FACEP
Board Liaison: Kevin M. Klauer, DO, EJD, FACEP
Staff Liaison: Robert Heard, MBA, CAE

1. Identify member educational needs based on assessments from a variety of sources, including state and facility CME requirements, board certification requirements, quality measures, test results, activity evaluations, member surveys, ACEP.org search terms and ACGME Milestones.

Outcome: Course and faculty evaluations were collected for each educational meeting and the data was used to assess the quality of the education program and to select future speakers and course content. An overall evaluation of each educational meeting was also conducted to assess the entire program and obtain additional course content desired by the learners and was used for future planning. Attendee and faculty cadaver lab post conference survey was used to measure which procedures should remain and which should be omitted. All other skills labs have a check-off list that the moderator completes before, during, and after the lab to ensure continuing improvement and future needs assessment. The 2018 needs assessment report is in progress. It will include data from PEER pretest results, findings from a closed-claims study of malpractice actions, trends from ACEP.org search terms, and more. This information will be presented to the Education Steering Committee in October 2018.

2. Design, implement, evaluate, and revise educational activities that meet identified needs and enhance ACEP's position as the primary source for state-of-the-art emergency medicine education, including:
   a. Live and enduring CME activities on the emergency medicine core content designed to reinforce cognitive expertise
   b. Alternative educational opportunities such as simulation courses for procedural competencies and skills
   c. Mobile and online CME courses and other activities that incorporate new learning technologies
   d. Podcasts, social media, FOAMed, (individual, group, text and graphical formats)
   e. PI-CME activities approved for ABEM MOC Assessment of Practice Performance
   f. Digital editions of ACEP titles published for a variety of reading devices
   g. EMS subspecialty certification prep resources
   h. Activities designed to help students, residents, and young physicians during early years of practice
   i. Activities specific to the issue of litigation stress
   j. Educational products related to CEDR Learning Collaborative

Outcome:
   a. New content was added to PEER, the premier content review and self-assessment resource for the specialty. More than 6,000 emergency physicians used PEER through individual subscriptions or through residency program dashboards. The Critical Decisions in Emergency Medicine editorial board continued to select its topics from the EM Model to ensure that it covered all core content topics over time.
   b. Two cadaver labs as pre-conference events and SIM ABCs during *Scientific Assembly* used simulation specifically to increase procedural competency. All other skills labs at *Scientific Assembly* included some simulation education.
   c. More than 70 new courses were added to ACEP eCME, the College's online and mobile learning platform. Members of the Online Education Subcommittee advised staff on topics and course selection.
   d. New episodes were added to two education podcasts: "ACEP Frontline" and "So what?" A third podcast, "ACEP SA Replay," was maintained with existing content. A new podcast, "Critical Decisions in Emergency Medicine," was launched in November 2017.
   e. A PI-CME activity on pediatric readiness is being reviewed by ABEM now. Another on palliative care will be submitted to ABEM in August. A third on handoffs is expected to be renewed. All three were created by the Continuing Competency and Certification Subcommittee.
   f. Digital editions and eBooks of three ACEP titles are now available through multiple retailers for all reading devices. Kindle editions of Critical Decisions in Emergency Medicine were released in early 2018. The new ECG book scheduled for release in January 2019 will be published as an eBook as well.
   g. Many courses at *ACEP17* and planned for *ACEP18* are indicated for resident education. Special registration pricing is available for residents for ED Directors Academy to gain the ED management and leadership education that is not typically taught during residency, as well as a financial management course for young physicians.

h. Many courses at *ACEP17* and planned for *ACEP18* are indicated for resident education. Special registration pricing is available for residents for ED Directors Academy to gain the ED management and leadership education that is not typically taught during residency, as well as a financial management course for young physicians. These courses are available on Virtual *ACEP17*.Students and residents are able to buy PEER at significant discounts. Their residency programs also are able to buy access for them at even deeper discounts. The "First Friday" series continues, which gives residents free access to two new lectures every month, one on a clinical topic and one on a management or professional skills topic. All resident members and all "RegYr1" members continue to receive Critical Decisions free as a member benefit.
i. Litigation stress was included in *ACEP17* and is planned for *ACEP18*. A course was included in the EDDA Phase I course in 2017 and 2018. This course is also available on Virtual *ACEP17*.
j. Several free educational resources selected by E-QUAL were added to the ACEP eCME catalog.

3. Submit a nomination for the 2018 ACEP Award for Outstanding Contribution in Education.

Outcome: A nomination was submitted by the deadline.

4. Investigate creating additional recognition or awards in education, publications, and other areas not currently acknowledged in the national awards structure.

Outcome: No action was taken on this objective. Several new awards were created by other committees in 2017-18.

5. Continue to pursue strategic partnerships with publishers and other organizations that contribute to the College's CME mission, goals, and objectives.

Outcome: ACEP partnered with the National Association of Freestanding Emergency Centers (NAFEC) to plan and implement their conference. ACEP also partnered with the American Hospital Association to plan the Hospital Flow Conference in 2018. Staff and members from ACEP, the AAP, and the AHA are investigating a new collaboration on pediatric life support education. A new relationship with HippoEM was established to brand "ERCast," and several others are being investigated. Relationships continue with EMSono, SonoSim, McGraw-Hill Education, Jones and Bartlett Learning, DK Publishing, Visual Dx, and others.

6. Develop CME activities for physicians and providers practicing emergency medicine in resource-limited settings.

Outcome: Several courses at *ACEP17* were identified as rural interest to this audience. A collection of courses selected by the Rural EM Section is available through ACEP eCME.

7. Explore cost-efficient ways to provide education to international emergency physicians. Enhance ACEP's expertise internationally in marketing publications and meetings.

Outcome: A new collection of online courses, "ACEP's Selected Topics for International Emergency Physicians," was released in June 2018. The individual courses were selected by the International Emergency Medicine Section. The collection is free to international physicians. A trailer (video) was created to post on YouTube.

8. Explore online and other EMS, disaster, and other related training for emergency physicians. Collaborate with the EMS Committee and the Disaster Preparedness & Response Committees. (Education is the lead committee.)

Outcome: This is an ongoing objective. The committee will continue to work with the EMS Committee and the Disaster Preparedness & Response Committee to identify and review relevant courses and training opportunities related to EMS, Disaster, and other related topics.

9. Maximize the delivery platform for educational products to improve discoverability and access.

Outcome: The Educational Meetings Subcommittee worked with ACEP's virtual products vendor to update the Virtual ACEP platform to improve usability for our members and non-member customers by updating the Virtual Website (improved layout and searchability) and the player (ability to take notes, increase playback speed, community discussions,

and ability to develop playlists). The Online Education Subcommittee made recommendations to improve the ACEP eCME user interface; staff have started working with the platform host to implement those improvements.

10. Explore ways to increase diversity in the faculty for ACEP educational meetings and education programs. Ensure educational programs include diversity and inclusion throughout offerings and include topics such as unconscious bias in clinical care and practice management. Collaborate with content experts from the Diversity & Inclusion Task Force.

Outcome: The Educational Meetings Subcommittee emphasized and achieved an increased level of diversity in planning *ACEP18*. A course about unconscious bias was offered at *ACEP17* and is planned for *ACEP18*. The Educational Meetings Subcommittee implemented a faculty mentoring program for *ACEP18* to support new speakers and a diverse faculty. The subcommittee continues to work on increasing diversity beyond gender. Additionally, a new online course on unconscious bias was developed and released on ACEP eCME in April 2018.

11. Collaborate with the Well-Being Committee to develop interactive online tutorials (several short modules) on resiliency strategies for members as part of Wellness Week activities and explore the possibility of providing CME. (Well-Being is the lead committee.)

Outcome: Work is in progress and will continue in 2018-19. Wellness Week added an international participation component. Additional work is underway with educational products on potential bundles focused on wellness.

12. Provide oversight for ACEP's international initiatives, including the international ambassador program and conference, international conference support, *Scientific Assembly* international scholarship program, and international networking reception at *Scientific Assembly*. Collaborate with the International Emergency Medicine Section.

Outcome: A new staff member was hired to manage and support international activities. The international ambassador program has been restructured and support for the International Emergency Medicine Section initiatives have been enhanced A specific bundle of *ACEP17* Virtual Products was created for the international audience. Additional educational products are being consider for future endeavors for the international audience. The criteria for International Scholarship program is underway to ensure that clinical leaders in other countries are selected. This redesign requires a written experience and clinical impact report from all award recipients. Leaders from the section were encouraged to apply for appointments within the Education Committee. ACEP's International Ambassador Conference was redesigned to include a bootcamp/orientation for new ambassadors and liaisons and an opportunity for Global EM Fellowship program interviews.

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Emergency Medicine Practice Committee

Chair: Michael A. Turturro, MD, FACEP
Board Liaison: Mark S. Rosenberg, DO, MBA, FACEP
Staff Liaison: Margaret Montgomery, RN, MSN

1. Review the following policies per the Policy Sunset Review process:
   - Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine
   - Availability of Hospital Diagnostic and Therapeutic Services
   - Emergency Medicine's Role in Organ and Tissue Donation
   - Emergency Physician Contractual Relationships – and the PREP
   - The Role of the Legacy Emergency Physician in the 21st Century
   - Selective Triage for Victims of Sexual Assault to Designated Exam Facilities

Outcome:
- Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine
  Reaffirmed by the Board February 2018.
- Availability of Hospital Diagnostic and Therapeutic Services
  Revised and approved by the Board February 2018.
- Emergency Medicine's Role in Organ and Tissue Donation
  Reaffirmed by the Board February 2018.
- Emergency Physician Contractual Relationships – and the PREP
  The revised policy statement was approved by the Board in June 2018. The Board reviewed the PREP in July 2018.
- The Role of the Legacy Emergency Physician in the 21st Century
  Reaffirmed by the Board February 2018.
- Selective Triage for Victims of Sexual Assault to Designated Exam Facilities
  Reaffirmed by the Board February 2018.

2. Continue to review and provide input to outside organizations (such as AHA, TJC, AMA) on emergency medicine practice issues.

Outcome: The following reviews were conducted by the committee:

- ACEP/AAP document on Access to Optimal Care of Pediatric Patients.
- AMA requested input on a document – Shatterproof = payer based strategies to improve SUD care.
- Joint Commission proposed requirements for pediatric emergency equipment/supplies for hospitals.
- Revisions to the 2009 Pediatric Readiness Guidelines.
- Assessing Cognitive Impairment in the ED- Summit Proceedings- National Academy of Neuropsychology.
- NFPA 451 Guide to Community Health Programs.
- Confusion and Agitation in the Elderly ED Patient: The ADEPT Tool.

3. Continue to collaborate with the Pain Management and Addiction Medicine Section to compile and develop resources for alternatives to opioids for patients treated in the ED for pain.

Outcome: The second set of non-opioid treatment resources were reviewed by the ACEP Board in June 2018. They include: Femoral Block, Haloperidol for Analgesia, Gabapentin, 98 Intravenous Lidocaine for Renal Colic, Occipital Nerve Blocks, Paraspinous Cervical Nerve Blocks, Transcutaneous Electrical Nerve Stimulation (TENS), 9 Trochanteric Bursitis Injection, and Ultrasound-guided Bicipital Tendinitis Injection. The first group of treatments developed are now being formatted for a web-based app and include: Forearm Nerve, Shoulder Injection, Ketamine, Ketamine for Non-Cancer Pain, Nitrous Oxide, Tibial Nerve, Sphenopalatine Ganglion, and Trigger Point Injections.

4. Continue collaboration with the Public Health & Injury Prevention Committee to review and compile resources on ED-initiated treatment of patients with substance use disorders. (Emergency Medicine Practice is the lead committee.)

Outcome: An information paper with FAQs concerning meditation assisted treatment for opioids was developed with input from the Public Health & Injury Prevention Committee and members of the Pain Management & Addiction Medicine Section. Links to resources on MAT and protocols from several hospitals were included. These resources will be available on the ACEP website.

5. Complete revisions to the policy statement "Interpretation of Imaging Diagnostic Studies" to reflect the intent of the guiding principles for critical communications for ED radiology findings (Amended Resolution 32-15).

Outcome: The Board approved the revised policy statement in June 2018. The revised policy was shared with ACR and endorsement was requested.

6. Identify best practices and strategies for throughput to make electronic health records (EHRs) more efficient. Compile resources such as order sets, templates and smart phrases or templates to aid providers with EMR efficiency.

Outcome: The committee developed an information paper Electronic Health Record (HER) Best Practices for Efficiency and Throughput." It was reviewed by the Board in June 2018 and will be available on the ACEP website.

7. Explore development of an award for innovative change in practice management.

Outcome: In June 2018, the Board approved the Award for Innovative Change in Practice Management. The award will be implemented in 2019.

8. Collaborate with the Membership Committee and the Well-Being Committee to develop a resiliency toolkit and include information such as decompression tips after a shift, debriefing after critical incidents, and multitasking. Explore the use of screening tools such as the Mayo Clinic document. Develop additional resources for medical directors and department chairs. (Well-Being is the lead committee.)

Outcome: The Resiliency Toolkit was completed in March 2018 and is available on the ACEP.org wellness page.

9. Solicit nominations and recommend to the Board the recipient(s) of the new Community Emergency Medicine Excellence Award.

Outcome: There were six nominations submitted for the award. The Board approved the first recipient in June 2018. The award will be presented at the committee meeting held during *ACEP18*.

10. Serve as a resource and provide input to the Quality & Patient Safety Committee regarding Choosing Wisely recommendations.

Outcome: ACEP was not asked to respond to any new Choosing Wisely recommendations.

11. Provide input to the Research Committee, in conjunction with the Federal Government Affairs Committee, Reimbursement Committee, the Emergency Medicine Foundation, and the Emergency Medicine Action Fund, to identify and coordinate health policy research. (Research is the lead committee.)

Outcome: EMF funded one health policy project and two NIDA grants

12. Work with the Quality & Patient Safety Committee to revise the policy statement "Definition of Boarded Patient." (Quality & Patient Safety is the lead committee.)

Outcome: The Quality & Patient Safety Committee is recommending that the policy statement be reaffirmed. The Board will review this recommendation at their September 2018 meeting.

13. Review ACEP's current policy statements and resources regarding opioid prescribing in the ED and determine if policy revisions or additional resources are needed to address Resolution 44(17) Guidelines for Opioid Prescribing in the ED.

Outcome: The committee reviewed the policy statement "Ensuring Emergency Department Patient Access to Appropriate Pain Treatment." The policy statement supports ACEP chapter autonomy to establish and coordinate evidence-based pain management guidelines that promote access to appropriate pain control with physician clinical judgement. The EQUAL Network has also developed guidelines in association with the EQUAL Opioid Management focus area.

14. Review Referred Resolution 33(17) Immigrant and Non-Citizen Access to Care and provide a recommendation to the Board regarding further action on the resolution.

Outcome: The committee reviewed the current policy statement "Delivery of Care to Undocumented Persons." Revisions were recommended to include reference to safe zones. The revised policy statement was approved by the Board in June 2018.

15. Review Referred Resolution 38(17) Prescription Drug Pricing and provide a recommendation to the Board regarding further action on the resolution. Obtain input from the AMA Section Council on Emergency Medicine regarding working the AMA and other stakeholders to support regulatory and legislative efforts to address prescription drug pricing.

Outcome: The committee prepared the policy statement, "Prescription Drug Pricing." It was approved by the Board in June 2018.

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EMS Committee

Chair: Jeffrey M. Goodloe, MD, FACEP
Board Liaison: Debra G. Perina, MD, FACEP
Staff Liaison: Rick Murray, EMT-P

1. Continue to collaborate with NAEMSP and other related organizations to develop strategies regarding EMS physician reimbursement for online and offline medical direction including programs such as CP/MIH.

Outcome: The committee revised and updated several policy statements addressing alternate transportation and destination, refusal of medical aid, and CP/MIH programs into one consolidated policy statement "Patient Autonomy and Destination Factors in Emergency Medical Services (EMS) & EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs." The committee will continue to explore opportunities for EMS physician reimbursement for online and offline medical direction.

2. Continue to collaborate with NAEMSP and other ACEP committees and subcommittees to create a guide for new EMS fellows and medical directors that includes information on finding jobs, what to expect in contracts, negotiations, and real-world advice.

Outcome: A list of key topics was identified and will be finalized in a format that can be shared with the EMS Section.

3. Continue to collaborate with NAEMSP and related stakeholders in the development of resources and guidelines for Mobile Integrated Healthcare (MIH) programs, including model quality measures of MIH programs and a model for review and certification/designation of MIH programs.

Outcome: The committee revised and updated several policy statements addressing alternate transportation and destination, refusal of medical aid, and CP/MIH programs into one consolidated policy statement "Patient Autonomy and Destination Factors in Emergency Medical Services (EMS) & EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs." The committee will continue to explore opportunities for EMS physician reimbursement for online and offline medical direction.

4. Collaborate with EMS representatives of the American College of Surgeons Committee on Trauma (ACS-COT), the National Association of EMS Physicians (NAEMSP), and other EMS organizations to establish strategies to implement EMS recommendations of the National Academies of Sciences, Engineering, and Medicine (NASEM, formerly the Institute of Medicine) report, "A National Trauma System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury."

Outcome: The committee identified EMS related items in nine of the eleven recommendations of the NASEM Report and developed an initial list of priorities to consider for developing strategies to implement. This work will continue as various meetings and workgroups proceed with addressing the individual recommendations over the coming months.

5. Continue collaboration with stakeholders involved in changes to current controlled substances regulations (e.g. DEA regulations) with focus on current legislation in Congress and develop educational resources related to any new DEA regulations for EMS medical directors.

Outcome: H.R. 304 – Protecting Patient Access to Emergency Medications Act of 2017 became law in December of 2017. Contact was made with DEA staff offering assistance in the development of new rules and regulations. Educational resources cannot be developed until the DEA completes the rule-making process. Work on this objective will continue in 2018-19.

6. Continue to develop resources for EMS leaders on the importance of the skill of critical thinking in EMS personnel, including development of an information paper on critical thinking in EMS, an on-line repository of critical thinking scenarios, and a question/answer bank.

Outcome: A list of references on critical thinking is in development and will be shared with the EMS Section.

7. Coordinate with the EMS-Prehospital Care Section and the Air Medical Transport Sections and submit a nomination for the 2018 ACEP Outstanding Contribution in EMS Award.

Outcome: A nomination was submitted by the deadline.

8. Review the following policies per the Policy Sunset Review process:
   - Ambulance Diversion – and the PREP
     Outcome: The Board rescinded the policy statement (and PREP) in February 2018. Relevant information was included in the new policy statement "Emergency Medical Services Interfaces with Health Care Systems" that was approved by the Board in February 2018.

   - Domestic Violence: The Role of EMS Personnel
     Outcome: The Board rescinded the policy statement in February 2018. Relevant information was included in the new policy statement "Special Roles for Emergency Medical Service Professionals" that was approved by the Board in February 2018.

   - Interfacility Transportation of the Critical Care Patient and its Medical Direction
     Outcome: The Board rescinded the policy statement in February 2018. Relevant information was included in the new policy statement "Emergency Medical Services Interfaces with Health Care Systems" that was approved by the Board in February 2018.

   - Medical Direction for Staffing of Ambulances
     Outcome: The Board rescinded the policy statement in October 2017. Relevant information was included in the new policy statement "The Role of the Physician Medical Director in EMS Leadership" that was approved by the Board in February 2018.

   - Medical Direction of Emergency Medical Services – and the PREP
     Outcome: The Board rescinded the policy statement (and PREP) in October 2017. Relevant information was included in the new policy statement "The Role of the Physician Medical Director in EMS Leadership" that was approved by the Board in October 2017.

9. Provide input to the Pediatric Emergency Medicine Committee to revise the policy statement "The Role of Emergency Physicians in Emergency Medical Services for Children." (Pediatric Emergency Medicine is the lead committee.)

Outcome: The committee provided input as requested. The Board of Directors reaffirmed the policy statement in February 2018.

16. Provide input to the Coding & Nomenclature Advisory Committee to explore the development of CPT codes for community paramedicine and mobile integrated health care. (Coding & Nomenclature Advisory is the lead committee.)

Outcome: The committee provided input as requested.

17. Serve as a resource and provide input to the Clinical Data Registry Committee on EMS-related measures. (Clinical Data Registry is the lead committee.)

Outcome: The Clinical Data Registry Committee decided against pursuing EMS-related measures at this time.

18. Serve as a resource and provide input to the Education Committee to explore online and other EMS, disaster, and other related training for emergency physicians (Education is the lead committee.)

Outcome: The committee provided input as requested.

19. Complete revisions to the "Appropriate and Safe Utilization of Helicopter Emergency Medical Services" policy statement.

Outcome: The committee reviewed the policy statement and is recommending that it be reaffirmed. The Board will discuss the committee's recommendation at their September 2018 meeting.

20. Complete revisions to the "Drug-Assisted Intubation in the Prehospital Setting" policy statement.

Outcome: The committee recommended sunsetting the policy and incorporating the relevant information in the new policy statement "The Clinical Practice of EMS Medicine." that was approved by the Board in October 2017.

21. Continue to work with NAEMSP and ACS-COT to complete revisions to the spinal motion restriction policy statement.

Outcome: The Board approved the joint policy statement "Spinal Motion Restriction in the Trauma Patient" in February 2018. It will be available on the ACEP website as soon as it is finalized by NAEMSP and ACS-COT.

22. Complete development of the joint policy statement on pediatric prehospital readiness with AAP, ENA, NAEMSP, and NAEMT.

Outcome: The draft policy statement was completed. AAP is currently sending the policy to the partner organizations for approval.

23. Continue collaboration with ACS-COT to complete the development of a policy statement on community disaster plans.

Outcome: The committee continued coordination with ACS-COT on the "Stop the Bleed" program to address community preparedness and response to incidents involving severe hemorrhage from disasters and other mass casualty incidents.

24. Develop a policy statement in response to Resolution 27(17) 911 Number Access and Prearrival Instructions. Obtain input from the State Legislative/Regulatory Committee. (EMS is the lead committee.)

Outcome: The policy statement "Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch & Public Emergency Aid Training" was approved by the Board in June 2018.

25. Provide input to the State Legislative/Regulatory Committee regarding Amended Resolution 29(17) CPR Training. (State Legislative Regulatory is the lead committee.)

Outcome: The committee provided input as requested.

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Ethics Committee

Chair: Arvind Venkat, MD, FACEP
Board Liaison: Christopher S. Kang, MD, FACEP
Staff Liaison: Leslie Moore, JD

1. Identify and develop educational opportunities and materials on ethics issues, including at least three articles for ACEP publications, including:
   - Ethical issues in for profit journals and open-access publishing
   - Ethical issues in the growth of FOAMED as a dominant educational strategy for emergency physicians
   - Ethical Issues in the Use of Interpreter Services in the ED
   - Moral Issues in Addressing Crowding in the ED
   - Ethical Issues in Productivity-Based Compensation Models for Emergency Physicians
   - ACEP Expert Witness Guidelines – *ACEP Now* article – Link to Data from Information Paper Below

Outcome: The following articles have been developed or are in the process of being developed for publication:
- Predatory Academic Medical Journals: Their Ethics and Identification
- Ethical Issues in FOAM
- Use of Interpreter Services in the Emergency Department (published in *Annals of Emergency Medicine* July 2018
- Another Look at the Persistent Problem of Emergency Department Crowding
- Compensation Models in Emergency Medicine: An Ethical Perspective
- ACEP's Code of Ethics: How Does It Apply to Me?
- Measurement Under the Microscope: High Variability and Limited Construct Validity in Emergency Department Patient-Experience Scores – published in Annals of Emergency Medicine December 2017
- Value of ED Patient Experience Data Falling Short – published in Health Data Management December 21, 2017
- Health Care Professionals & Law Enforcement (published in *The New England Journal of Medicine* Dec 2017)
- Providing ethical healthcare in resource-poor environments (published in *HEC Forum Online* January 2018)
- The Ethics of Real-time EMS Direction (published in *Prehospital and Disaster Medicine* February 2018
- Ethics of virtual reality in medical education and licensure (published in *Cambridge Quarterly of Healthcare Ethics* April 2018)
- Do-Not-Resuscitate Tattoos: Are They Valid? (published in *ACEP Now* April 2018)
- Doctor in, and for, the Family? Physicians Reflect on Care for Loved Ones (published in *Narrative Inquiry in Bioethics* Spring 2018)
- Moral Conflicts and Religious Convictions: What Role for Clinical Ethics Consultants? published in *HEC Forum* May 2018)
- Against-Medical-Advice (AMA) Discharges from the Hospital: Optimizing Prevention and Management to Promote High Quality, Patient-Centered Care (Hardcover Book published in 2018)
- The Care of VIP's in the Emergency Department Triage, Treatment and Ethics (published in *The American Journal of Emergency Medicine* July 2018)

2. Review the *Policy Compendium of the Code of Ethics for Emergency Physicians* and recommend needed revisions to the Board of Directors.

Outcome: The Board approved the updated *Policy Compendium* in May 2018.

3. Review and provide recommendations to the Board of Directors on ethics complaints.

Outcome: Three ethics charges were reviewed by a subcommittee of the Ethics Committee. Two of the committee's recommendations were approved by the Board in February and May 2018. The third recommendation will be reviewed by the Board in September 2018.

4. Develop the following information papers:
   - Empiric and Descriptive Analysis of Previous Ethics Complaints and Lessons Learned
     Outcome: The Board reviewed the information paper in April 2018 and it is available on the ACEP website.

- State-Level Legislation on Physician Assistance with Dying and the Ethical Implications for Emergency Physicians.
  Outcome: The Board reviewed the information paper and it was submitted to *Annals of Emergency Medicine* for publication consideration.

- Organizational Ethics Addressing Hospital and Health System Regulations and Metrics that May Compete with Providing Quality Patient Care
  Outcome: The information paper will be submitted to the Board for review in September 2018.

5. Review current ethics policies and procedures that address issues regarding patient care, research, and contract management and develop guidance to inform members of the process for filing such complaints.

Outcome: An article was developed and submitted to *ACEP Now* for publication consideration.

6. Provide an assessment to the Board of Directors of the capacity of the Ethics Committee to evaluate ethics complaints and the potential need for an independent mechanism to adjudicate ethics complaints from members.

Outcome: A report was provided to the Board of Directors in February 2018.

7. Develop a policy statement on ethical issues with observers in the ED.

Outcome: The Board approved the new policy statement "Observers in Emergency Medical Settings" in February 2018.

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Federal Government Affairs Committee

Chair: Ashley B. Norse, MD, FACEP
Board Liaison: John J. Rogers, MD, CPE, FACEP, President-Elect
Staff Liaison: Laura Wooster, MPH

1. Analyze and recommend legislative and regulatory priorities for the Second Session of the 115th Congress and develop new legislative/regulatory recommendations as appropriate reflecting congressional debate in 2017 on repeal and replacement bills for the ACA.

Outcome: The Board approved the committee's recommendations for the legislative and regulatory priorities for the 2nd Session of 115th Congress in February 2018.

2. Maintain and expand the 9-1-1 legislative network. Evaluate and enhance the network's role in advancing ACEP's legislative/regulatory agenda. Encourage committee members to meet with their congressional representatives either locally or on Capitol Hill.

Outcome: Overall participation in the 911 Network as of June 2018 is 3,987, which has almost doubled (previous stat was 2,200 members**)** and resident participation has increased two-fold.

- Created target list of legislators for ED visits based on member visits during White Coat Day and LAC18 and strategic targeting on new legislators and those on key health care committees or in competitive re-election races. Working with Soapbox, currently have a target list of 40 lawmakers (and growing with input from LAC18) with 16 completed since January of 2018.
- Coordinated tele town hall on gun violence and injury health care reform including recording messages, promotion, providing poll questions and obtaining guest Rep. Seth Moulton – hundreds of ACEP members participated.
- Worked with Soapbox Consulting to schedule Hill visits for 800+ registrants at White Coat Day in October 2017 and 363 Hill visits for 512 participants during LAC18.
- Sent action alerts on Drug Shortage letter, Opioid alert to HELP Committee, and urging no Medicare cuts in tax extenders bill.

Twitter statistics: 981 Followers, 497 tweets
Facebook: 289 followers
Phone2Action LAC18 Info:

- 284 attendees took action
- 586 emails sent to legislators
- 198 advocates shared on Twitter
- 118 Facebook shares
- 284 advocates opted-in to receive text messages.

3. Establish and maintain a regular dialogue with Congressional members and staff on the critical issues in emergency medicine, specifically on the value-added services that emergency medicine provides to the health care system.

Outcome: ACEP staff conducted more than 200 meetings with members of Congress and staff. Conducted multiple leader visit programs regarding opioids, psychiatric services for emergency patients, out-of-network/reimbursement, and regulatory relief. Four ACEP members testified before Congress on opioids, synthetic drugs, and regulatory relief.

4. Continue to evaluate and educate members on the impact of MIPS, MACRA, and track the impact of continued implementation of the ACA and/or any modifications to it through repeal, repair, or replace.

Outcome: Regarding ACA:

- Successfully defended emergency services included in Essential Health Benefits (EHB) provisions of law during health reform 2.0 efforts.

Regarding MACRA:

- Reviewed and provided detailed comments on the Calendar Year (CY) 2018 Quality Payment Program Proposed Rule.

- Monitored key announcements around MACRA implementation and made members aware of important deadlines through the weekly 911 update and other mechanisms.
- Worked with CMS to clarify confusing requirements and definitions of the Quality Payment Program, such as when groups are exempt from the Advancing Care Information Category of MIPS. Created fact sheets or other materials to help educate members about these specific issues.
- Coordinated with CEDR and QPSC to ensure that members understood the requirements around using qualified clinical data registries (QCDRs) to report measures in MIPS. Met periodically with CMS to discuss QCDR issues and have established ongoing quarterly meetings with CMS' quality leadership team.

5. Develop strategies to remove the exemption of Medicaid from the prudent layperson standard. Collaborate with content experts from the Reimbursement Committee. (Federal Government Affairs is the lead committee.)

Outcome: As part of continued advocacy on the Prudent Layperson Standard (PLS), held discussions with lawmakers about potential legislative solutions to extend PLS protections to Medicaid fee-for-service. Identified legislative champions for potential introduction of legislation to expand PLS to Medicaid fee-for-service for early in the 116th Congress. Co-authored letter to CMS on Centene diagnosis list-based downcodings of Medicaid MCO visits in certain states.

6. Continue to assess the likelihood of legislation at the state and federal level and other activity on out-of-network/balance billing and the advisability of introducing federal legislation. Collaborate with content experts from the ACEP-EDPMA Joint Task Force, Reimbursement Committee, and State Legislative/Regulatory Committee. (Federal Government Affairs is the lead committee.)

Outcome: Worked with the ACEP-EDPMA Joint Task Force around advocating at the state level for a Minimum Benefit Standard (MBS) linked to the 80th Percentile of a Usual, Customary, and Reasonable (UCR) charge database, such as FAIRHealth. Worked with EDPMA at the federal level on legislative, regulatory, and sub-regulatory options for addressing the current "Greatest of Three" regulations, including starting to develop federal legislation that would establish an MBS for out-of-network emergency services and define the term UCR, and drafting Frequently Asked Questions (FAQs) as a first-line to be used in the legislative champions' discussions with CCIIO.

7. Provide programming ideas for the 2018 Leadership & Advocacy Conference to the ACEP President and course director.

Outcome: The committee provided recommendations for the 2018 conference. The sessions with speakers that would be relevant to those topics, such as emergency preparedness, opioids, entitlement reform, and others.

8. Review the following policies per the Policy Sunset Review process:
   - Delivery of Care to Undocumented Persons

   Outcome: The Board reaffirmed the policy statement in June 2018.

9. Coordinate with leaders of other emergency medicine organizations such as AAEM, Physicians for Fair Coverage, ENA, etc., to share messaging and talking points.

Outcome: ACEP led coalition efforts to achieve enactment of the EMS standing orders law, to extend rural ambulance reimbursements, to provide reasonable reimbursement for out-of-network emergency services, and to provide due process rights for all emergency physicians. Worked with AAEM on refining language in legislation on due process introduced by Rep. Chris Collins. Worked with AAEM on a letter to CMS that encouraged the department to ensure protection of due process rights for emergency physicians.

10. Provide input to the Research Committee, in conjunction with the Emergency Medicine Practice Committee, Reimbursement Committee, the Emergency Medicine Foundation, and the Emergency Medicine Action Fund to identify and coordinate health policy research. (Research is the lead committee.)

Outcome: The committee coordinated and provided input on research proposals related to out-of-network and the prudent layperson standard.

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Finance Committee

Chair: Gary Starr, MD, FACEP
Board Liaison: Stephen H. Anderson, MD, FACEP, Secretary-Treasurer
Staff Liaison: Layla Powers, MBA

1. Perform duties as delineated in the *Compendium of Financial Policies and Operational Guidelines*, including:
   - Review the annual College budget and make recommendations to the Board.
   - Review the financial status of the College monthly.
   - Consider budget modifications and make recommendations to the Board.
   - Review and monitor expenses for the Clinical Emergency Data Registry

Outcome: The budget for FY 2018-2019 was approved by the committee and the Board in June 2018. The committee reviewed the financial statements monthly and held video conferences throughout the year. The committee reviewed all budget modifications year and received monthly updates on the Clinical Emergency Data Registry and membership renewals.

2. Review the *Compendium of Financial Policies and Operational Guidelines* and make recommendations to the Board regarding any necessary revisions.

Outcome: A subcommittee is developing proposed revisions to the *Compendium* that will be reviewed by the Board in January 2019.

3. Conduct an annual review of contributions made by ACEP to affiliated organizations.

Outcome: The committee continued to review contributions related to affiliated organizations.

4. Review and report on return on investment for all new expenditures greater than $100,000 in aggregate.

Outcome: This is an ongoing objective. The committee has formed a subcommittee to determine the best way to measure return on investment depending on the type of investment.

5. Collaborate with the National/Chapter Relations Committee to develop resources to assist chapters with audits and expense review. (Finance is the lead committee.)

Outcome: Committee members and staff provided training to chapter leaders at the 2018 Leadership & Advocacy Conference. The training provided information on audits vs. reviews, the role of the treasurer, fiduciary responsibilities, Board oversight, etc.

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Medical-Legal Committee

Chair: John Bedolla, MD, FACEP
Board Liaison: Kevin M. Klauer, DO, EJD, FACEP
Staff Liaison: Craig Price, CAE

1. Review, update, and provide information to members on medical legal matters that impact the administrative and clinical practice of emergency medicine.

Outcome: The committee provided information in response to several requests for opinion and feedback from members and other committees on a variety of topics: EMTALA interpretation; what to do when subpoenaed; the Emergency Physician Contractual Relationships PREP; interpretation of application of HIPAA in certain circumstances; and an AMA amicus brief Winter v. Gardens.

2. Participate in the review of clinical policies and provide information on potential medical-legal issues.

Outcome: The committee provided comments on the draft clinical policy on unscheduled procedural sedation.

3. Provide input to the Clinical Policies Committee on clinical policies that need to be developed for clinical conditions that have high malpractice incidences.

Outcome: The committee provided data to the Clinical Policies Committee on the top ten clinical conditions that have the highest incidences of malpractice claims.

4. Review ACEP's Choosing Wisely recommendations to determine any medical-legal issues and report findings to the Quality & Patient Safety Committee.

Outcome: The committee prepared a report highlighting the limitations of Choosing Wisely in terms of offering medical-legal protections. The report acknowledges that such guidelines still serve as useful resources as needed for claims management and medical legal defense. The report will be submitted to the Board for review in September 2018.

5. Develop a policy statement that defines EMTALA and appropriate uses of the law.

Outcome: The Board approved the policy statement, "Interpretation of EMTALA In Medical Malpractice Litigation" in June 2018.

6. Submit a nomination for the 2018 Rorrie Health Policy Award.

Outcome: The committee submitted a nomination by the deadline.

7. Investigate ways to ensure expert witnesses are aware of and follow ACEP's Expert Witness Guidelines for the Specialty of Emergency Medicine to reduce all egregious testimony.

Outcome: This is an ongoing objective. The committee explored the feasibility of developing a certification program for expert witnesses in emergency medicine, but determined it should not be pursued at this time. The committee will focus on potentially resuscitating ACEP's largely dormant Standard of Care Review process. This objective will continue, in collaboration with the Ethics Committee, in 2018-19.

8. Review the medical legal resources, including litigation stress, on the ACEP website and develop new or additional resources. Collaborate with content experts from the Well-Being Committee regarding litigation stress. (Medical-Legal is the lead committee.)

Outcome: This is an ongoing objective. The redesign of the ACEP website delayed the committee's efforts. The committee expects to complete the review of documents and other resources by October 2018.

9. Complete development of a policy statement regarding professionalism in the use of social media.

Outcome: The raft policy statement "Use of Social Media by Emergency Physicians" was submitted to the Board in June 2018. The Board referred the policy back to the committee with recommendations for a few revisions. The revised draft policy statement will be submitted to the Board in September 2018.

10. Review Referred Resolution 47(17) Improving Patient Safety Through Transparency in Medical Malpractice Settlements and provide a recommendation to the Board regarding further work on the resolution.

Outcome: In June 2018, the Board of Directors approved the committee's recommendation not to pursue the recommendations contained in the resolution at this time. An objective was assigned to the committee for 2018-19 to explore opportunities to use information from the National Practitioner Data Bank or related closed claims materials that might provide teachable information that may help reduce medical errors and improve patient safety.

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Membership Committee

Chair: Kathleen Clem, MD, FACEP
Board Liaison: Alison J. Haddock, MD, FACEP
Staff Liaison: Michele Byers, CAE, CMP

1. Build on recruitment and retention tools to easily use as resources for emergency physicians at each major stage of their life cycle/career, specifically late career physicians, transitioning members, and board certified physicians.
   a. Include end of career transitioning tools, networking opportunities for mid-career physicians, and resources to aid in work-life balance for mid- and late-career members.
   b. Expand ACEP's social media presence as appropriate for communications to members in various stages of member life cycles to increase member and potential member awareness of value and recognition of ACEP.
   c. Collaborate with the Emergency Medicine Practice Committee and the Well-Being Committee to develop a resiliency toolkit and include information such as decompression tips after a shift, debriefing after critical incidents, and multitasking. Explore the use of screening tools such as the Mayo Clinic document. Develop additional resources for medical directors and department chairs. (Well-Being is the lead committee.)

Outcome: This has been an ongoing objective for the past five years. The Member Needs survey results reflect that retention has increased for members aged 30-39, retired members, graduating residents, and members of large physician groups. The Resiliency Toolkit was completed in March 2018 and is available on the ACEP.org wellness page

2. Analyze the results of the diversity and inclusion survey for membership recruitment and retention strategies.

Outcome: The survey results will be reviewed as soon as they are released. This objective will continue in 2018-19.

3. Utilize the 2016 Member Needs Assessment data to develop targeted member communications and benefits.

Outcome: This is an ongoing objective. The committee will compare the 2019 Member Needs Assessment to determine the effectiveness of changes implemented that were based on the 2016 assessment.

4. Inventory current communications and tools and identify gaps to demonstrate the value (return on investment) of ACEP membership and encourage the allocation of funds for membership and educational opportunities to:
   a. individual physicians
   b. medical directors
   c. residency program directors
   d. department chairs
   e. employment group executives
   f. other decision makers

Outcome: The inventory and identification of gaps in communications and tools are complete and CME has been identified as a primary gap. CME is available through a variety of other sources and ACEP is no longer the main source for emergency medicine CME. The membership survey has indicated there are other areas for emphasis that need to be addressed by the Membership Committee.

5. Review the benefits and requirements for emergency physician group participation in the 100% Club and provide recommendations for program improvements. Include information about group pricing incentives for participation in CEDR.

Outcome: CEDR implemented discount incentives for groups in the 100% Club. To date, six new groups have decided to participate in CEDR.

6. Explore ways to use social media to increase member engagement and expanded dissemination of toolkits and other resources developed by the committees (e.g., human trafficking, observation, DART program, etc.).

Outcome: ACEP increased the use of social media outlets to reach members, particularly graduating residents and early career physicians. The committee recommended highlighting the 2018 ACEP Fellows on Facebook and other social media platforms. The committee also recommended posting podcasts, such as "So What," on Facebook and Twitter.

7. Serve as a resource in the development of a group and residency portal to facilitate administrative efficiency for group enrollment of multiple members.

Outcome: Development of the portal has been delayed. This objective will continue in 2018-19.

8. Demonstrate to eligible members the value of FACEP designation and encourage young physicians to aspire to this designation.

Outcome: The committee recommended commemorating FACEP as a life event during *ACEP18* by reposting photos from the 2017 President's Awards Gala and having a photo booth available with props and signage at the 2018 Gala to promote posting the photos on social media and using #FACEP to promote the honor by the new Fellows. A new FACEP web page and video were developed. Logistics for adding the FACEP application fee to membership statements of eligible Fellows is being investigated.

9. Provide input to content development for the membership recruitment, renewal, and benefit sections of the new ACEP.org website.

Outcome: The committee provided input as requested.

10. Review efforts to increase the percentage of board certified diplomates who are members of ACEP.

Outcome: The recommendations implemented include personal notes to first time and recertifying ABEM diplomates and targeted emails to ABEM diplomates that the LLSA articles are available at no charge on the ACEP website.

11. Provide input to the National/Chapter Relations Committee and the State Legislative/Regulatory Committee to identify opportunities for regional collaboration and conferences. (National/Chapter Relations is the lead committee.)

Outcome: The National/Chapter Relations Committee did not identify additional opportunities for regional collaboration and conferences. Their investigation determined that collaboration between chapters occurs as needed. (See additional information in the National/Chapter Relations Committee annual report.

12. Explore novel approaches to leverage ACEP's 50th anniversary to increase membership.

Outcome: ACEP's 50th anniversary was used to promote membership to all membership segments.

Membership Committee – Sections Subcommittee
Chair: Michelle Blanda, MD, FACEP
Board Liaison: Alison J. Haddock, MD, FACEP
Staff Liaison: Kelly Peasley

1. Oversee the annual section grant process and recommend grant recipients to the Board of Directors

Outcome: The Board approved the subcommittee's recommendations for 2017-18 section grants in June 2018. Nine grants were approved for a total funding package of $50,168.

2. Select recipients of the annual section awards for recommendation to the Board of Directors.

Outcome: The Board approved the subcommittee's recommendations for section awards in September 2018.

3. Revise the Section Grant Criteria to reflect preference to section grants that promote efficiency or physician wellness.

- Consider removing "educate the public" from the criteria to generate products that become member benefits.
- Clarify the non-eligible expenses.

Outcome: The section grant criteria was revised as directed.

4. Provide recommendations to increase the value of section membership and encourage ACEP members to join a section.

Outcome: The subcommittee is in the process of fine tuning the section grant criteria and will utilize the new engagED member community to add value to section membership.

5. Address section issues such as membership compliance for councillor allocation.

Outcome: This is an ongoing objective and will continue in 2018-19.

6. Review requests for formation of new sections and provide recommendations to the Board of Directors.

Outcome: The Emergency Medicine Locum Tenens Section and the Diversity, Inclusion, & Health Equity Section were approved by the Board in February 2018. Information about forming and joining new sections is available on the ACEP website.

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National/Chapter Relations Committee

Chair:-Antonia Helbling, MD
Board Liaison: William P. Jaquis, MD, FACEP
Staff Liaison: Maude Hancock

1. Explore ways to expand promotion of completed chapter grant projects to other chapters.

Outcome: The redesigned ACEP website will feature a dedicated page for chapter grant products. Chapter Services staff will soon begin adding the content. ACEP communications (*EM Today, Weekend Review)* include announcements of the chapter grants when they are awarded. The information is also included in the Featured News section of ACEP.org, on the Chapter Services/Chapter Grants Program page, and promoted on ACEP's social media sites. The same efforts are utilized to promote the chapter grant products once the chapter grant projects are completed.

2. Administer, maintain, and evaluate the Chapter Grant Program.

Outcome: The committee reviewed seven chapter grant applications and forwarded five chapter grant applications to the Board of Directors. The Board approved funding five grants (four regular chapter grants and one development grant) totaling $45,000 in February 2018.

3. Analyze the results of the 2017 chapter leadership development survey. Develop and promote chapter resources and best practices in cultivating current and future leaders.

Outcome: A subcommittee reviewed the 2017 survey results and provided several recommendations to staff. Staff will work with the 2018-19 committee chair to evaluate and prioritize the recommendations:

- Create a list of best practices in chapters that foster leadership development and develop "how to" guides for chapters that are not already employing these practices.
- Continue to support leadership development of residents and explore resource support of EMRA's Leadership Academy. There is potential to use their Leadership Academy as a future pipeline program for resident and medical student leadership development at the chapter level.
- Evaluate the EM Futures program (Texas Chapter program) to increase multigenerational and diversity/inclusion leadership development at the chapter level through member engagement.
- Review the 2018 survey results and contact chapters that have not responded to the 2018 leadership survey.

In preparation for the Chapter Leadership session at the 2018 Leadership & Advocacy Conference (LAC), and to increase awareness of the services ACEP offers to chapters and chapter leaders, Chapter Services developed a brochure outlining the resources ACEP offers to chapter leaders. A follow up message was sent to all chapter leaders after LAC that included staff contact information, links to resources available to chapter leaders on the ACEP website, and an electronic copy of the brochure.

Staff also reinstated the "Welcome Letter" to new chapter presidents when elected. The letter includes useful and important information for chapter leaders, links to resources, and contact information for staff at national ACEP.

4. Survey past and current presidents of small chapters to identify the greatest unmet needs of small chapters. Develop resources to address those needs.

Outcome: The Annual Chapter Presidents Survey was sent in February 2018 with the following questions:

1. What do you consider to be the greatest unmet need of your chapter that ACEP could improve?
   a. national ACEP leader accessibility
   b. chapter strategic planning
   c. membership recruitment/engagement
   d. advocacy resources
   e. public relations

f. physician leadership development;
g. chapter staffing needs

2. How could ACEP best help meet the need described above?

A subcommittee reviewed the survey results and determined that the greatest unmet need of small state chapters was member recruitment through leadership development. The complete chapter president survey is available for review from ACEP. The subcommittee considered existing resources and decided that the biggest hurdle in growing small chapters is identifying leaders to recruit new members to the chapter. After examining the offerings at LAC and the ED Director's Academy, the subcommittee recommended contacting the Educational Meetings Subcommittee for the enhancement of educational tracks at *Scientific Assembly*. As an educational opportunity for all emergency physicians, the *Scientific Assembly* is uniquely positioned to offer introductory leadership courses on a variety of topics to: 1) highlight the value of small chapters; 2) encourage member participation in small state chapters; 3) enable self-identification of leadership potential; and 4) promote ACEP tools for small chapter growth and membership recruitment. The list of proposed topics was provided to the Educational Meetings Subcommittee with a request to add the topics to new or existing educational tracks. A conference call was held to discuss the request. The discussion and next steps include:

Discussion:

1. The current "Professional and Leadership" track at ACEP is open to recommendations for lectures at ACEP19. There is an online process for submitting recommendations. It might be possible to create a "topics of interest" to highlight lectures at *ACEP18* that small chapters would be interested in promoting. This identification would be added to the Schedule portion of the registration page.
2. Several additional opportunities to explore were discussed. A timeline for developing additional ideas would likely go beyond *ACEP18*. Funding for such activities would need to be considered. It could be a worthwhile chapter grant project.
   a. All lectures, except for workshops and hands-on skills labs, are currently recorded and made available for purchase via Virtual ACEP. Lectures of potential interest to small chapters could be identified and special pricing evaluated
   b. Potential to develop an online course with resources from larger chapters that already have programs developed.
   c. Consider a pre-conference course to pilot a workshop for small chapter leadership development and utilize the resources/speakers from larger chapters that already have programs developed.

Next steps

- Submit topic recommendations through the ACEP19 course proposal process.
- Review technical possibility of adding a "topics of interest for small chapters leadership/membership development" grouping of *ACEP18* lectures for registrants.
- Review accepted *ACEP18* topics for a "Small chapter leadership/membership development" track within *Scientific Assembly.*
- Identify interest in a chapter grant for developing a leadership/membership development course for small chapters.

5. Develop an online resource for chapter executives to facilitate sharing of resources and best practices in ACEP chapter management.

Outcome: A Basecamp community group was launched for Chapter Executives in October 2017. Basecamp was replaced by the new engagED community group in August 2018. The goal is to build a searchable resource library for chapters.

6. Review and revise as needed resources contained in "Fundamentals of Chapter Management" and include resources to assist chapters in officer orientation.

Outcome: This is an ongoing objective. A subcommittee identified several items for revision. The revised document will be available on the ACEP website when completed. It was suggested that ACEP create a template/checklist of items that chapters and/or chapter officers are expected to complete each month. The committee will work on this objective in 2018-19 and evaluate whether a complete revision and reorganization of "Fundamentals of Chapter Management" is needed.

7. Provide input to the Finance Committee to develop resources to assist chapters with audits and expense review. (Finance is the lead committee.)

Outcome: Input was provided to the Finance Committee. The Finance Committee is currently reviewing the information and will provide their recommendations.

8. Collaborate with the Membership Committee and the State Legislative/Regulatory Committee to identify opportunities for regional collaboration and conferences. (National/Chapter Relations is the lead committee.)

Outcome: The committees were not able to identify areas of meaningful collaboration or opportunities for regional collaboration and conferences. Concerns were expressed that the objective was broad and collaboration between chapters usually occurs organically. Chapters that do not currently have an annual educational conference may be suitable to collaborate on a joint meeting and to gather information (challenges, best practices, etc.) from chapters that currently collaborate on programs. A toolkit of resources could be developed for chapters seeking to create regional collaboration and conferences.

9. Develop strategies to address Amended Resolution 23 Information Sharing, Regular ACEP/Chapter Contact, and Regional State/Chapter Relationships and develop a report to the 2018 Council.

Outcome: The following strategies were implemented:

1. Implement Basecamp as a collaboration tool for sharing information and resources between chapter executives. See report on objective #5.
2. Regular communication from national to the chapters with information about Board meetings, communications from the president, and ACEP Leadership Updates.
3. Regular communication about national activities, programs, partnerships, opportunities, etc. to chapter executives and chapter presidents with encouragement to include relevant notifications in communications to chapter members as appropriate.
4. Continued to hold bi-annual all-chapter audio conferences.
5. Continued to provide funding for the Chapter Leader Visit Rotation Program (national ACEP provides funding for national leaders to visit up to 20 chapters each year).
6. Send “Welcome” letters to newly installed/elected chapter presidents (with copy to the chapter executive director). The letter highlights the resources and support provided by national ACEP to chapters.
7. Held a Chapter Leadership session at LAC18. This addition to the LAC program was for current or aspiring chapter leaders and offered strategies for effectiveness in their role. The format consisted of panel presentations with past or current chapter leaders, chapter executives and/or ACEP staff, and was moderated by ACEP Board members. Topics included state advocacy, chapter finances, how to be an effective chapter leader, how to create an effective and diverse Board, and succession planning.
8. ACEP launched a new online community, engaged. Additional community groups could be created for many topic areas or groups, such as Chapter Officers to discuss issues, share resources, ask questions and Chapter Membership Chairs to share best practices, challenges on membership recruitment, retention, and engagement.

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Pediatric Emergency Medicine Committee

Chair: Mohsen Saidinejad, MD, MBA, FACEP
Board Liaison: Debra G. Perina, MD, FACEP
Staff Liaison: Sam Shahid

1. Be integrally involved with the National Pediatric Readiness Survey and collaborate with the Public Relations Committee to assure that emergency medicine is appropriately represented, including:
   - Develop a model position description for the pediatric emergency care coordinator, as recommended for each ED.
   - Increase awareness of resources available and in development for pediatric preparedness of community EDs.

Outcome: This is on ongoing objective. The Board of Directors approved the joint policy statement (with the American Academy of Pediatrics and the Emergency Nurses Association) "Pediatric Readiness in the Emergency Department" in June 2018. It is schedule for simultaneous publication with AAP and ENA in November 2018. Work on this objective will continue in 2018-19.

2. Collaborate with the EMSC Innovation & Improvement Center (EIIC) to:
   - Ensure ACEP is recognized as a full partner of the EIIC.
   - Create its leadership and policy infrastructure and to develop strategies to optimize resource utilization between general emergency medicine and pediatric emergency medicine.
   - Ensure ongoing collaboration with the committee and the ACEP grant-funded staff from EIIC.

Outcome: This is an ongoing objective. ACEP participated in the Pediatric Readiness Quality Collaborative. Subcommittee members served as subject matter experts on the quality improvement bundle interventions. The committee also assisted in identifying recourses and members to serve as champions for Pediatric Readiness. ACEP was invited to continue participation in the project and work on this objective will continue in 2018-19.

3. Collaborate with American Academy of Pediatrics to revise and update the joint policy statement and the Emergency Information Form (EIF) for all children.

Outcome: The committee provided proposed revisions to AAP in May 2018.

4. Continue working with the Academic Affairs Committee to develop resources to encourage emergency medicine residents to enter pediatric emergency medicine and improve competency of training. (Pediatric Emergency Medicine is the lead committee.)

Outcome: This is an ongoing objective. The Board approved ACEP's participation in the Pediatric Emergency Medicine Simulation Curriculum Collaborative in April 2018. The Collaborative was launched in July 2018. Work on this objective will continue in 2018-19. Other work completed this year:

- 2018 SAEM Consensus Conference – Aligning the Pediatric Research Agenda to Reduce Health Outcomes Gaps
- Developing a series of podcasts on topics relevant to residents considering a pediatric emergency medicine fellowship.
- EMRA launched a new website that includes information about the EMRA Pediatric EM Virtual Mentorship Program.
- ACEP's Pediatric Emergency Medicine Section includes and updated Pediatric Emergency Medicine Speaker Database.

5. Serve as a resource and provide a representative to the Clinical Data Registry Committee regarding the development of pediatric emergency medicine-specific quality measures. (Clinical Data Registry is the lead committee.)

Outcome: The committee assigned a representative to the Clinical Data Registry Committee. There were no measures developed for pediatric emergency medicine.

6. Collaborate with the American Academy of Pediatrics and the Pediatric Surgery Society to develop a policy statement on trauma imaging in the pediatric patient population according to existing guidelines and decreasing unnecessary radiation in pediatric trauma patients.

Outcome: The committee provided comments to AAP and the PSS on a draft policy statement. The final document will be provided to the ACEP Board of Directors for review once it is received from AAP. Work on this objective will continue in 2018-19.

7. Collaborate with content experts from the Telemedicine Section to develop an information paper on the role of telemedicine in pediatric emergency care and in support of community emergency departments. (Pediatric Emergency Medicine is the lead committee.)

Outcome: The draft information paper was provided to the Telemedicine Section for review. The committee expects to submit the information to the Board for review when completed. and aim to have it completed this year. We will be sending it to the Telemedicine Section for review once completed and we will be wrapping this objective up this year.

8. Develop a policy statement on the use of antitussive medications, specifically opiate-containing antitussives, and their utility in the treatment of pediatric patients.

Outcome: Work is in progress and will continue in 2018-19.

9. Collaborate with the American College of Radiology to provide pediatric content expertise in generating recommendations for radiographic tests in the emergency management of children.

Outcome: Work is in progress and will continue in 2018-19. Committee members are serving as ACEP representatives on various topics: Cerebrovascular Disease, Head Trauma, Seizures, Sinusitis, Suspected Spine Trauma, Acutely Limping Child and Painful Hip, Antenatal Hydronephrosis, and Suspected Appendicitis.

10. Collaborate with the American Academy of Pediatrics and the Emergency Nurses Association to develop a common policy statement to optimize pediatric safety in the emergency care setting.

Outcome: Work is in progress and will continue in 2018-19. A letter of intent was submitted to AAP requesting that the policy be developed as a joint policy between ACEP, AAP, and ENA. AAP has not yet responded.

11. Review the following policies per the Policy Sunset Review process:
    - Boarding of Pediatric Patients in the ED
      Outcome: The Board will review the committee's recommendations in September 2018.

    - Patient and Family Centered Care and the Role of the Emergency Physician Providing Care to a Child in the ED
      Outcome: The Board will review the committee's recommendations in September 2018.

    - Pediatric Mental Health Emergencies in the Emergency Medical Services System
      Outcome: The Board will review the committee's recommendations in September 2018.

    - The Role of Emergency Physicians in Emergency Medical Services for Children. Collaborate with the EMS Committee. (Pediatric Emergency Medicine is the lead committee.)
      Outcome: The Board of Directors reaffirmed the policy statement in February 2018.

12. Provide input to the Disaster Preparedness & Response Committee to refine the Mass Casualty Medical Operations Management Course to include pediatric disaster education. (Disaster Preparedness & Response is the lead committee.)

Outcome: The committee provided input as requested. Work on this objective will continue in 2018-19.

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Public Health & Injury Prevention Committee

Chair: Isabel A. Barata, MD, MPH, FACEP
Board Liaison: James J. Augustine, MD, FACEP
Staff Liaison: Margaret Montgomery, RN, MSN

1. Review the following policies per the Policy Sunset Review process:
   - Alcohol Advertising
   - Injury Control/Trauma Data Banks
   - Non-Discrimination and Harassment
   - Trauma Care System Development, Evaluation, and Funding

Outcome:
- Alcohol Advertising
  Policy revised and approved by the Board in April.
- Injury Control/Trauma Data Banks
- Trauma Care System Development, Evaluation, and Funding
  The "Injury Control" and "Trauma Care System Development" policies were combined and the revised policy was approved by the Board in April.
- Non-Discrimination and Harassment
  Revised and approved by the Board in June.

2. Continue development of talking points or "smart phrases" for discharge summaries and/or educational resources on public health, injury prevention issues. Develop a talking point for providers addressing the American College of Radiology's Appropriate Use Criteria.

Outcome: Two smart phrases were completed: head CT for minor head injury and MRI for low back pain.

3. Compile and distribute information on health care disparities and strategies to address the disparities. Collaborate with content experts from the Diversity & Inclusion Task Force. (Public Health & Injury Prevention is the lead committee.

Outcome: The information paper "Disparities in Emergency Care" was reviewed by the Board in October 2017.

4. Review the literature and research on contagion-related suicide risk for teens.

Outcome: An information paper was prepared and will be reviewed by the Board in September 2018.

5. Collaborate with the Epidemic Expert Panel to investigate and disseminate information to members about regional emerging infectious diseases.

Outcome: The Epidemic Expert Panel's discussions focused on the flu season and best practices for caring for these patients and balancing the implementation of sepsis core measures. An algorithm was developed and will be available on ACEP's website.

6. Collaborate with the Emergency Medicine Practice Committee to review and compile resources on ED-initiated treatment of patients with substance use disorders. (Emergency Medicine Practice is the lead committee.)

Outcome: An information paper with FAQs concerning meditation assisted treatment for opioids was developed by the Emergency Medicine Practice Committee with input from the Public Health & Injury Prevention Committee and members of the Pain Management & Addiction Medicine Section. Links to resources on MAT and protocols from several hospitals were included. These resources will be available on the ACEP website.

7. Continue to explore tangible ways members can decrease incidents of firearm violence in their communities.

Outcome: A list of resources related to firearm injures was compiled and will be available on the new ACEP Resources section of the website. Resources include: prevention practice resources, emergency medicine related firearm violence and injury prevention programs, firearm suicide prevention programs by state, and program implementation materials. The committee also investigated the data to determine potential correlation between laws and injury. It was determined that reliable data availability is a limiting factor for any further action on this effort.

8. Develop a policy statement or information paper to address Amended Resolution 31(17) Development and Study of Supervised Injection Facilities.

Outcome: The committee has begun development of an information paper. This objective will continue in 2018-19.

9. Review Referred Resolution 46(17) Impact of Climate Change on Patient Health and Implications for Emergency Physicians and provide a recommendation to the Board regarding further action on the resolution.

Outcome: The Board of Directors approved the policy statement " Impact of Climate Change on Public Health and Implications for Emergency Medicine" in June 2018.

10. Develop a policy statement or information paper to address Resolution 52(17) Support for Harm Reduction and Syringe Services Programs.

Outcome: The committee has begun development of an information paper. This objective will continue in 2018-19.

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Public Relations Committee

Chair: Howard K. Mell, MD, MPH, FACEP
Board Liaison: Stephen H. Anderson, MD, FACEP
Staff Liaison: Laura Gore

1. Provide direction to public relations staff on promoting the specialty of emergency medicine, focusing on ACEP's priority issues and key message, including:
   - promoting the interests of emergency physicians and emergency patients
   - continuing to conduct ACEP's Fair Coverage Campaign, promoting the value of emergency medicine, and shifting blame for "surprise bills" to health insurance companies.
   - increasing ACEP's name recognition (branding) and relevancy of emergency medicine among its public audiences (advocacy)
   - mobilizing public support for funding emergency care and promoting the need for tort reform
   - refuting myths about emergency medicine and advocating to reduce "boarding"
   - communicating the need to protect access to emergency care as regulations are developed to implement the health care reform legislation and deflect efforts to harm the prudent layperson
   - developing and reviewing public relations materials distributed to the news media and the general public
   - promoting the value of emergency medicine and positive stories about emergency physicians caring for patients of all ages.
   - promoting placement of ACEP spokespersons in media roles, such as medical correspondents, to help represent emergency physicians to the public
   - promote the diversity and inclusion of emergency physicians and breadth of the patient population they serve

Outcome: This is an ongoing objective. Committee members provided significant input on the messaging for three national ACEP campaigns: 1) Fair Coverage (about Anthem/Blue Cross Blue Shield); 2) a marketing campaign about Anthem targeting the general public; and 3) a marketing campaign about opioids targeting the general public. A committee member also served as a cast member for a viral video developed by ACEP about Anthem. Members input included specific focuses on how to promote the interests of emergency physicians and emergency patients.

Committee members provided medical review of ACEP's consumer press releases on health and safety topics. These public education pieces promoted the value of emergency medicine and portrayed emergency physicians as experts. Additionally, many committee members engaged in social media to promote the value of emergency medicine, promote diversity, and refuted myths about emergency medicine.

Committee members conducted scores of news media interviews, all promoting ACEP's brand and many promoting the value of emergency medicine. These efforts contributed to achieving more than 672,017 media hits (including two Anthem viral videos) from July 1, 2017, to June 30, 2018 — doubling the media hits over the previous year. Committee members contributed to the more than 204 national news stories, including eight CNN hits, four in the *New York Times*, 10 in the *Washington Post*, four in the *Wall Street Journal*, three on NBC News, 15 on MSN, three on ABC News, two on CNBC, two on CBS News, three in *USA Today,* and three in the *Los Angeles Times*.

Committee members discussed diversity issues at length, including how to communicate effectively with a diverse medical specialty and how to convey that diversity to the general public. Members also discussed how to message the need for tort reform.

2. Provide technical review and consultation for promoting *Annals of Emergency Medicine*.

Outcome: This is an ongoing objective. Committee members worked with the public relations staff and held regular conference calls to discuss upcoming new research in the journal. Based on the discussions, 12 papers were selected for promotion with press releases, and two were selected for promotion with audio news releases. Promotion of *Annals* generated press coverage — nearly 10,000 hits — in news organizations including CNN, CBS News, NPR, the *Washington Post*, *MSN, Fierce Healthcare, National Geographic, Stat News, AARP News,* and *Modern Healthcare*. *Annals* studies also were featured on the CDC website, the *British Medical Journal* and the *New England Journal of Medicine Journal Watch*.

3. Provide oversight to the ACEP Journalism Awards Program.

Outcome: A subcommittee reviewed the candidates and selected the recipients, who were approved by ACEP's president and recognized during 2018 Leadership & Advocacy Conference:

- Dr. Joel Cooper for "Overcrowding in the Emergency Department: Causes, Fallacies, and Fixes," published in the Medical Bag blog.
- Dr. Howard Forman for "Why Hospitals Need To Stop Boarding Patients in Emergency Rooms," published in the *Wall Street Journal*.

The committee also developed a new social media award. The Board approved the first recipient in April 2018. The award was presented at the 2018 Leadership & Advocacy Conference.

4. Expand and further unify the spokesperson network to deliver messages at the local level more effectively.

Outcome: Committee members worked with staff to provide direction to chapters in states where Anthem is active (Georgia, Indiana, Kentucky, Maine, Missouri and New Hampshire). As a result, staff developed and distributed joint press releases, enlisted spokespersons at the local level to do interviews and submit letters to the editor and editorials, and conducted coordinated social media in support of the chapter's efforts. Public relations staff worked closely with chapters to engage in media relations related to disasters, such as hurricanes and mass shootings. Some committee members also submitted letters to the editor to their local newspapers on behalf of ACEP.

5. Provide input and increase ACEP's name recognition thru social media platforms. Expand ACEP's social media presence to increase Twitter, Facebook, Vine, You Tube, and podcasts, etc.

Outcome: This is an ongoing objective. Committee members engaged in social media, especially as new members were added who are very active on Twitter. Members provided input on ACEP's new social media playbook crisis communications plan, including the first responder network team, which was approved by the Board of Directors in February 2018. Members provided Doc Blogs for ACEP's consumer website EmergencyCareforYou.org, and several members monitored and engaged in doctor-only sites in support of ACEP. Several committee members participated in filming 50th anniversary videos that are available on ACEP.org and promoted through social media.

6. Provide input into the implementation of the comprehensive public relations plan, including internal and external messaging.

Outcome: This is an ongoing objective. The committee chairs serves on the *ACEP Now* Editorial Advisory Board, which enables coordinating messaging between internal and external communications. ACEP's member communications director is also active with the committee and provided information about the social media crisis plan and received critical feedback on messaging for controversial issues, such as REBOA and firearms safety and violence. Committee members continued to work toward integration of external and internal communications and engaged in discussions about ACEP members who communicate messages that are in conflict with ACEP messages and how to resolve those conflicts. Public relations staff met bi-weekly with internal communications staff to coordinate activities and messaging.

7. Collaborate with the Pediatric Emergency Medicine Committee to increase awareness and promote educational materials regarding the National Pediatric Readiness Project, including resources available and in development, for pediatric preparedness of community EDs. (Pediatric Emergency Medicine is the lead committee.)

Outcome: ACEP's pediatric emergency medicine physicians monitored the progress of the National Pediatric Readiness Project and provided input to the Pediatric Emergency Medicine Committee. The committee stands ready to help promote the project and promote emergency physicians as experts in caring for children.

8. Implement Amended Resolution 30(17) Demonstrating the Value of Emergency Medicine to Policy Makers and the Public and develop a report to the 2018 Council on the development and distribution of public relations materials demonstrating the value of emergency medicine to policy makers and the public.

Outcome: A repository of materials was developed demonstrating the value of emergency medicine and is available on the ACEP website. Additionally:

- Developed a new fact sheet about the value of emergency medicine.
- As part of promoting ACEP's 50th anniversary, filmed and posted dozens of one-minute videos of members telling their stories about the value of emergency medicine.
- Developed and promoted a public opinion poll about the value of emergency medicine. The poll results found high trust and high satisfaction for emergency care.
- Continued to promote the Saving Millions campaign to policymakers and the general public Campaign tools included web and print advertising in Washington, DC, policymaker publications and included a link to ACEP's website www.SavingMillions.org.

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Quality & Patient Safety Committee

Chair: Michael P. Phelan, MD, FACEP
Co-Chair: Richard Griffey, MD, FACEP
Board Liaison: Aisha T. Liferidge, MD, MPH, FACEP
Staff Liaison: Pawan Goyal, MD

1. Measure Review & Comment
   - Monitor quality initiatives and comment on behalf of ACEP to external organizations to ensure appropriateness of quality measures that impact the practice of emergency medicine, the emergency department, and the reimbursement of emergency physicians.
   - Develop and submit recommended measures and measure concepts to the Board of Directors through the multi-stakeholder Quality Measures Technical Expert Panel that protect and enhance emergency medicine.
     a. Follow through on the development, specification, and testing of the ACEP Board approved or adopted measure concepts through QCDR implementation.
     b. Initiate the next phase of quality measures development by:
        - Continue exploring methods to reduce measurement burden by aligning with hospital efforts for quality measurement.
        - Align measure development work with the Clinical Data Registry Committee to ensure valid and reliable measures are developed for CEDR.
        - Collaborate with the Clinical Policies Committee to identify performance measures in new and revised clinical policies. (Quality & Patient Safety is the lead committee).

Outcome:

- Worked with other entries and their Technical Expert Panel to respond to quality initiatives, such as: NQF, CMS, ACR, and AUA.
- Fostered collaboration with external quality organizations, such as the American Hospital Association and the American College of Healthcare Executives.
- Conducted a Quality Measures Strategic Planning Summit at ACEP in February 2018 and developed a 3- year roadmap for identified priorities.
- Data validation projects were initiated with Yale University for sepsis measures and with EMI for other measures.
- Worked with CMS to provide clarity on 30 CEDR/QCDR measures that require consolidation, reconciliation, and harmonization. Twenty-four CEDR measures given provisional approval by CMS for 2018 QCDR MIPS submission.
- Responded to MACRA Measures Development Grant:
  - Application as ACEP Prime: 16 measures proposed across 5 buckets areas – Opioids, Alternate payment Models (APM), Admission Efficiency, Geriatrics, and Imaging Efficiency
  - Application as sub-recipient to John Hopkins – 3 measures for Patient Reported Outcomes
  - Application as sub-recipient to Society of Neuro Interventional Surgery (SNIS) – 6 measures for Stroke

2. Nominations
   - Nominate emergency physicians to represent ACEP to internal and external bodies developing quality measures that have relevance to the practice of emergency care. Provide a report to Sonja quarterly

Outcome: The nominations workgroup made recommendations to the ACEP president to ensure emergency physicians representation to several national quality initiatives:

Nominee	Organization	Workgroup
Dr. Richard Griffey	ACR Measures Committee	Quality and Safety Sub-Committee
Dr. Kelly Gray-Eurom	Hospital Star Rating TEP	
Dr. Anne Docimo	Hospital Star Rating TEP	
Dr. Andy Jagoda	American Academy of Neurology	Epilepsy Workgroup

Dr. Jordan Celeste	CMS	MACRA Episode-Based Cost Measures Project
Dr. Ethan Booker	CMS	MACRA Episode-Based Cost Measures Project
Dr. Heather Marshall	CMS	MACRA Episode-Based Cost Measures Project
Dr. William P. Jaquis	CMS	MACRA Episode-Based Cost Measures Project
Dr. David Friedenson	CMS	MACRA Episode-Based Cost Measures Project
Dr. Michael Phelan	CMS	Quality Measure Development
Dr. Arjun Venkatesh	CMS	Quality Measure Development
Dr. Dave Talan	CMS	Antibiotic Resistant Bacteria
Dr. Greg Moran	CMS	Antibiotic Resistant Bacteria
Dr. Steve Huff	AAN	Quality and Safety Subcommittee
Dr. Margaret Greenwood Ericksen	NQF	Rural Workgroup
Dr. Stephen Jameson	NQF	Rural Workgroup
Dr. Kendall Webb	NQF	Patient Safety
Dr. Richard Griffey	NQF	Patient Safety
Dr. Jesse Pines	NQF	Patient Safety
Dr. Deborah Diercks	CMS	MACRA Episode-Based Cost Measures Project - Wave 2
Dr. Chris Moore	CMS	MACRA Episode-Based Cost Measures Project - Wave 2

3. Federal Regulations & Education
   - Comment on the quality provisions of the Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), the Physician Fee Schedule (PFS), Medicare Access and CHIP Reauthorization Act (MACRA), and educate members regarding implementation and best practices for quality measures and federal quality measurement programs.
   - Develop educational resources and tools to assist members with navigating the Merit-Based Incentive Payment System (MIPS).
   - Collaborate with the Alternate Payment Models Task Force to monitor quality measures in Alternative Payment Models.
   - Lead Development of Maintenance of Certification Part IV.

Outcome:
- Submitted a formal comment on the 2018 QPP Proposed Rule in August 2018.
- Monthly webinars were conducted from July to December 2017 and every other month from January to June 2018 to educate members on MACRA, MIPS, CEDR, QCDR etc.
- Two Alternative Payment Model measures were added to the MACRA Grant application.
- Developed an Automated Interface between CEDR and ABEM.

4. Choosing Wisely Initiative
   - Monitor and respond to requests from the Choosing Wisely initiative. Obtain input from the Emergency Medicine Practice Committee and the Medical-Legal Committee.
     a. Provide periodic evidence-based literature review and updates to existing Choosing Wisely recommendations. Obtain input from the Emergency Medicine Practice Committee and Medical-Legal Committee.
     b. Provide periodic evidence-based reviews and consensus activities to support new areas for ACEP Choosing Wisely recommendations.
     c. Monitor recommendations of other Choosing Wisely partners for their potential impact on emergency care. Identify opportunities for collaboration on future efforts.
     d. Make recommendations for responding to other requests from the Choosing Wisely initiative.

Outcome:

- Nominations for inaugural EM Choosing Wisely Champions were solicited to recognize ACEP members who have promoted the Choosing Wisely concepts of avoiding low-value care through research, QI projects, advocacy, or educational initiatives.
  - Several dozen applications received representing academic and community sites, individual, department, and clinical system-level projects across the country.
  - Three recipients were selected and awards were presented at *ACEP17*.
- Submitted a paper to *Annals* about the relevance to emergency medicine of the Choosing Wisely recommendations from other specialties.
- Options for revising/removing/adding outdated CW recommendation presented to ACEP Board. Decision made to keep current recommendations with revised language.

5. Quality Improvement & Performance Improvement
   - Formalize role and workflow for new measure solicitation and manage measure lifecycles.
   - Collect candidate quality improvement projects and develop improvement tools.

Outcome: The measure owner program was created. Ten concept areas were assigned to 20 measure owners.

6. Patient Safety
   - Work to improve quality and patient safety by reducing unconscious bias and preventing knowledge gaps in the treatment of diverse populations.
   - Collaborate with content experts from the Diversity & Inclusion Task Force regarding development of health disparity quality measures.
   - Identify and collect articles for the new Quality E-Newsletter .

Outcome:

- A workgroup is developing a patient safety toolkit that can be disseminated in EDs across the country.
- The Quality E-Newsletter is published quarterly.

7. Review the following policies per the Policy Sunset Review process:
   - Standards for Measuring and Reporting of Emergency Department Wait Times

Outcome: The committee recommended that the policy statement be reaffirmed. The Board will review the committee's recommendation in September 2018.

8. Work with the Emergency Medicine Practice Committee to revise the policy statement "Definition of Boarded Patient." (Quality & Patient Safety is the lead committee.)

Outcome: The committee recommended that the policy statement be reaffirmed. The Board will review the committee's recommendation in September 2018.

2017-18
Annual Report

Reimbursement Committee

Chair: Michael A. Granovsky, MD, FACEP
Board Liaison: Jon Mark Hirshon, MD, PhD, MPH, FACEP
Staff Liaison: David McKenzie, CAE

1. Identify and analyze the governmental reimbursement environment as it pertains to emergency medicine and assist in positioning the College appropriately on issues of importance. Concentrate on audit activity and payment policies throughout the Medicare system.

Outcome: Work Group 1 tracked the audit experience survey this year, concentrating on the CMS Comprehensive Billing Report (CBR) survey and the impact on emergency physicians. The committee continued to monitor CMS MIPS and MACRA developments for emergency medicine.

2. Continue to identify and analyze reimbursement challenges that impact emergency medicine and recommend strategic solutions. Continue to monitor private payer practices such as balance billing and fair payment, and challenge health plan claim bundling practices. Track out of network payments and payer mix shifts based on the ACA and databases such as FAIR Health.

Outcome: In consultation with the Coding & Nomenclature Committee (CNAC) and the Joint Task Force (JTF), the committee continued to recognize the challenges presented by private payer practices to physician reimbursement. Work Group 2 addressed downcoding and denial issues from multiple insurers in more than a dozen states and continued to report to the committee and the State Legislative/Regulatory Committee on out-of-network/balance billing issues in more than 25 states during the 2017-18 legislative session.

3. Continue to support the efforts of the liaisons to the AMA RBRVS process, and advocate for improvement of work, practice expense, and malpractice relative values. Participate in any episode of care development activity in that venue.

Outcome: The CPT and RUC Teams continued their strong work on behalf of ACEP and emergency medicine with the successful survey of the E/M codes (99281-85) along with a re-survey of the code for changing a gastronomy tube (43760). Although the final values will not be available until November 2019, the resulting work values under consideration appear to be positive.

4. Identify and develop educational materials such as articles, webinars, and Frequently Asked Questions (FAQs) to provide members with practical information on developing reimbursement trends. Develop specific content for residents and young physicians. Develop FAQs on ERISA and ERISA exempt plans.

Outcome: Work Group 4 completed a review and update of five Reimbursement FAQs. Work included revising the Teaching Physician FAQ for compliance along with reaching out to CMS to get further clarification on the rule. The Work Group also completed a FAQ on ERISA plans as well as X-Rays and EKGs interpretation. The FAQs are available on the ACEP website.

5. Develop a strategy for emergency medicine to be represented in alternate payment models, including episodes and population health, to prepare for the transition from fee for service reimbursement to value-based reimbursement. Provide analysis of new payment models for emergency physician services that may replace or supplement the predominant fee for service model and offer advice on how ACEP members should prepare for these new models (ACOs, bundled payment, value-based reimbursement, etc.) Collaborate with the Alternative Payment Models Task Force as needed.

Outcome: The committee continues to support the work of the APM Task Force and provides recommendations when requested. The committee was informed of the first two APM submissions to the PTAC and is ready to assist in the coming year as needed. Work Group 5 is tracking emergency medicine experience in numerous evolving APMs.

6. Monitor Medicaid reforms at the state level and provide resources as appropriate. Participate as necessary with the National Conference of Insurance Legislators (NCOIL) on related activity addressing fair payment issues.

Outcome: The committee provided feedback and support on Medicaid reform. Work Group 6 worked on both Medicaid and Managed Medicaid issues in several states including Modifier 25 issues, downcoding of claims, and diagnosis lists.

7. Provide input to the Federal Government Affairs Committee to develop strategies to remove the exemption of Medicaid from the prudent layperson standard. (Federal Government Affairs is the lead committee.)

Outcome: The committee is available to assist the Federal Government Affairs Committee on this objective as needed.

8. Collaborate with the ACEP/EDPMA Task Force, Federal Government Affairs Committee, and State Legislative/ Regulatory Committee to assess the likelihood of federal and state legislation and other activity on out-of-network/balance billing and the advisability of introducing federal legislation. (Federal Government Affairs is the lead committee.)

Outcome: The committee continues to assist these committees and the task force on overreaching out-of-network/balance billing laws and regulations proposed in Congress and at the state level. The committee has completed a review of model legislation and advocacy materials.

9. Provide input to the State Legislative/Regulatory Committee and the ACEP-EDPMA Joint Task Force to develop resources to assist chapters with advocating for legislative solutions addressing fair payment and restrictions on balance billing. (State Legislative/Regulatory is the lead committee.)

Outcome: The committee assisted the Joint Task Force on out-of-network/balance billing issues in individual states. Work Group 2 was instrumental in providing a review of proposed payment methodologies in more than a dozen states. Additionally, committee members were selected to serve on the Joint Task Force Regional Strike Teams established to provide a quick response to state-level out-of-network/balance billing issues.

10. Develop messaging for return on investment per physician for ACEP's reimbursement initiatives.

Outcome: The committee developed an ROI information paper that describes the significant contribution the committee has provided to protecting emergency physician reimbursement over the past few years.

11. Investigate alternatives to FAIR Health for determining fair payment levels for emergency physicians.

Outcome: The committee Work Groups have looked at several alternatives to the FAIR Health Charges Database including the National Emergency Department Sample (NEDS), allowable payment databases (insurer controlled), Medicare, and state all-payer databases. The committee will continue to examine additional alternatives as well as rule out alternatives that are not suitable for preservation of emergency physician reimbursement. This objective will continue in 2018-19.

12. Develop resources (such as information paper, slides, podcast, etc.) on the transparency of the reimbursement process for all members.

Outcome: The committee created a slide presentation on the basics of emergency physician reimbursement and how to learn more about the process. The committee will work with ACEP staff to create additional resources in 2018-19.

13. Review the following policies per the Policy Sunset Review process:
    - Assignment of Benefits

Outcome: The Board of Directors reaffirmed the policy statement in February 2018.

14. Collaborate with the Academic Affairs Committee to develop an information paper on documentation by medical student on electronic health records and incorporating billing strategies. (Academic Affairs is the lead committee.)

Outcome: The committee provided input as requested. The information was added to the reimbursement area of the ACEP website as an FAQ.

15. Provide input to the Research Committee, in conjunction with the Emergency Medicine Practice Committee, Federal Government Affairs Committee, the Emergency Medicine Foundation, and the Emergency Medicine Action Fund to identify and coordinate health policy research. (Research is the lead committee.)

Outcome: The committee provided input as requested. EMF funded one health policy project and two NIDA grants.

16. Review Amended Resolution 28(17) Coverage for Patient Home Medication While Under Observation Status and determine if additional language is needed to develop a policy statement.

Outcome: The committee reviewed the language in the resolution and submitted the policy statement "Coverage for Patient Home Medication While Under Observation Status" to the Board of Directors. The policy statement was approved by the Board in June 2018.

17. Review Referred Resolution 41(17) Reimbursement for Hepatitis C Virus Testing in the ED and provide a recommendation to the Board regarding further action on the resolution.

Outcome: The committee assigned Work Group 6 to review the resolution and develop a recommendation. Work on this objective will continue in 2018-19.

2017-18
Annual Report

Research Committee

Chair: Phillip D. Levy, MD, FACEP
Board Liaison: Aisha T. Liferidge, MD, MPH, FACEP
Staff Liaison: Sandra Schneider, MD, FACEP

General Research Committee Objectives

1. Submit a nomination(s) for the 2018 ACEP Award for Outstanding Contribution in Research.

Outcome: The committee submitted a nomination by the deadline.

2. In collaboration with the American College of Osteopathic Emergency Physicians (ACOEP), identify strategies and resources to assist emergency medicine osteopathic residency programs accredited in the ACGME's single accreditation system (SAS) in meeting scholarly activity requirements for faculty and residents.

Outcome: This is an ongoing objective. A survey was drafted and the committee plans to obtain IRB approval, distribute the survey, and seek publication of the results. Work on this objective will continue in 2018-19.

3. In collaboration with SAEM's Research Committee, review and submit responses to the NIH's requests for information (RFIs).

Outcome: Two requests were received and responses were submitted.

4. Collaborate with the American College of Osteopathic Emergency Physicians and the Diversity & Inclusion Task Force to identify and promote future leaders in emergency medicine research.

Outcome: This is an ongoing objective. A validated survey was developed and approved by ACOEP to measure levels of grant funding as a baseline for leadership. The survey was administered by EMF in July 2018 with the goal of having results and a draft manuscript ready by fall. Work on this objective will continue in 2018-19.

5. Explore issues regarding erroneous reporting of research data and the process for submitting ethics complaints.

Outcome: The committee prepared a draft a process, but ultimately determined it was not within the scope of their work since there are other processes in place to address these issues. The president approved ceasing further work on the objective.

6. Investigate ways to identify, prevent, and counter egregious research (i.e., research whose funding source is not transparent and/or results that are misrepresented).

Outcome: The committee determined it was not within the scope of their work since there are other processes in place to address these issues. The president approved ceasing further work on the objective.

7. Identify emergency medicine research that results in innovative practice changes and promote the research at ACEP's annual meeting.

Outcome: A plenary session will be held at the 2018 Research Forum: "State-of-the-Art: Emergency Care Research Crossing the Boundary of Specialties."

8. Educate members on the work of SIREN and PETAL networks from the NIH and support/assist in the development of multi-institutional research networks.

Outcome: Work is in progress. The committee plans to develop a manuscript for submission to *Annals* and prepare an article for *ACEP Now.*

9. Develop an award presentation for research presented at Research Forum that year.

Outcome: Award recipients were notified during the 2017 *Research Forum*.

10. Develop a networking opportunity between residents, fellows, and senior emergency medicine researchers.

Outcome: The 2018 *Research Forum* will include a new networking space with abstracts available for viewing and ample space for researchers to gather. It will be co-branded and co-sponsored with EMF.

11. Develop strategies to create awareness and participation in the Emergency Medicine Practice Research Network (EMPRN).

Outcome: The committee developed an article for *ACEPNow* and is awaiting publication notification.

12. Collaborate with the Scientific Review Subcommittee to review and revise (as needed) EMF training and development grant opportunities.

Outcome: The committee determined that no revisions were needed at this time.

13. Collaborate with the Federal Government Affairs Committee, Emergency Medicine Practice Committee, Reimbursement Committee, the Emergency Medicine Foundation, and the Emergency Medicine Action Fund to identify and coordinate health policy research. (Research is the lead committee.)

Outcome: EMF funded one health policy project and two NIDA grants.

14. Complete development of a roadmap to enhance research education in emergency medicine residency programs.

Outcome: Work is in progress and will continue in 2018-19.

Research Forum Subcommittee
14. Implement the 2018 *Research Forum* meeting and evaluate the integration of *Research Forum* with *ACEP18*.

Outcome: Six plenary and state-of-the-art sessions will include CME. More than 800 abstract submissions were received and 421 were accepted (in addition to the state-of-the art of plenary sessions). The integration of the *Research Forum* into the programming for *Scientific Assembly* has been successful.

15. Identify strategies to improve and promote the *Research Forum*, including development of promotional language addressing the value and integration into *Scientific Assembly*.

Outcome: Social media promotional efforts were developed.

16. Select recipients for medical students, residents, young investigators, and best paper awards.

Outcome: Award recipients were notified during the 2017 *Research Forum*.

17. Develop and maintain a working list of past, present, and potential future non-committee member *Research Forum* abstract reviewers and e-poster session moderators.

Outcome: This objective was completed and staff maintain the list.

18. Develop a proposal for a research plenary session during the *ACEP19* opening session.

Outcome: A proposal was developed and submitted to the Education Committee.

Scientific Review Subcommittee
21. Assist EMF with funding opportunities.

Outcome: This is an ongoing objective. Relationships established with corporate, foundation, and government agencies.

22. Continue to explore potential collaborations with other specialty groups for grants.

Outcome: This is an ongoing objective. Discussions are occurring with NAEMSP, Envision, FAAR, Schumacher, and AFFIRM.

23. Review grant proposals for EMF and recommend applicant funding and provide on-going monitoring of funded grant progress reports.

Outcome: The subcommittee reviewed and scored more than 90 grant proposals and recommended 20 grant awards to EMF for funding. The subcommittee chair reviewed and approved the mid-term progress reports.

24. Continue to identify potential areas of further targeted research that are of interest to the members.

Outcome: This is an ongoing objective. Ideas were generated from discussions at the Corporate Council meeting and in discussions with committees and section members.

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Annual Report

State Legislative/Regulatory Committee

Chair: Chadd Kraus, DO, DrPH, FACEP
Board Liaison: Alison J. Haddock, MD, FACEP
Staff Liaison: Harry Monroe

1. Report on the effects of state Medicaid waivers on the practice of emergency medicine and patient access to care. Specifically, include effects from changes in copays for emergency department visits, or varied Medicaid state reimbursement based on "non-emergent" visits to the emergency department. Collaborate with content experts from the ACEP-EDPMA Joint Task Force.

Outcome: The Board reviewed the information paper "Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine" in June 2018. The paper will be available on the ACEP website when finalized. A summary document was also produced and shared with EDPMA and chapters.

2. Summarize the status of Medicaid program developments that compromise the prudent layperson standard. Update the toolkit of resources that can be used by states responding to challenges to the prudent layperson standard by legislatures, regulatory agencies, and managed care vendors. Collaborate with content experts from the ACEP-EDPMA Joint Task Force.

Outcome: Work is in progress and will continue in 2018-19.

3. Research and report on current state legislation addressing fair payment and restrictions on balance billing, and state legislation that sets forth a methodology for determining reimbursement from insurers for out-of-network services when balance billing is restricted or prohibited. Collaborate with content experts from the Reimbursement Committee. (State Legislative/Regulatory is the lead committee.)

Outcome: A document is in development that summarizes challenges in key states this year. The document will be used as a resource for strategic planning in 2018-19.

4. Provide input to the ACEP-EDPMA Joint Task Force, Federal Government Affairs Committee, and the Reimbursement Committee to assess the likelihood of federal and state legislation and other activity on out-of-network/balance billing and the advisability of introducing federal legislation. (Federal Government Affairs is the lead committee.)

Outcome: There were no significant developments at the federal level. Committee members worked with the Reimbursement Committee, the ACEP/EDPMA Joint Task Force, and staff to monitor this issue.

5. Research and report on legislative mandates and restrictions on opioid prescriptions in the emergency department, with a focus on how legislation comports with evidence based medical practice.

Outcome: The committee compiled information and it will be available on the ACEP website.

6. Review the "ER is for Emergencies" program in Washington State. Identify elements of the program that would be transferable to other states and develop resources to promote those items.

Outcome: The committee collected information regarding the Washington State program and organized the material into recommendations for other states to utilize.

7. Research and report on efforts by states to address mental health boarding in EDs, including the extent of the problem, state responses that have been successful, and identification of resources for EDs.

Outcome: The work group collected and organized material from various sources outlining the availability of mental health resources in all states. The material will be shared with state chapters as both practice and advocacy resources.

8. Continue to promote and administer the state public policy grant program.

Outcome: Grants in excess of $37,500 were approved by the Board of Directors. A work group is in the process of developing a mechanism for better follow up as to how the grants are used.

9. Submit a nomination for the 2018 Rorrie Health Policy Award.

Outcome: The committee submitted a nomination by the deadline.

10. Submit a nomination for the 2018 Policy Pioneer Award.

Outcome: The committee submitted a recommendation for the first award recipient. The Board approved the nominee in April 2018.

11. Identify physicians and others with connection to emergency medicine interested in seeking state-elected office. Create resources to assist in their decision-making process.

Outcome: The committee developed a document outlining a method for identifying and maintaining a list of those seeking elective office and includes resources for potential candidates. The document will be provided to the Board for review in September 2018. It will then be distributed to all chapters and made available on the ACEP website.

12. Develop a system to track legislator's connections to emergency medicine and their votes on emergency medicine related bills in the state.

Outcome: Mechanisms for fulfilling and maintaining the information were considered. Maintenance of the information would require significant staff resources.

13. Review the following policies per the Policy Sunset Review process:
    - Ensuring Emergency Department Patient Access to Adequate and Appropriate Pain Treatment
      Outcome: The Board approved the revised policy statement in February 2018.

    - Good Samaritan Protection
      Outcome: The Board approved the revised policy statement in February 2018.

    - Opposition to Routine Abscess Culturing. Provide input to the Clinical Policies Committee on state legislative requirements for this policy. (Clinical Policies is the lead committee.)
      Outcome: The Board approved the revised policy statement in February 2018.

14. Provide input to the National Chapter/Relations Committee and Membership Committee to identify opportunities for regional collaboration and conferences. (National/Chapter Relations is the lead committee.)

Outcome: The committees were not able to identify areas of meaningful collaboration or opportunities for regional collaboration and conferences. Concerns were expressed that the objective was broad and collaboration between chapters usually occurs organically. Chapters that do not currently have an annual educational conference may be suitable to collaborate on a joint meeting and to gather information (challenges, best practices, etc.) from chapters that currently collaborate on programs. A toolkit of resources could be developed for chapters seeking to create regional collaboration and conferences.

15. Identify and disseminate information on alternative funding programs to fund Medicaid and uncompensated care.

Outcome: This objective is in progress and will focus on some California approaches to finding alternative funding.

16. Provide input to the EMS Committee to address Resolution 27(17) 911 Number Access and Prearrival Instructions. (EMS is the lead committee.)

Outcome: The committee provided input as requested. The policy statement "Access to 9-1-1 Public Safety Centers, Emergency Medical Dispatch & Public Emergency Aid Training" was approved by the Board in June 2018.

17. Obtain input from the EMS Committee regarding Amended Resolution 29(17) CPR Training. (State Legislative Regulatory is the lead committee.)

Outcome: The committee collaborated with the EMS committee and obtained material from outside resources to develop a toolkit of resources. The resources are available on the ACEP website.

18. Develop a policy statement in response to Amended Resolution 39(17) ACEP Involvement in State Legislative Activities.

Outcome: The Board approved a policy in May 2018.

19. Develop strategies to address Amended Resolution 55(17) Workplace Violence, including model legislative and regulatory language that can be shared with state chapters and hospitals addressing workplace violence

Outcome: The committee has compiled information and resources that will be used to develop a toolkit for chapters.

2017-18
Annual Report

Well-Being Committee

Chair: Rita Manfredi-Shutler, MD, FACEP
Board Liaison: Debra G. Perina, MD, FACEP
Staff Liaison: Veronica Mason, Nicole Tidwell

1. Wellness Week
   - Continue to enhance and implement the Wellness Week program for emergency physicians and providers to encourage personal and professional wellness strategies.
   - Promote Wellness Week and wellness activities and strive for a 30% participation rate of all ACEP members.
   - Develop an electronic repository for documentation of Wellness Week events by participants.

Outcome: Wellness Week occurred Sunday, March 11, 2018 through Saturday March 17, 2018. The committee will continue to enhance and implement the Wellness Week Program and will include an international collaboration with other emergency medicine organizations in 2019. The response to the 2018 Wellness Week was higher than the previous year. Wellness Week 2019 will be held Sunday April 7, 2019 through Saturday April 13, 2019.

Initiatives Identified for the 2018 Wellness Week
- Email themes for the day followed the seven spokes of the Wellness Wheel
- Individual Daily Challenges posted to Facebook and Twitter
- Departmental Challenge
- International participation included EM organizations from Canada, Australia, and Turkey

Email Statistics
The list has grown by 200 since last year's Wellness Week and the average unique open rate is about 48% with an average click rate of about 17%. Last year for the entire week, the open rate was higher (58%), but the click rate was lower (5%), which indicates members are finding more value in the email content this year since they are clicking through to learn more.

	Sent	Opened (%)	Unique Opened (%)	Clicked (%)	Unsubscribed (%)
Sunday	708	1400 (198%)	370 (52%)	277 (39%)	1 (0%)
Monday	715	1114 (156%)	350 (49%)	93 (13%)	2 (0%)
Tuesday	737	970 (132%)	368 (50%)	130 (18%)	0 (0%)
Wednesday	743	882 (119%)	366 (49%)	164 (22%)	0 (0%)
Thursday	745	622 (83%)	320 (43%)	54 (7%)	1 (0%)
Friday	745	747 (103%)	317 (44%)	96 (13%)	1 (0%)
Saturday	745	668 (91%)	339 (46%)	38 (5%)	1 (0%)

Social Media Statistics
Facebook
- 220 new followers
- 50 posts
- 5.5 average engagements per post
- Fairly steady engagement and impression

Twitter – @ACEPNow
- 105 new followers
- 50 tweets
- 5.6 average engagement per tweet
- Fairly steady with large growth toward the end of the week

Twitter – #iEMWell18
- Approximately 2,500 tweets (compared to 915 tweets in 2017)
- Approximately 3.6 million impressions (compared to 1.5 million in 2017)
- 426 contributors (compared to 306 in 2017)

2. Promote wellness information available for members. Develop a multimodal campaign for a culture change for emergency physicians to focus on the positive accomplishments in the ED.

Outcome: The Gratification in Emergency Medicine (GEM) project was developed to focus on the critical components of joy in emergency medicine as outlined in the IHI Framework for Improving Joy in Work. The GEM logo was created to embody the value of emergency physicians and to incorporate the nine critical components visually. The first phase of the project included Rewards and Recognition and was launched through a survey to ACEP wellness members. An executive summary was produced from the results with recommendations were to focus on the rewards and recognition component of GEM. This data will be displayed at *ACEP18* at the Wellness Booth in poster form. Additional presentations/publications are not yet determined. The goal is for this facet to be the beginning of a longitudinal project with each facet to be addressed.

3. Continue collaborating with the Education Committee to develop interactive online tutorials (several short modules) on resiliency strategies for members as part of Wellness Week activities and explore the possibility of providing CME. (Well-Being is the lead committee.)

Outcome: The Resiliency Toolkit was completed in March 2018 and is available on the ACEP.org wellness page. "52 Tips for Building Resiliency" was initiated as a weekly post (Wellness Wednesday) beginning June 20, 2018, on the EMDocs Facebook page. These are short resilience "tidbits" specific to emergency medicine that feature approaches to increasing resiliency. This objective will continue in 2018-19.

4. Explore and evaluate 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.

Outcome: The committee conducted a review of the medical literature to evaluate reasons for physician and nurse turnover. There is a paucity of literature in emergency medicine. The Emergency Nurses Association agreed to partner with ACEP and share data. A survey was developed to gather data on the reasons emergency physicians leave practice. ABEM was contacted to request using their longitudinal survey data to provide insight regarding physician turnover. ABEM's response is pending. Questions were also developed for the ACEP Wellness Survey that will be disseminated late 2018. Work on this objective will continue in 2018-19.

5. Develop a series of articles for submission to *ACEP Now*, including how to improve being well in emergency medicine and bringing "joy" to practice.

Outcome: Six articles were submitted for publication consideration. One article was included in the print edition, two are under consideration for publishing, and three are available on the ACEP website.

- Turning the ACEP Wellness Wheel into My Sabbatical
- Procedural Prowess as a Shield for Burnout
- Wellness is More Than Eating Right and Exercising More: ACEP's Visionary Concept of Well-Being

6. Monitor the 2017 Wellness Center and provide recommendations for 2018. Provide resources to ACEP members with innovation and outreach for all age groups of emergency physicians. Implement changes to address Resolution 18(17) Wellness Center Services.

Outcome: Several changes have been made for the 2018 Wellness Center:

- Reinstated blood draws for 2018 and increased the fee to cover the cost.
- Reviewed the burnout survey and added online capability or iPad on site.
- Moved the pet therapy booth next to the wellness pod.
- Individual tasked with a hand clicker, scanner, wall-based scanned (how to incentivize attendees to scan their own badge on a wall) have giveaways of wellness t-shirt etc. to incentivize people to scan in be counted as a visitor.
- Wellness Center backdrop with hashtag to encourage group photos.
- Increase the speaker volume and add TED talk signage.
- Allow freelance drawing instead of an artist's mural.
- Additional signage to promote the Story Booth.
- Additional seating, background music, and charging stations.

- Promote the Wellness Center on social media.
- Provide fun photo opportunities.
- Distribute buttons, t-shirts, and a water bottle with the wellness logo or #Wellness.
- Ask Wellness Champions to announce speakers.

7. Collaborate with the Emergency Nurses Association, the Society for Emergency Medicine Physician Assistants, and the American Academy of Nurse Practitioners to identify exemplary practices that promote wellness.

Outcome: Work is in progress and will continue in 2018-19.

8. Coordinate wellness efforts between ACEP and other major emergency medicine organizations. Conduct outreach with international emergency medicine organizations to share ideas and opportunities for collaborate on an international basis. Collaborate with the International Emergency Medicine Section and the Disaster Medicine Section. Investigate the potential of creating a Wellness Institute.

Outcome: A list of organizations was developed with committee members assigned to each. A subcommittee discussed opportunities for outreach, engagement, and collaboration with international emergency medicine organizations. Emergency medicine organizations in Australia, Canada, and Turkey participated in Wellness Week and the activities conducted by these countries was compiled. The committee will continue collaborating with these three countries and engage other countries if possible.

9. Review the following policies per the Policy Sunset Review process:
   - Family Leave of Absence

Outcome: The Board of Directors will review the revised policy statement in September 2018.

10. Provide input to the Medical-Legal Committee in the review of medical legal resources, including litigation stress, on the ACEP website and develop new or additional resources regarding litigation stress. (Medical-Legal is the lead committee.)

Outcome: The committee provided input as requested.

11. Continue collaboration with Academic Affairs Committee and EMRA to identify and/or develop resources for residents and medical students to address resiliency and coping mechanisms. (Academic Affairs is the lead committee.)

Outcome: Work is in progress and will continue in 2018-19.

12. Collaborate with the ACEP/ABEM Task Force on Aging Physicians to develop resources. Review ACEP's current resources and develop resources as needed to address interruption of clinical emergency medicine practice as directed by Resolution 51(17) Retirement or Interruption of Clinical Emergency Medicine Practice.

Outcome: Work is in progress and will continue in 2018-19.

13. Collaborate with the Emergency Medicine Practice Committee and the Membership Committee to develop a resiliency toolkit and include information such as decompression tips after a shift, debriefing after critical incidents, and multitasking. Explore the use of screening tools such as the Mayo Clinic document. Develop additional resources for medical directors and department chairs. (Well-Being is the lead committee.)

Outcome: The Resiliency Toolkit was completed in March 2018 and is available on the ACEP.org wellness page.
"52 Tips for Building Resiliency" was initiated as a weekly post (Wellness Wednesday) beginning June 20, 2018, on the EMDocs Facebook page. These are short resilience "tidbits" specific to emergency medicine that feature approaches to increasing resiliency. This objective will continue in 2018-19.

14. Develop a policy statement on paid parental leave for emergency physicians and develop an information paper on best practices regarding paid parental leave for emergency physicians in response to Amended Resolution 36(17) Maternity and Paternity Leave.

Outcome: The Board of Directors will review a draft policy statement in September 2018.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2018-19 Committee Structure

COMMITTEE	CHAIR	STAFF LIAISON
Academic Affairs Committee (Dr. Schmitz)	Chad Kessler, MD, MHPE, FACEP	Sandy Schneider, MD, FACEP
Audit Committee (Dr. Anderson)	Joshua B. Moskovitz, MD, FACEP	Layla Powers, MBA
Awards Committee (Prsesident-Elect)	President-Elect	Sonja Montgomery, CAE
Bylaws Committee (Vice President)	Larisa M. Traill, MD, FACEP	Leslie Moore, JD
Bylaws Interpretation Committee (President-Elect)		Leslie Moore, JD
Clinical Emergency Data Registry Committee (Dr. Augustine)	Abhi Mehrotra, MD, FACEP	Pawan Goyal, MD
Clinical Policies Committee (Dr. Hirshon)	Stephen J. Wolf, MD, FACEP	Rhonda Whitson, RHIA Travis Schulz, MLS, AHIP
Coding & Nomenclature Advisory Committee (Dr. Hirshon)	David G. Friedenson, MD, FACEP	David McKenzie, CAE
Compensation Committee	Marco Coppola, DO, FACEP	Layla Powers, MBA
Disaster Preparedness & Response Committee (Dr. Kang)	Marc S. Rosenthal, DO, FACEP	Pat Elmes, EMT-P
Education Committee (Dr. Klauer)	Matthew Bitner, MD, FACEP	Robert Heard, MBA, CAE
Emergency Medicine Practice Committee (Dr. Rosenberg)	Michael A. Turturro, MD, FACEP	Margaret Montgomery, RN, MSN
EMS Committee (Dr. Perina)	Julio R. Lairet, DO, FACEP	Rick Murray, EMT-P
Ethics Committee (Dr. Kang)	Raquel M. Schears, MD, FACEP	Leslie Moore, JD
Federal Government Affairs Committee (President-Elect)	Carlton E. Heine, MD, FACEP	Laura Wooster, MPH
Finance Committee (Dr. Anderson)	Gary C. Starr, MD, FACEP	Layla Powers, MBA
Medical-Legal Committee (Dr. Klauer)	John Bedolla, MD, FACEP	Craig Price, CAE

COMMITTEE	CHAIR	STAFF LIAISON
Membership Committee (Dr. Haddock)	Achyut B. Kamat, MD, FACEP	Michele Byers, CAE, CMP
National/Chapter Relations Committee (Dr. Jaquis)	Mark Notash, MD, FACEP	Maude Hancock
Pediatric Emergency Medicine Committee (Dr. Perina)	Mohsen Saidinejad, MD, MBA, FACEP	Sam Shahid, MBBS, MPH
Public Health & Injury Prevention Committee (Dr. Augustine)	Alan Heins, MD, FACEP	Margaret Montgomery, RN, MSN
Public Relations Committee (Dr. Anderson)	Rade Vukmir, MD, JD, FACEP	Laura Gore
Quality & Patient Safety Committee (Dr. Liferidge)	Richard Griffey, MD, MPH, FACEP	Pawan Goyal, MD
Reimbursement Committee (Dr. Hirshon)	Heather A. Marshall, MD, FACEP	David McKenzie, CAE
Research Committee (Dr. Liferidge)	Manish Shah, MD, FACEP	Sandy Schneider, MD, FACEP
State Legislative/Regulatory Committee (Dr. Haddock)	Chadd Kraus, DO, DrPH, MPH, FACEP	Harry Monroe
Well-Being Committee (Dr. Perina)	Arlene Chung, MD	Nicole Tidwell Veronica Mason

2018-19
Final Committee Objectives

Academic Affairs Committee

Chair: Chad Kessler, MD, MHPE, MD, FACEP
Board Liaison: Gillian R. Schmitz, MD, FACEP
Staff Liaison: Loren Rives, MNA

1. Continue collaboration with EMRA to:
   a. Complete development of a leadership/business curriculum for medical students and residents.
   b. Complete the development of a personal financial literacy curriculum for medical students and residents.

2. Continue collaboration with EMRA and the Well-Being Committee to identify and/or develop resources for residents and medical students to address resiliency and coping mechanisms. (Well-Being is the lead committee.)

3. Develop and provide resources that highlight the benefits of residency programs to the institution, including information on how EM programs are funded and alternative methodologies for funding.

4. Solicit nominations and recommend recipients for the:
   a. National Faculty and Junior Faculty Teaching Awards (nominations are approved by the Board)
   b. Excellence in Bedside Teaching Award (nominations are approved by the Board)
   c. National Outstanding Medical Student Award (nominations approved by the Board)
   d. Local Medical Student Awards (nominations are approved by the Academic Affairs Committee)

5. Review and recommend journal articles, texts, practice guidelines, and important advances relating to ABEM's Lifelong Learning Self-Assessment (LLSA) and emergency medicine practice.

6. Complete development of the following information papers:
   a. Complete benefits of the academic partnership between the VA and a residency program.

7. Identify aspects of an academic practice that lead to low burnout rates and greater career satisfaction.

8. Provide resources for faculty and residents on EM Model Milestones Project 2.0.

9. Develop a resource for medical students and residents about subspecialty certifications and opportunities after EM residency. Collaborate with EMRA.

10. Develop a guide for writing letters of recommendation for academic promotion.

11. Explore resources and opportunities for returning physicians for focused practice improvement.

12. Review the following policy per the Policy Sunset Review Process:
    - Scholarly Sabbatical Leave for Emergency Medicine Faculty

    Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

13. Explore ways to encourage support of protected time for faculty in residency programs. Collaborate with the Research Committee. (Academic Affairs is the lead committee.)

14. Explore development of an information paper, FAQs, or other resources to address falsifying data in research. Collaborate with the Research Committee. (Academic Affairs is lead committee.)

2018-19
Final Committee Objectives

Audit Committee

Chair: Josh Moskovitz, MD, FACEP
Board Liaison: Stephen H. Anderson, MD, FACEP, Secretary Treasurer
Staff Liaison: Layla Powers, MBA

1. Oversee the audit function of the College as stated in the Audit Committee charter.

2. Continue to monitor and test the Cyber Security System.

2018-19
Final Committee Objectives

Awards Committee

Chair: President-Elect
Board Liaison: President-Elect
Staff Liaison: Sonja Montgomery, CAE

1. Recommend 2019 award recipients.

2018-19
Final Committee Objectives

Bylaws Committee

Chair: Larissa Traill, MD, FACEP
Board Liaison: Vice President
Staff Liaison: Leslie Moore, JD

1. Provide ongoing review of national Bylaws to identify areas where revision may be appropriate and submit recommendations to the Board of Directors

2. Continue implementation of the revised Chapter Bylaws Review Plan.

3. Review and revise the chapter bylaws review and approval process to ensure effectiveness and efficiency. Reassess communications with chapters and educate committee members on best practices to accomplish their assigned tasks.

4. Review proposed 2019 Bylaws resolutions to determine if there are conflicts with other portions of the Bylaws. Review proposed 2019 Council Standing Rules and proposed 2019 College Manual resolutions to determine if there are implications for the Bylaws if these resolutions are adopted. Provide comments to the resolution authors as needed.

5. Review 2018 Bylaws amendments adopted by the Council and the Board for potential Bylaws Committee action.

6. Complete revisions to the Guidelines for Bylaws and Model Chapter Bylaws.

2018-19
Final Committee Objectives

Bylaws Interpretation Committee

Chair: Elected by Committee Members
Board Liaison: Vice President
Staff Liaison: Leslie Moore, JD

Note: The committee is assigned as needed for definitive interpretation of Articles VIII – Council, IX – Board of Directors, X – Officers/Executive Director, XI – Committees, and XIII – Amendments, of the ACEP Bylaws.

2018-19
Final Committee Objectives

Clinical Emergency Data Registry Committee

Chair: Abhi Mehrotra, MD, FACEP
Board Liaison: James J. Augustine, MD, FACEP
Staff Liaison: Pawan Goyal, MD

1. Develop data analytics capabilities to meet the following goals
   a. Annual data validation and reliability testing
   b. Annual reporting of summary statistics and benchmarking
   c. Cleaned, deidentified data for research
   d. Ad hoc responses to government requests

2. Support the quality development lifecycle by providing feedback on existing quality measures and supporting testing efforts for new quality measures.

3. Revise and update the Clinical Emergency Data Registry dashboard to provide continuous quality feedback to members.

4. Review materials developed by ACEP staff that support the Clinical Emergency Data Registry.

5. Publish a quarterly newsletter for participants.

6. Work with E-QUAL and ABEM to develop a learning lifecycle for ACEP members.

2018-19
Final Committee Objectives

Clinical Policies Committee

Chair: Stephen J. Wolf, MD, FACEP
Board Liaison: Jon Mark Hirshon, MD, PhD, MPH, FACEP
Staff Liaisons: Rhonda Whitson, RHIA, Travis Schulz, MLS, AHIP

1. Continue to monitor clinical policies developed by other organizations, abstract information pertinent to emergency medicine, post the abstraction on the ACEP website, and communicate the information to members through ACEP communications.

2. Review and comment on other organizations' guidelines under development or for which endorsement has been requested, post the endorsement information on the ACEP website, and communicate the information to members through ACEP communications.

3. Provide recommendations for appointments to outside entities requesting member representation on guideline development panels.

4. Continue updating or modification of current clinical policies as necessary:
   a. Opioids: (Include elements of Amended Resolution 35-15: Create clinical practice guidelines for treatment of patients presenting to the ED in opioid or benzodiazepine withdrawal; and create a practice resource to educate emergency providers about the science of opioid and benzodiazepine addiction.)
   b. Acute heart failure syndromes
   c. Headache
   d. Mild traumatic brain injury
   e. Community-acquired pneumonia
   f. Appendicitis
   g. Acute blunt abdominal trauma
   h. Asymptomatic elevated blood pressure
   i. Procedural sedation
   j. Seizures
   k. Thoracic aortic dissection
   l. tPA for acute ischemic stroke

5. Serve as a resource and continue working with the Quality & Patient Safety Committee to identify performance measures in new and revised clinical policies. (Quality & Patient Safety is the lead committee.)

6. Review the following policy per the Policy Sunset Review Process:
   - Use of Peak Expiratory Flow Rate Monitoring for Management of Asthma in the ED (and PREP)

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

2018-19
Final Committee Objectives

Coding & Nomenclature Advisory Committee

Chair: David Friedenson, MD, FACEP
Board Liaison: Jon Mark Hirshon, MD, PhD, MPH, FACEP
Staff Liaison: David McKenzie, CAE

1. Identify and analyze Medicare, Medicaid, and private payer claims processing policies that deviate from CPT principles and/or documentation guidelines and recommend strategic solutions. Track payer issues such as denials, rates, appeals, and pay for performance. Monitor the Recovery Audit Contractor (RAC), and other audit activities, and react appropriately to issues affecting emergency medicine.

2. Track ICD-10 implementation and continue to provide educational material on ICD-10 for members to aid in their reimbursement. Collaborate with content experts from the Quality & Performance Committee to ensure ACEP measures use appropriate ICD-10-CM/PCS mapping assignments. Continue to monitor the impact of ICD-10 implementation, evaluate the effect on reimbursement, and modify educational materials as needed.

3. Continue to advocate nationally for emergency medicine issues through the AMA CPT process and through possible CMS development of physician or facility documentation guidelines. Monitor efforts for transparency and claims processing edits. Explore development of an ED-specific code, such as using alternative payment models (APMs), for care coordination or transition to the post-acute setting.

4. Identify and develop educational materials such as articles, webinars, and Frequently Asked Questions (FAQs) to provide members with up-to-date information that will facilitate an effective balance between optimal coding and compliance.

5. Develop a strategy to seek reimbursement for counseling on safe opiate use, reversal agent instruction, and drug abuse counseling for patients as directed in Resolution 28(16) Reimbursement for Opioid Counseling.

6. Investigate the creation of a mechanism to collect information for use in fighting down-coding and show value of ED services and make a recommendation for implementation.

7. Explore developing codes for alternative payment models, including community paramedicine and mobile integrated health care. Collaborate with the EMS Committee and other committees as needed. (CNAC lead committee.)

2018-19
Final Committee Objectives

Compensation Committee

Chair: Marco Coppola, DO, FACEP
Board Liaison: None
Staff Liaison: Layla Powers, MBA

1. Establish stipends for Board members, Board officers, and Council officers.

2. Monitor compensation trends for the Board of Directors and officers of other medical specialties to ensure ACEP members are compensated appropriately.

2018-19
Final Committee Objectives

Disaster Preparedness & Response Committee

Chair: Marc Rosenthal, DO, FACEP
Board Liaison: Christopher S. Kang, MD, FACEP
Staff Liaison: Pat Elmes, EMT-P

1. Continue to utilize identified national and international organizations active in disaster medical preparedness and response to assure appropriate liaisons and channels of communication with ACEP to seek opportunities to increase collaboration and development of in-time resources available to working ED doctors for when events happen.

2. Collaborate with the Disaster Medicine Section and the Pediatric Emergency Medicine Committee to explore incorporating an advanced level within the existing Mass Casualty Medical Operations Course or a separate course using the current course as a prerequisite. (Disaster Preparedness & Response Committee is the lead committee.)

3. Develop recommendations for improved system response in disasters and high threat situations through ACEP interaction with related external organizations such as ACS, NDMS, federal governmental agencies, ACOEP and hospitals, as well as, other ACEP committees and sections to develop recommendations for disasters and high threat situations.

4. Implement the Disaster Medical Sciences Award.

5. Monitor the national disaster medicine environment for federal regulations, new guidelines, standards, and technologies that potentially significantly impact disaster medicine and provide recommendations to the Board as needed.

6. Serve as a resource and provide input to the Education Committee to explore online and other EMS, disaster, and other related training for emergency physicians. (Education is the lead committee.)

7. Collaborate with fellowship directors to compile a list/database of all disaster fellowships and similarities/differences and continue to explore development of a Disaster Medicine board certification.

8. Explore ways to collaborate with existing groups, such as the National Center for Disaster Public Health (NCDPH), to collect disaster data and engage members to share data and reports about disaster events.

9. Review the following policies per the Policy Sunset Review Process:
   - Disaster Medical Response
   - Handling of Hazardous Materials
   - Support for National Disaster Medical System and Other Response Teams

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

10. Provide input to the Education Committee to explore online and other EMS, disaster, and other related training for emergency physicians. (Education is the lead committee.)

11. Provide input to the EMS Committee to continue the work started by the High Threat Casualty Care Task Force (HTCCTF) towards:
    - creation of a high-threat incident database, standardized data-gathering tool, and support the creation of data-gathering rapid response to enable rapid dissemination of lessons-learned
    - enhance the translation of military lessons learned, consistent with Mission Zero, throughout the emergency medicine community
    - develop a public relations information campaign centered on mitigation, preparedness, response to and recovery from high-threat incidents. (EMS the lead committee.)

2018-19
Final Committee Objectives

Education Committee

Chair: Matthew Bitner, MD, FACEP
Board Liaison: Kevin M. Klauer, DO, EJD, FACEP
Staff Liaison: Robert Heard, MBA, CAE

1. Identify member educational needs based on assessments from a variety of sources, including state and facility CME requirements, board certification requirements, quality measures, test results, activity evaluations, member surveys, ACEP.org search terms and ACGME Milestones.

2. Design, implement, evaluate, and revise educational activities that meet identified needs and enhance ACEP's position as the primary source for state-of-the-art emergency medicine education, including:
   a. Live and enduring CME activities on the emergency medicine core content designed to reinforce cognitive expertise.
   b. Alternative educational opportunities such as simulation courses for procedural competencies and skills.
   c. Mobile and online CME courses and other activities that incorporate new learning technologies.
   d. Podcasts, social media, FOAMed.
   e. Performance Improvement-CME activities approved for the ABEM Improvement in Medical Practice requirements; Explore MOC on Mental Health in the ED (Adults and Children).
   f. Digital editions of ACEP titles published for a variety of reading devices.
   g. EMS subspecialty certification prep resources.
   h. Activities designed to help students, residents, and young physicians during early years of practice.
   i. Activities specific to the issue of litigation stress.
   j. Educational products related to the Clinical Emergency Data Registry Learning Collaborative.
   k. Educational products related to Geriatric Emergency Department Accreditation (GEDA) Learning Collaborative.
   l. Develop educational products for preventing prescription opioid misuse and addiction

3. Submit a nomination for the 2019 ACEP Award for Outstanding Contribution in Education.

4. Pursue strategic partnerships with publishers and other organizations that contribute to the College's CME mission, goals, and objectives.

5. Develop CME activities for physicians and providers practicing emergency medicine in resource-limited settings.

6. Explore cost-efficient ways to provide education to international emergency physicians. Enhance ACEP's expertise internationally in marketing publications and meetings. Design and implement ACEP International Global Leadership program. Create ACEP Live channel for International members and audience to have access to educational online products.

7. Explore online and other EMS, disaster, and other related training for emergency physicians. Collaborate with the EMS Committee and the Disaster Preparedness & Response Committees. (Education is the lead committee.)

8. Maximize the delivery platform for educational products to improve discoverability and access.

9. Continue exploring ways to increase diversity in the faculty for ACEP educational meetings and education programs. Ensure educational products to include diversity and inclusion throughout offerings and include topics such as unconscious bias in clinical care and practice management.

10. Provide oversight for ACEP's international initiatives, including the international ambassador program and conference, international conference support, *Scientific Assembly* international scholarship program, and international networking reception at *Scientific Assembly*. Also provide oversight on projects involving educational offerings for international members/societies. Collaborate with the International Emergency Medicine Section.

11. Collaborate with the Well-Being Committee to complete development of interactive tutorials on resiliency strategies for members as part of Wellness Week activities and explore the possibility of providing CME. (Well-Being is the lead committee.)

2018-19
Final Committee Objectives

12. Explore online and other EMS, disaster, and other related training for emergency physicians. Collaborate with the EMS Committee and the Distaster Preparedness & Response Committee. (Education is the lead committee

13. Provide input to the Pediatric Emergency Medicine Committee to develop a simulation-based consensus curriculum for pediatric emergency medicine, in collaboration with other organizations and for open access. (Pediatric Emergency Medicine is the lead committee.)

14. Provide input to the National/Chapter Relations Committee to develop resources to address the needs of small and medium sized chapters that were identified by the 2018 chapter services survey. (National/Chapter Relations is the lead committee.)

15. Work with the Research Committee to implement a research plenary session during the *ACEP19* opening session. (Education is the lead committee.)

2018-19
Final Committee Objectives

Emergency Medicine Practice Committee

Chair: Michael A. Turturro, MD, FACEP
Board Liaison: Mark S. Rosenberg, DO, MBA, FACEP
Staff Liaison: Margaret Montgomery, RN, MSN

1. Review the following policies per the Policy Sunset Review Process:
   - Crowding
   - Economic Credentialing
   - Emergency Medicine Telemedicine
   - EMTALA and On-call Responsibility for Emergency Department Patients
   - Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department
   - Patient Medical Condition Identification Systems
   - Patient Support Services
   - Providers of Unsupervised Emergency Department Care
   - Providing Telephone Advice from the Emergency Department

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

2. Compile information on existing models for addressing transitions of care for patients with opioid use disorders. Collaborate with the Pain Management & Addiction Medicine Section and the Public Health & Injury Prevention Committee. (Emergency Medicine Practice is the lead committee.)

3. Collaborate with the Pain Management & Addiction Medicine Section to explore development of webinars on alternatives to opioid treatments highlighted in the web based app. (Emergency Medicine Practice is the lead committee.)

4. Continue to review and provide input to outside organizations (such as AHA, TJC, AMA) on emergency medicine practice issues.

5. Review and identify gaps in current beside tools for clinicians.

6. Implement the 2019 Community Emergency Medicine Award and Innovation in Practice Award.

2018-19
Final Committee Objectives

EMS Committee

Chair: Julio Lairet, DO, FACEP
Board Liaison: Debra G. Perina, MD, FACEP
Staff Liaison: Rick Murray, EMT-P

1. Continue to develop resources and guidelines for EMS medical directors addressing Mobile Integrated Healthcare (MIH) and Community Paramedicine (CP) programs and collaborate with NAEMSP and related stakeholders as needed.

2. Continue collaboration with stakeholders involved in changes to current controlled substances regulations (e.g., DEA regulations) and develop educational resources related to any new DEA regulations for EMS medical directors.

3. Develop resources for EMS medical directors, such as an information paper, articles for ACEP publications, or a toolkit, addressing the opioid crisis and alternative pain management options.

4. Continue to develop resources to promote and support the subspecialty of EMS medicine and the roles of the EMS medical director, such as EMS medical director reimbursement and the need for specific EMS training and experience. Collaborate with NAEMSP and related stakeholders as needed.

5. Collaborate with AAP, NAEMSP, ENA, the Pediatric Emergency Medicine Committee, and other stakeholders to develop resources for assessing pediatric readiness of EMS systems and pediatric medication dosing. (EMS is the lead committee.)

6. Collaborate with the Geriatric Emergency Medicine Section to develop resources for geriatric out-of-hospital care.

7. Collaborate with the Palliative Medicine Section to develop resources for EMS related to palliative/end-of-life care.

8. Collaborate with the Education Committee/EMS Education Subcommittee to explore the need for resources including educational offerings at *Scientific Assembly* for the EMS medical director on topics such as geriatric prehospital care, and palliative/end-of-life care. (EMS is the lead committee.)

9. Serve as a resource and provide input to the Education Committee to explore online and other EMS, disaster, and other related training for emergency physicians (Education is the lead committee.)

10. Coordinate with the EMS Section and the Air Medical Transport Section to submit a nomination for the 2019 ACEP Outstanding Contribution in EMS Award.

11. Continue to review current EMS-related policies and PREPs for possible consolidation.

12. Review the following policy per the Policy Sunset Review Process:
    - Transfer of Patient Care Between EMS Providers and Receiving Facilities

    Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

13. Provide input to the Coding & Nomenclature Advisory Committee to explore developing codes for alternative payment models, including community paramedicine and mobile integrated health care. (Coding & Nomenclature is the lead committee.)

14. Continue work started by the High Threat Casualty Care Task Force (HTCCTF) towards:
    - creation of a high-threat incident database, standardized data-gathering tool, and support the creation of data-gathering rapid response to enable rapid dissemination of lessons-learned
    - enhance the translation of military lessons learned, consistent with Mission Zero, throughout the emergency medicine community
    - develop a public relations information campaign centered on mitigation, preparedness, response to and recovery from high-threat incidents.

Collaborate with the Disaster Preparedness & Response Committee, Federal Government Affairs Committee, and the Public Health & Injury Prevention Committee. (EMS the lead committee.)

15. Provide input to the Education Committee to explore online and other EMS, disaster, and other related training for emergency physicians. (Education is the lead committee.)

2018-19
Final Committee Objectives

Ethics Committee

Chair: Raquel Schears, MD, FACEP
Board Liaison: Christopher S. Kang, MD, FACEP
Staff Liaison: Leslie Moore, JD

1. Identify and develop educational opportunities and materials on ethics issues, including at least three articles for ACEP publications including:
   - Ethics of opiates in the heroin era.
   - Ethical issues in EMR usage.
   - Effects of the changes to the ACA for patients.
   - Supporting the prudent layperson's definition of an emergency is an important provision to help secure health equity for ED patients post ACA.
   - Publication that highlights the "Principles of Ethics for Emergency Physicians."
   - Diversity Pipeline: What are institutions responsibilities to recruit and support minority physicians?

2. Review the *Policy Compendium of the Code of Ethics for Emergency Physicians* and recommend needed revisions to the Board of Directors.

3. Review and provide recommendations to the Board of Directors on ethics complaints.

4. Develop the following information papers:
   - Guidance to emergency physicians regarding concerns surrounding medical treatment of minors, such as parental consent, confidentiality and psychosocial issues. (Collaborate with the Pediatric Emergency Medicine Committee. (Ethics is the lead committee.)
   - Assessing safety for discharge of psychiatric patients from the ED. Collaborate with the Coalition on Psychiatric Emergencies.
   - Ethical challenges that arise from long-term boarding of mental health patients both in reference to their care and the impact on the staff and ED functioning.
   - Ethical issues surrounding advance care planning directives and symptomatic treatment of terminally ill patients within the emergency department.

5. Review the following policies per the Policy Sunset Review Process:
   - Advertising and Publicity of Emergency Medical Care
   - Antitrust
   - Emergency Physician Stewardship of Finite Resources
   - Resource Utilization in the Emergency Department: The Duty of Stewardship (PREP)

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

6. Provide input to the Federal Government Affairs Committee on draft legislation for the 116th Congress to address ED-specific end-of-life issues. (Federal Government Affairs is the lead committee).

7. Provide input to the Medical-Legal Committee to promote awareness and adoption of ACEP's "Expert Witness Guidelines for the Specialty of Emergency Medicine" to reduce egregious testimony. (Medical-Legal is the lead committee.)

2018-19
Final Committee Objectives

Federal Government Affairs Committee

Chair: Carlton Heine, MD, FACEP
Board Liaison: Vidor E. Friedman, MD, FACEP, President-Elect
Staff Liaison: Laura Wooster, MPH

1. Analyze and recommend legislative and regulatory priorities for the First Session of the 116th Congress.

2. Develop strategies to further expand the 9-1-1 Advocacy Network. Encourage committee members to meet with their congressional representatives either locally or on Capitol Hill.

3. Develop a regulatory and/or legislative strategy to encourage the use of appropriate alternatives to Emergency Department copays in State Medicaid waiver applications that embrace the prudent layperson concept. Collaborate with content experts from the Reimbursement Committee and the State Legislative/Regulatory Committee. (Federal Government Affairs is the lead committee.)

4. Develop a legislative and/or regulator strategy to address the growing drug shortage issue at the federal level.

5. Develop draft legislation for the 116th Congress to address mental health/psychiatric boarding issues. Collaborate with content experts from other committees as needed.

6. Develop draft legislation for the 116th Congress to address ED-specific end-of-life issues. Collaborate with content experts from the Ethics Committee and State Legislative/Regulatory Committee. (Federal Government Affairs is the lead committee).

7. Develop a legislative and/or regulatory strategy to facilitate and require Indian Health Service data-sharing with prescription drug monitoring programs.

8. Identify new opportunities to work with federal agencies, including the Veterans Administration, Department of Defense, Indian Health Services, etc.

9. Develop and assess potential innovative approaches to improving the way care is delivered and reimbursed in rural areas, with the goal of improving patient access to emergency department services in these areas. Collaborate with content experts from other committees and task forces as needed.

10. Develop and assess potential legislative ideas to address firearm safety and injury prevention.

11. Develop recommendations for federal legislative and/or regulatory strategies to ensure telemedicine can advance emergency medicine while protecting the practice environment for emergency physicians and quality of care for patients.

12. Develop an annual report to all ACEP members regarding advocacy work done on behalf of emergency medicine.

13. Develop a proactive federal-level strategy on out-of-network/balance billing, including consideration of introducing federal legislation. Collaborate with content experts from the ACEP-EDPMA Joint Task Force, Reimbursement Committee, and State Legislative/Regulatory Committee. (Federal Government Affairs is the lead committee.)

14. Review the following policy per the Policy Sunset Review Process:
    - Supporting Political Advocacy in the ED

    Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

15. Provide input to the EMS Committee to continue the work started by the High Threat Casualty Care Task Force (HTCCTF) towards:
    - creation of a high-threat incident database, standardized data-gathering tool, and support the creation of data-

gathering rapid response to enable rapid dissemination of lessons-learned

- enhance the translation of military lessons learned, consistent with Mission Zero, throughout the emergency medicine community
- develop a public relations information campaign centered on mitigation, preparedness, response to and recovery from high-threat incidents. (EMS the lead committee.)

2018-19
Final Committee Objectives

Finance Committee

Chair: Gary Starr, MD, FACEP
Board Liaison: Secretary-Treasurer
Staff Liaison: Layla Powers, MBA

1. Perform duties as delineated in the *Compendium of Financial Policies and Operational Guidelines*, including:
   - Cash flow analysis
   - Review the annual College budget and make recommendations to the Board.
   - Review the financial status of the College monthly.
   - Consider budget modifications and make recommendations to the Board.
   - Review and monitor expenses for the Clinical Emergency Data Registry

2. Review the *Compendium of Financial Policies and Operational Guidelines* and provide recommendations to the Board for any necessary revisions. Develop a policy for using Member Equity to fund projects and future strategic initiatives.

3. Conduct an annual review of contributions made by ACEP to affiliated organizations.

4. Review and report on return on investment for all new expenditures greater than $100,000 in aggregate.

5. Update compendium to include policy

2018-19
Final Committee Objectives

Medical-Legal Committee

Chair: John Bedolla, MD, FACEP
Board Liaison: Kevin M. Klauer, DO, EJD, FACEP
Staff Liaison: Craig Price, CAE

1. Review, update, and provide information to members on medical legal matters that impact the administrative and clinical practice of emergency medicine.

2. Participate in the review of new clinical policies; provide information on potential medical-legal issues.

3. Provide input to the Clinical Policies Committee on any clinical policies that need to be developed for clinical conditions that have high malpractice incidence.

4. Submit a nomination for the 2018 Rorrie Health Policy Award.

5. Collaborate with the Ethics Committee to promote awareness and adoption of ACEP's "Expert Witness Guidelines for the Specialty of Emergency Medicine" to reduce egregious testimony. (Medical-Legal is the lead committee.)

6. Collaborate with the Ethics Committee to explore ways of enhancing the egregious testimony review process and advancing the effort to reduce egregious testimony in medical liability cases involving emergency physicians.

7. Review and update medical legal resources on the ACEP website.

8. Explore legal strategies and tactics to support efforts to protect emergency physicians from unfair insurer payment practices such as retrospective denial of payment (review legal cases, identify reasons for success or failure, identify areas of improvement such as better chart documentation, etc.)

9. Review and revise the information paper on due process.

10. Develop an information paper summarizing cases involving cross-state venue shopping and identify successful strategies used to prevent it.

11. Investigate the possibility of accessing malpractice data from the National Practitioner Data Bank (NPDB) that might provide teachable information from resolved cases that may help reduce medical errors and improve patient safety. (Referred Resolution 47-17 Improving Patient Safety Through Transparency in Medical Malpractice Settlements.)

2018-19
Final Committee Objectives

Membership Committee

Chair: Aychut Kamat, MD, FACEP
Board Liaison: Alison J. Haddock, MD, FACEP
Staff Liaison: Michele Byers, CAE, CMP

1. Analyze the results of the Membership Retention Study and provide recommendations to the Board on strategies for implementation.

2. Promote ACEP membership to early career physicians through social media.

3. Provide input to content development for the membership recruitment, renewal, and benefit sections of the new ACEP.org website.

4. Review and provide guidance for the rollout of new section and committee communities (via Higher Logic platform).

5. Analyze the results of the diversity and inclusion survey for membership recruitment and retention strategies. Implement changes based on the report.

6. Section Governance
   a. Oversee the annual section grant process and recommend grant recipients to the Board of Directors.
   b. Select recipients of the annual section awards for recommendation to the Board of Directors.
   c. Review requests for formation of new sections and provide recommendations to the Board of Directors.
   d. Review rules for section membership compliance and make recommendations for changes as needed.
   e. Revise the Section Grant Criteria to reflect current priorities of the college as recommended by the Board of Directors.

7. Study the impact and potential benefit of a chapter or section representing locums physicians as directed in Amended Resolution 26(17) Study of Locums Physicians Representation. Assess whether a chapter or section would best meet their needs.

8. Provide recommendations to increase the value of section membership and encourage ACEP members to join a section.

9. Serve as a resource in the development of a group and residency portal to facilitate administrative efficiency for group enrollment of multiple members.

10. Develop a recommendation to the Board regarding verification of Bylaws-mandated membership requirements.

11. Develop recommendations to retain late career physicians transitioning into non-traditional emergency medicine practice settings.

12. Provide input to the National/Chapter Relations Committee to develop resources to address the needs of small and medium sized chapters that were identified by the 2018 chapter services survey. National/Chapter Relations is the lead committee.)

2018-19
Final Committee Objectives

National/Chapter Relations Committee

Chair:-Mark Notash, MD, FACEP
Board Liaison: William P. Jaquis, MD, FACEP
Staff Liaison: Maude Hancock

1. Administer, maintain, and evaluate the Chapter Grant Program.

2. Implement the 2019 Diane K. Bollman Chapter Advocate Award.

3. Analyze the results of the 2018 chapter leadership development survey. Develop and promote chapter resources and best practices in cultivating current and future leaders.

4. Develop resources to address the needs of small and medium sized chapters that were identified by the 2018 chapter services survey. Collaborate with the Education Committee and Membership Committee. (National/Chapter Relations is the lead committee.)

5. Review and revise as needed resources contained in “Fundamentals of Chapter Management” and include resources to assist chapters in officer orientation.

2018-19
Final Committee Objectives

Pediatric Emergency Medicine Committee

Chair: Mohsen Saidinejad, MD, MBA, FACEP
Board Liaison: Debra G. Perina, MD, FACEP
Staff Liaison: Sam Shahid, MBBS, MPH

1. Develop a policy statement on the role and responsibilities of emergency medicine providers in the initial management of acute pediatric mental health emergencies.

2. Develop the following information papers:
   - Antibiotic stewardship in pediatric emergency care.
   - Opioid crises in children and adolescents.
   - Alternatives to opioids in management of acute pain in pediatric emergency care (including non-pharmacologic).
   - Complete development of the information paper on the role of telemedicine in pediatric emergency care and in support of community emergency departments. Collaborate with the emergency Telemedicine Section. (Pediatric Emergency Medicine is the lead committee.

3. Continue to support Pediatric Readiness and assist in developing resources to promote ED preparedness.

4. Continue to work with EMSC Innovation & Improvement Center (EIIC) to:
   - Ensure ACEP is recognized as a full partner of the EIIC.
   - Create its leadership and policy infrastructure and to develop strategies to optimize resource utilization between general emergency medicine and pediatric emergency medicine.
   - Ensure ongoing collaboration with the committee and the ACEP grant-funded staff from EIIC.

5. Collaborate with the American College of Radiology (ACR) to provide pediatric content expertise in generating recommendations for radiographic tests in the emergency management of children.

6. Collaborate with the American Academy of Pediatrics (AAP) and the Emergency Nurses Association (ENA) to develop a common policy statement to optimize pediatric safety in the emergency care setting.

7. Continue to work with the American Academy of Pediatrics (AAP) to develop new and review current technical report papers and policy statements as needed.

8. Review the following policies per the Policy Sunset Review Process:
   - Death of a Child in the ED
   - The Role of Emergency Physicians in the Care of Children
   - Report Preparedness of the ED for the Care of Children (PREP)

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

9. Collaborate with the Education Committee, Simulation Subcommittee, and Pediatric Emergency Medicine Section to develop an open access simulation-based consensus curriculum for pediatric emergency medicine, in collaboration with other organizations and stakeholders. (Pediatric Emergency Medicine is the lead committee.)

10. Provide input to the Disaster Preparedness & Response Committee to refine the Mass Casualty Medical Operations Management Course to include pediatric disaster education or a separate course using the current course as a prerequisite. (Disaster Preparedness & Response is the lead committee.*)*

11. Provide input to the EMS Committee, in collaboration with AAP, NAEMSP, ENA, and other stakeholders, to develop resources for assessing pediatric readiness of EMS systems and pediatric medication dosing. (EMS is the lead committee.*)*

12. Provide input to the Ethics Committee on the development of an information paper for Emergency Medical Treatment of Minors, to include issues of consent and confidentiality. (Ethics is the lead committee.*)*

2018-19
Final Committee Objectives

13. Provide input to the Education Committee on the planning of the Pediatric Emergency Medicine Assembly. (Education is the lead committee).

14. Collaborate with the Academic Affairs Committee to develop resources to encourage emergency medicine residents to enter pediatric emergency medicine and improve competency of training. (Pediatric Emergency Medicine is the lead committee.)

15. Complete development of a joint policy statement with the American Academy of Pediatrics and the Pediatric Surgery Society on trauma imaging in the pediatric patient population according to existing guidelines and decreasing unnecessary radiation in pediatric trauma patients. Collaborate

16. Complete development of a policy statement on the use of antitussive medications, specifically opiate-containing antitussives, and their utility in the treatment of pediatric patients.

2018-19
Final Committee Objectives

Public Health & Injury Prevention Committee

Chair: Alan Heins, MD, FACEP
Board Liaison: James J. Augustine, MD, FACEP
Staff Liaison: Margaret Montgomery, RN, MSN

1. Review the following policies per the Policy Sunset Review Process:
   - Domestic Family Violence (and PREP)
   - Firearm Safety and Injury Prevention
   - Intoxication and Motorized Recreational Vehicle and Watercraft Operation
   - Motorized Recreational Vehicle and Watercraft Safety
   - School Bus Safety
   - Violence-Free Society

   Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

2. Provide input to the Emergency Medicine Practice Committee and the Pain Management & Addiction Medicine Section on identifying and compiling information on existing models for addressing transitions of care for patients with Opioid Use Disorder (OUD). (Emergency Medicine Practice is the lead committee.)

3. Continue development of talking points or "smart phrases" for discharge summaries and/or educational resources on public health, injury prevention issues. Collaborate with the Coalition on Psychiatric Emergencies on smart phrases related to suicide prevention.

4. Collaborate with the Epidemic Expert Panel to explore development of best practices for treating patients with flu or flu-like illness that meet sepsis guidelines during the flu season.

6. Complete development of an information paper on supervised injection facilities and syringe services programs in response to Resolution 52(17) Support for Harm Reduction and Syringe Services Programs.

7. Explore development of an information paper on PCR (urine) vs. cervical culture for STDs.

8. Provide input to the EMS Committee to continue the work started by the High Threat Casualty Care Task Force (HTCCTF) towards:
   - creation of a high-threat incident database, standardized data-gathering tool, and support the creation of data-gathering rapid response to enable rapid dissemination of lessons-learned
   - enhance the translation of military lessons learned, consistent with Mission Zero, throughout the emergency medicine community
   - develop a public relations information campaign centered on mitigation, preparedness, response to and recovery from high-threat incidents. (EMS the lead committee.)

9. Complete development of an information paper to address Amended Resolution 31(17) Development and Study of Supervised Injection Facilities.

10. Complete development of an information paper to address Resolution 52(17) Support for Harm Reduction and Syringe Services Programs.

2018-19
Final Committee Objectives

Public Relations Committee

Chair: Rade Vukmir, MD, FACEP
Board Liaison: Stephen H. Anderson, MD, FACEP
Staff Liaison: Laura Gore

1. Provide direction to public relations staff on promoting the specialty of emergency medicine, focusing on ACEP's priority issues and key message, including:
   - promoting the interests of emergency physicians and emergency patients
   - continuing to conduct ACEP's Fair Coverage Campaign, promoting the value of emergency medicine, and shifting blame for "surprise bills" to health insurance companies.
   - increasing ACEP's name recognition (branding) and relevancy of emergency medicine among its public audiences (advocacy)
   - mobilizing public support for funding emergency care and promoting the need for tort reform
   - refuting myths about emergency medicine and advocating to reduce "boarding"
   - communicating the need to protect access to emergency care as regulations are developed to implement the health care reform legislation and deflect efforts to harm the prudent layperson
   - developing and reviewing public relations materials distributed to the news media and the general public
   - promoting the value of emergency medicine and positive stories about emergency physicians caring for patients of all ages.
   - promoting placement of ACEP spokespersons in media roles, such as medical correspondents, to help represent emergency physicians to the public
   - promote the diversity and inclusion of emergency physicians and breadth of the patient population they serve

2. Provide technical review and consultation for promoting *Annals of Emergency Medicine*.

3. Provide oversight to the ACEP Journalism Awards Program.

4. Expand and further unify the spokesperson network to more effectively deliver messages at the local level.

5. Provide input and increase ACEP's name recognition thru social media platforms. Expand ACEP's social media presence to increase Twitter, Facebook, Vine, You Tube, and podcasts, etc. Collaborate with content experts from the Membership Committee. (Public Relations is the lead committee.)

6. Provide input into the implementation of the comprehensive public relations plan, including internal and external messaging.

2018-19
Final Committee Objectives

Quality & Patient Safety Committee

Chair: Richard Griffey, MD, FACEP
Board Liaison: Aisha T. Liferidge, MD, MPH, FACEP
Staff Liaison: Pawan Goyal, MD

1. **Measure Lifecycle Management**
   - Manage the quality measure lifecycle at ACEP by:
     a. Performing maintenance on current ACEP measures and working with staff and vendors and make improvements or recommending measures for retirement.
     b. Reviewing five measures in development pipeline to determine if they are meaningful enough to move forward with development.
   - Use information from 2018 Quality Measures Summit to develop and operationalize a Quality Measurement Strategic Plan.
   - Research funding opportunities to support quality measure development and work with ACEP staff to complete funding proposals.
   - Educate members in quality measurement to develop new leaders for the quality measure development program.
   - Assist with the quality measure lifecycle on behalf of external organizations by monitoring quality initiatives and commenting on behalf of ACEP on the appropriateness of quality measures that impact the practice of emergency medicine, the emergency department, and the reimbursement of emergency physicians.
   - Work with the APM task force to develop quality measures that might be used across both the MIPS and APM arms of the QPP program.

2. **Nomination**
   - Nominate emergency physicians to represent ACEP to internal and external bodies develop quality measures that have relevance to the practice of emergency care.

3. **Clinical Policies and Federal Review**
   - Comment on the quality provisions of the Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), the Physician Fee Schedule (PFS), Medicare Access and CHIP Reauthorization Act (MACRA).
   - Educate members regarding implementation and best practices for quality measures and federal quality measurement programs.
   - Develop educational resources and tools to assist members with navigating the Merit-Based Incentive Payment System (MIPS).
   - Work with content experts from the Federal Government Affairs Committee, Reimbursement Committee, and the Observation Section to develop an information paper on readmissions vs. observation as an “outcome” of quality measures. (Quality & Patient Safety is the lead committee.)

4. **Patient Safety**
   - Work to improve quality and patient safety by ameliorating the effects of unconscious bias in clinical practice and closing knowledge and competency gaps in the treatment of diverse populations.
   - Develop a behavioral health toolkit (Amended Resolution 14-16 Development & Application of Dashboard Quality Clinical Data Related to the Management of Behavioral Health Patients in the ED)
   - Collect candidate quality improvement projects and develop improvement tools. Develop emergency medicine-specific improvement activities for the QPP program.

2018-19
Final Committee Objectives

Reimbursement Committee

Chair: Heather Marshall, MD, FACEP
Board Liaison: Jon Mark Hirshon, MD, PhD, MPH,
FACEP Staff Liaison: David McKenzie, CAE

1. Identify and analyze the governmental reimbursement environment as it pertains to emergency medicine and assist in positioning the College appropriately on issues of importance. Concentrate on audit activity and payment policies throughout the Medicare system.

2. Continue to identify and analyze reimbursement challenges that impact emergency medicine and recommend strategic solutions. Continue to monitor private payer practices such as balance billing and fair payment, and challenge health plan claim bundling practices. Track out of network payments and payer mix shifts based on the ACA and databases such as FAIR Health.

3. Continue to support the efforts of the liaisons to the AMA RBRVS process, and advocate for improvement of work, practice expense, and malpractice relative values. Participate in any episode of care development activity in that venue.

4. Identify and develop educational materials such as articles, webinars, and Frequently Asked Questions (FAQs) to provide members with practical information on developing reimbursement trends. Develop specific content for residents and young physicians.

5. Develop a strategy for emergency medicine to be represented in alternate payment models, including episodes and population health, to prepare for the transition from fee for service reimbursement to value-based reimbursement. Provide analysis of new payment models for emergency physician services that may replace or supplement the predominant fee for service model and offer advice on how ACEP members should prepare for these new models (ACOs, bundled payment, value based reimbursement, etc.) Seek input from the Alternative Payment Models Task Force.

5. Monitor Medicaid reforms at the state level and provide resources as appropriate. Participate as necessary with the National Conference of Insurance Legislators (NCOIL) on related activity addressing fair payment issues.

6. Investigate alternatives to FAIR Health for determining fair payment levels for emergency physicians.

7. Develop resources (such as an information paper, slides, podcast, etc.) on the transparency of the reimbursement process for all members.

8. Provide input to the Federal Government Affairs Committee to develop a regulatory and/or legislative strategy to encourage the use of appropriate alternatives to Emergency Department copays in State Medicaid waiver applications that embrace the prudent layperson concept. (Federal Government Affairs is the lead committee.)

9. Provide input to the Federal Government Affairs Committee in developing a proactive federal-level strategy on out-of-network/balance billing, including consideration of introducing federal legislation. (Federal Government Affairs is the lead committee.)

10. Provide input to the State Legislative/Regulatory Committee and the ACEP-EDPMA Joint Task Force to develop resources to assist chapters with advocating for legislative solutions addressing fair payment and restrictions on balance billing. (State Legislative/Regulatory is the lead committee.)

11. Provide input to the State Legislative/Regulatory Committee and the ACEP-EDPMA Joint Task Force and the out-of-network/balance billing “strike team” leaders to provide expertise and resources to states addressing balance billing/out-of-network legislation. (State Legislative/Regulatory is the lead committee.)

12. Provide input to the Academic Affairs Committee to develop an information paper on documentation by medical student on electronic health records and incorporating billing strategies. (Academic Affairs is the lead committee.)

2018-19
Final Committee Objectives

13. Review the following policy per the Policy Sunset Review Process:
    - Medical Services Coding

    Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

14. Review Referred Resolution 41(17) Reimbursement for Hepatitis C Virus Testing in the ED and provide a recommendation to the Board regarding further action on the resolution.

2018-19
Final Committee Objectives

Research Committee

Chair: Manish Shah, MD, FACEP
Board Liaison: Aisha T. Liferidge, MD, MPH, FACEP
Staff Liaison: Loren Rives, MNA

General Research Committee Objectives

1. Submit a nomination for the 2019 ACEP Award for Outstanding Contribution in Research.
2. Collaborate with the American College of Osteopathic Emergency Physicians (ACOEP) to identify strategies and resources to assist emergency medicine osteopathic residency programs accredited in the ACGME's single accreditation system (SAS) in meeting scholarly activity requirements for faculty and residents.
3. In collaboration with SAEM's Research Committee, review and submit responses to the NIH's requests for information (RFIs).
4. Collaborate with ACOEP and the Diversity, Inclusion, & Health Equity Section, to identify and promote future leaders in emergency medicine research through a pipeline and mentorship initiative.
5. Provide input to the Academic Affairs Committee to explore ways to encourage support of protected time for faculty in residency programs. (Academic Affairs is the lead committee.)
6 Explore collaborative opportunities with IFEM and EUSEM
7. Collaborate with EMF to develop a consensus process that includes the opinions of Research Committee members, EMF, research leaders, and membership more broadly to identify strategies for future research support and development.
8. Provide input to the Academic Affairs Committee to explore development of an information paper, FAQs, or other resources to address falsifying data in research. (Academic Affairs is lead committee.)
9. Develop resources that members can use for institutional IRBs that explain exception for informed consent (EFIC) and its value to emergency medicine research.

Research Forum Subcommittee

10. Implement the 2019 *Research Forum* meeting and evaluate the integration of *Research Forum* with *ACEP18*.
11. Identify strategies to improve and promote the *Research Forum*, including development of promotional language addressing the value and integration into *Scientific Assembly*.
12. Select recipients for medical students, residents, young investigators, and best paper awards.
13. Explore ways to highlight basic science and senior researchers during Research Forum.
14. Identify emergency medicine research that results in innovative practice changes and promote the research at ACEP's annual meeting.
15. Work with the Education Committee to implement a research plenary session during the *ACEP19* opening session. (Education is the lead committee.)
16. Collaborate with EMF to offer a networking opportunity between residents, fellows, and senior emergency medicine researchers at Research Forum.

Scientific Review Subcommittee

17. Assist EMF with funding opportunities.
18. Continue to explore potential collaborations with other specialty groups for grants.
19. Review grant proposals for EMF and recommend applicant funding and provide on-going monitoring of funded grant progress reports.
20. Expand the pool of EMF grant reviewers through development of a junior faculty mentorship program and establishment of a list of pre-approved ad hoc reviewers.
21. Initiate a standardized process for EMF grant reviewer development.
22. Continue to identify potential areas of further targeted research that are of interest to the members.
23. Re-evaluate the current grant review form and revise as needed.
24. Review the EMF grant portfolio with a specific focus on pipeline (i.e., training and development) awards and revise as needed.

2018-19
Final Committee Objectives

State Legislative/Regulatory Committee

Chair: Chadd Kraus, DO, DrPH, FACEP
Board Liaison: Alison J. Haddock, MD, FACEP
Staff Liaison: Harry Monroe

1. Evaluate the effect of ongoing and new state Medicaid waivers on the practice of emergency medicine and patient access to care. Provide guiding principles with specific case studies of examples to chapters addressing Medicaid expansion issues. Collaborate with content experts from the ACEP-EDPMA Joint Task Force.

2. Summarize the status of Medicaid program developments that compromise the prudent layperson standard. Update the toolkit of resources that can be used by states responding to challenges to the prudent layperson standard by legislatures, regulatory agencies, and managed care vendors. Recent activity in Kansas, Kentucky, and Iowa may provide specific examples that can be used in preparing these additional resources. Provide expertise to chapters addressing Medicaid prudent layperson challenges. Collaborate with content experts from the ACEP-EDPMA Joint Task Force.

3. Participate with the ACEP-EDPMA Joint Task Force and the out-of-network/balance billing "strike team" leaders to provide expertise and resources to states addressing balance billing/out of network legislation. Collaborate with content experts from the Reimbursement Committee. (State Legislative/Regulatory is the lead committee.)

4. Research and update materials outlining legislative mandates and restrictions on opioid prescriptions in the emergency department, with a focus on how legislation comports with evidence based medical practice. Provide subject matter expertise to states addressing legislation on these issues.

5. Research and report on efforts by states to address mental health boarding in EDs, including best practices regarding making available inpatient bed registries and other resources for transitioning care.

6. Provide input to the Federal Government Affairs Committee to develop a regulatory and/or legislative strategy to encourage the use of appropriate alternatives to Emergency Department copays in State Medicaid waiver applications that embrace the prudent layperson concept. (Federal Government Affairs is the lead committee.)

7. Provide input to the Federal Government Affairs Committee in developing a proactive federal-level strategy on out-of-network/balance billing, including consideration of introducing federal legislation. (Federal Government Affairs is the lead committee.)

8. Provide a report to the FGA Federal Government Affairs Committee on model state legislation regarding end of life care. (Federal Government Affairs is the lead committee).

9. Continue to promote and administer the state public policy grant program.

10. Submit a nomination for the 2019 Rorrie Health Policy Award.

11. Submit a nomination for the 2019 Policy Pioneer Award.

2018-19
Final Committee Objectives

Well-Being Committee

Chair: Arlene Chung, MD, FACEP
Board Liaison: Debra G. Perina, MD, FACEP
Staff Liaison: Nicole Tidwell, Veronica Mason

1. 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. Strive for a 30% participation rate of all ACEP members.

2. Collaborate with the Education Committee to complete development of interactive tutorials on resiliency strategies for members as part of Wellness Week activities and explore the possibility of providing CME. (Well-Being is the lead committee.)

3. 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.

4. Update "Being Well in Emergency Medicine: ACEP's Guide to Investing in Yourself**."**

5. 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.

6. Develop a series of articles for submission to *ACEP Now*, including how to improve being well in emergency medicine and bringing "joy" to practice.

7. Evolve the 2018 Wellness Center based on learnings and recommendations from 2017.

8. Collaborate with other emergency medicine organizations and groups:
   a. Emergency Nurses Association, the Society for Emergency Medicine Physician Assistants, and the American Academy of Nurse Practitioners to identify exemplary practices that promote wellness.
   b. Conduct outreach with international emergency medicine organizations to share ideas and opportunities for collaboration. Investigate the potential for working with the International Federation of Emergency Medicine to develop international working groups focused on well-being in emergency medicine.
   c. Implement the Wellness Institute.

9. Discover exemplary practices that contribute to wellness in emergency medicine and disseminate the information to all EDs in the U.S

10. Continue collaboration with EMRA and the Academic Affairs Committee to identify and/or develop resources for residents and medical students to address resiliency and coping mechanisms. (Well-Being is the lead committee.)

11. Develop a policy statement on paid parental leave for emergency physicians and develop an information paper on best practices regarding paid parental leave for emergency physicians. (Amended Resolution 36-17 Maternity and Paternity Leave)

12. Review ACEP's current resources and develop resources as needed to address interruption of clinical emergency medicine practice. (Resolution 51-17 Retirement or Interruption of Clinical Emergency Medicine Practice)

13. Review the following policies per the Policy Sunset Review Process:
    - Physician Impairment
    - Support for Nursing Mothers

    Determine by December 15 if the policies should be reaffirmed, revised, rescinded, or sunsetted. Submit any proposed revisions to the Board for approval by the end of the committee year.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

ACEP Strategic Plan for 2018-2021

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.

Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.

Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Objective G – Achieve meaningful medical liability reform at the state and federal levels.

Objective H – Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement

Objective A – Improve member well-being and improve resiliency.

Objective B – Increase total membership and graduating resident retention.

Objective C – Provide robust communications and educational offerings, including novel delivery methods.

Objective D – Ensure optimal organizational infrastructure and governance to support membership.

Objective E – Provide and promote leadership development among emergency medicine organizations and strengthen liaison relationships.

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

Fiscal Year 2017-2018 Accomplishments

EMF Highlights

- Revenue exceeded $2 million in FY 2017-2018.
- Awarded $684,171 in research grants in FY 2018-2019.
- Launched new website in March 2018.
- Expanded EMF's role for Research Forum at ACEP18. Increased the scope of the EMF Grant Showcase Luncheon and created table sponsorship opportunity for institutions funded by EMF grant awards.
- Kicked off two-year $500,000 Endowment Match Campaign. All endowment donors will be recognized at a special luncheon at ACEP20 and donors giving $10,000 or more will be listed on the donor wall inside ACEP HQ.
- Received the Charity Navigator 4-star rating for the fourth consecutive year.
- Raised $19,258 for EMF Staff campaign with $9,000 designated for the endowment campaign.

Wiegenstein Legacy Society

- 82 members / Estimated value $2,500,00
- Received first WLS gift in June 2018

EMF at ACEP18

- List of activities attached

2018-2019 Grantee Flyer attached

EMF Activities
ACEP18 – San Diego, CA

Friday, September 28

3:00pm – 6:00pm	EMF Council Challenge, *Grand Hyatt, Grand Hall Foyer*

Saturday, September 29

8:00am – 5:00pm	EMF Council Challenge, *Grand Hyatt, Grand Hall Foyer*

Sunday, September 30

8:00am – 5:00pm	EMF Council Challenge, *Grand Hyatt, Grand Hall Foyer*

Monday, October 1

7:00am – 4:00pm	EMF Major Donor Lounge, *SDCC, Upper Level, Sails Pavilion*
9:00am – 4:00pm	EMF Silent Auction, *SDCC, Upper Level, Sails Pavilion*
6:30pm – 8:30pm	EMF VIP Reception, *USS Midway Museum (Invitation only)*

Tuesday, October 2

7:00am – 4:00pm	EMF Major Donor Lounge, *SDCC, Upper Level, Sails Pavilion*
8:30am – 10:30am	EMF Board of Trustees Meeting, *Marriott Marquis, South Tower, 3rd Floor, Marina Ballroom, Salon D*
9:00am – 4:00pm	EMF Silent Auction, *SDCC, Upper Level, Sails Pavilion*
12:00pm – 1:45pm	EMF Grant Showcase Luncheon, *SDCC, Upper Level, Sails Pavilion, EMF Networking Lounge (Ticket required)*
6:00pm – 8:00pm	Wiegenstein Legacy Society Reception, *Grand Hyatt, 32nd Floor, Bayview (Invitation only)*

Wednesday, October 3

7:00am – 3:00pm	EMF Major Donor Lounge, *SDCC, Upper Level, Sails Pavilion*
9:00am – 11:00am	Annals Author Workshop, *SDCC, Upper Level, Sails Pavilion, EMF Networking Lounge*
9:00am – 4:00pm	EMF Silent Auction, *SDCC, Upper Level, Sails Pavilion*

EMF Emergency Medicine Foundation

research → education → patient care

Help us meet the $150,000 goal!

Donate at
emfoundation.org/council

22nd Annual Council Challenge

The ACEP Council is the largest and longest sustaining supporter of EMF. Because of your generosity, EMF is funding innovative research to improve the practice of emergency medicine.

2018–2019 EMF GRANTEES

EMF/GE Research Challenge




Joshua S. Broder, MD, FACEP
Duke University School of Medicine
3D Augmented Ultrasound for Identification of Abdominal/Pelvic Traumatic Hemorrhagic Shock
$200,000

Douglas A. Blank, MD
The Royal Women's Hospital and Monash University, Australia
The Description of Lung Ultrasound from Initial Neonatal Transition in Extremely Preterm Infants
$50,000

Mark Favot, MD, FACEP
Wayne State University
The Impact of Noninvasive Positive Pressure Ventilation on Left Ventricular Strain in Acute HF
$50,000

Andrew Liteplo, MD, FACEP
Massachusetts General Hospital
Carotid Ultrasound in Sepsis and Hypotension (CUSH)
$50,000

EMF/ACEP Value of Emergency Care

Laura G. Burke, MD, MPH, FACEP
Beth Israel Deaconess Medical Center
Trends in the Cost and Quality of Emergency Care
$150,000

Early Career Research Development

Jessica Galarraga, MD, MPH
MedStar Health Research Institute
Impact of Global Budgeting & Pay-for-Performance Incentives on Emergency Care Delivery
$149,951 over two years

EMF/FAAR Directed Grant

Michael P. Wilson, MD, PhD, FAAEM, FACEP
University of Arkansas for Medical Sciences
Utility of the Computerized Assessment and Referral System (CARS) Screener for Mental Health Evaluations in the Emergency Setting
$64,511

Health Policy Research

Amber K. Sabbatini, MD
University of Washington
Consumer Driven Health Plans in the ED: Implications for Quality and Costs
$50,000

Pilot Research




Vijay C. Kannan, MD
Beth Israel Deaconess Medical Center
Pilot of a Novel World Health Organization Trauma Data Initiative
$50,000

Philip Mudd, MD, PhD
Washington University
Evaluating the Impact of T Cell Responses Directed Against Influenza Virus
$50,000

Paul Musey, MD, MS, FACEP
Indiana University
SMS Messaging Follow-up Evaluation for Subjects with Low-Risk Chest Pain Associated with Low-Risk Chest Pain Associated with Anxiety
$50,000

Margaret E. Samuels-Kalow, MD, MPhil, MSHP
Massachusetts General Hospital
Unmet Social Needs in the Emergency Department
$49,380

EMF/EMAF Clinical Intensity

Jeremiah D. Schuur, MD, MHS, FACEP
Department of Emergency Medicine,
Brigham and Women's Hospital
Changes in the Burden and Workforce of Emergency Care in the US
$50,000

EMF Clinical Intensity

Michelle Lin, MD, MPH, MS
Icahn School of Medicine at Mount Sinai
Evaluating ED Clinical Work Intensity and the Shift from Inpatient to Outpatient Care
$50,000

EMF/CORD Emergency Medicine Education Research

Mira Mamtani, MD, MSEd
University of Pennsylvania
The Gender Gap: A Multi-Site, Mixed Method Study Exploring Gender Differences in Feedback to EM Trainees
$25,000

EMF/NIDA Mentored Training Grant in Substance Use Disorders Science Dissemination

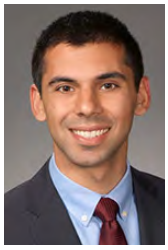
Megan McElhinny, MD
Maricopa Integrated Health System
Creation and Dissemination of Opioid and Harm Reduction Curricula for Clinicians
$9,500

Phillip Summers, MD, MPH
University of California, Davis
Implementation of Emergency Department Buprenorphine Protocol and Provider Toolkits
$12,000

Thank You For Your Contribution!

Leadership Circle: $5,000
1972 Club: $1,972
Friend of EMF: $1,200
Wilcox Challenge Level: $600

EMF/EMRA Resident Research



Arvin R. Akhavan, MD
University of Washington
Assessing the Prognostic Value of Lactate Levels in The Presence of Ethanol
$9,200

Cosby G. Arnold, MD, MPH
University of Tennessee Health Science Center
Use of the Pulse Oximeter Plethysmograph Waveform to Measure Ankle-Brachial Index
$9,140

EMF/SAEMF Medical Student Research

Morgan R. Bobb, BS
University of Iowa—Roy J. and Lucille A. Carver College of Medicine
Rural Pediatric Trauma Undertriage: A Statewide Administrative Data Pilot Project
$5,000

Katherine Goldsmith, BA
Stony Brook University
Effect of Tadalafil on Reepithelialization of Partial Thickness Porcine Burns
$5,000

William L. Scheving, ScB
Vanderbilt University
Examining Emergency Department Delays for Patients with Acute Ischemic Stroke
$5,000

Christopher Zalesky, BS
Emory University School of Medicine
Improving ED Care for Patients with a Possible mTBI using Clinical Decision Support
$5,000

Emergency Medicine Basic Research Skills (EMBRS) Workshop

Anthony Hackett, DO
Carl R. Darnall Army Medical Center
Ketamine for the Treatment of Primary Headache in the Emergency Department vs Standard Therapy with Metoclopramide
$5,000

Please contact Tanya L. Downing at tdowning@acep.org or call 469-499-0296 if you have any questions about the Council Challenge.

Report to the ACEP Council

The National Emergency Medicine Political Action Committee (NEMPAC)

and

The ACEP 911 Legislative Network

ACEP 50th Anniversary Celebration

San Diego, CA
October 2018

NEMPAC
National Emergency Medicine PAC

NEMPAC

A small, forward thinking group of ACEP members founded NEMPAC back in 1980 to help ACEP promote our legislative goals and express the concerns of emergency medicine to Members of Congress. Back then, the founders determined they would need to raise $10,000 to make a difference on the issue of independent contractor status for emergency physicians. Today, due to the increased costs of running for office and the many issues that ACEP can influence in Congress, our goal is to raise more than $1 million annually.

Just like our Board today, NEMPAC's founders were from all parts of the country and were "party" blind when it came to selecting candidates worthy of NEMPAC support. And just like today, NEMPAC is the only national PAC solely dedicated to representing our bi-partisan interests in the nation's capital.

Over the years, NEMPAC has opened doors, educated new and veteran lawmakers, and helped emergency medicine identify friends and champions in the U.S. Congress. This access created opportunities to express our well-reasoned viewpoints on the issues of the day for nearly 40 years. Issues like physician payment reform, medical liability reform, solutions to the opioid and mental health crisis, protecting the prudent layperson standard, and funding for research and graduate medical education, to name a few.

Today, by combining and carefully allocating donations from thousands of individual emergency physicians, NEMPAC has grown to be one of most recognized and credible health care PACs in the nation and is THE VOICE of emergency medicine in the political process.

Here is a brief history of NEMPAC's inception, growth and successes through the years along with the Council's influence:

1980 – NEMPAC is formed by a few visionary ACEP members contributing a total of $775.

1980s – ACEP Councilors urged during Scientific Assembly to "help carry the water."

1983 – ACEP DC Office opens

1985 – The first NEMPAC newsletter, *ACCESS*, is published.

1987 - ARTICLES OF ASSOCIATION OF NEMPAC initially approved by a vote of the ACEP Board of Directors

1987 – a $25 "suggested amount" for NEMPAC was added to the ACEP dues statement.
The amount was raised 3 times since then and is currently at $200.

1990s – Inception of the Annual ACEP Council Challenge at ACEP Scientific Assembly with goal of 100% participation by all ACEP Councilors present. First challenge raises $15,000.

1999 – NEMPAC conducted first independent expenditure campaign by commissioning a poll for a member of congress in Pennsylvania.

2000 – ACEP Board approves first tele-marketing campaign for NEMPAC which raises $134,200, nearly 1/3 of NEMPAC receipts in that year.

2004 – NEMPAC raises more than $500,000 for the first time.

2005 – "Give-a-Shift" campaign begins – 146 ACEP members gave at that level in 2005.

2008 – EM Groups begin to organize campaigns to support NEMPAC. CEP and EMP set the bar, with both group collecting more than $100,000 from their ACEP member physicians.
Eastside Emergency physicians and FEP begin the tradition of 100% participation in NEMPAC at the Give a shift level by all their ACEP member physicians.

2008 – ACEP Board of Directors voted in April 2008 to restructure the NEMPAC Board of Trustees, adding members, developing governance structure, and more Trustee responsibilities

2008 - NEMPAC exceeded $1 million in receipts for the first time (goal set by ACEP Board of Directors) raising $1,045,136

In 2008, NEMPAC jumped to 4th among specialty physician PACs receipts – remains there today.

In 2010 elections, NEMPAC raised and spent more than $2 million for federal candidates and party committees for the first time. NEMPAC has consistently reached and exceeded this $2 million mark in every election cycle since then.

2010 began to recognize ACEP members who donated at the Give a shift level consecutively for 5 years

In 2010 through campaign support and independent expenditures, NEMPAC took the lead in supporting the campaign of Dr. Joe Heck, the first board certified emergency physician and ACEP member elected to serve in Congress. Dr. Heck served as the U.S. Representative for Nevada's 3rd congressional district from 2011 to 2017.

In 2012, NEMPAC support helped elect a second board-certified emergency physician and ACEP member to Congress, Rep. Raul Ruiz. A Democrat, he has been a member of the United States House of Representatives representing CA-36 since winning election in 2012 in what was considered a major upset. He was re-elected in 2014 and 2016 and continues to serve today.

2014 – NEMPAC Board authorized a record amount of $250,000 in independent expenditures for five physician candidates, all whom were elected.

2015 began to recognize ACEP members who donated at the Give a Shift level for 10 years or more.

In 2015, NEMPAC Board of Trustees developed new donor levels for ACEP members recognizing the need to continue to grow and strengthen the PAC while providing more options for ACEP members transitioning from residency to attending status and members who may be retiring from active practice.

2015 – NEMPAC begins to host candidate "dine-arounds" at LAC to offer unique opportunities for NEMPAC donors to interact with ACEP friends and champions in congress in small group settings.

2016 – NEMPAC adds a Resident member to the Board of Trustees.

2016 – NEMPAC Board approves $195,000 for independent expenditure campaign for 5 candidates, including co-founding the Silver State "Super" PAC to drive a positive message about ACEP Member Dr. Joe Heck who was running for the U.S. Senate in Nevada.

2017 Give-a-Shift membership exceeds 600 for the first time.

2018 –25+ years of the NEMPAC Council Challenge. Councilors now contribute more than $300,000 annually to NEMPAC, more than ¼ of all annual donations.

2018 – CEP, USACS, TeamHealth, Eastside Emergency Physicians, Northeast Emergency Medicine Specialists, WEPPA and NEA continue to lead the way in EM Group participation in NEMPAC.

Currently, NEMPAC is the 4th largest physician specialty PAC and the 5th largest health care professional PAC in the nation. (See Chart A)

2018 Election Cycle Highlights

In 2017, NEMPAC raised $1,121,241 toward our goal of $2.3 million for the 2018 election cycle. This was an increase of 7.5 % from the 2016 amount raised. As of September 1, 2018, NEMPAC raised $605,000 and we anticipate raising more than $1 million again this year.

In the 1988 elections, NEMPAC contributed just under $100,00 to 13 Senate and 73 Congressional candidates. **30 years later, NEMPAC is tracking to contribute more than $2.2 million to 27 Senate candidates, 150 House candidates, and other national party committees.**

The number of "Give-A-Shift" ($1,200 and above) donors continues to grow exponentially. In 2004, 70 ACEP members contributed at the "Give-a-Shift" level. As of September 1, 450 ACEP members are donating at the "Give-a-Shift" level. Our goal by year-end is 500+ Give-a-Shift donors including residents (the "Give-a-Shift" level for residents is $120).

In 2009, we instituted the ***"Five Year Give-a-Shift"*** level which recognized 71 ACEP members. Today, we have 131 ACEP members at this level.

In 2014, we began to recognize ***"10 Year Give-a-Shift"*** donors. Currently, there are 107 ACEP members at this level.

15 ACEP members currently donate at the $2500 "Platinum" Level.

NEMPAC Honor Roll

The Board of Trustees of the National Emergency Medicine Political Action Committee (NEMPAC) would like to thank the following ACEP members for their generous support.
*List is as of September 5, 2018 and will be updated post ACEP18. A complete list of all Give a Shift donors is available on the NEMPAC website at www.emergencyphysicianspac.org

Platinum Donors ($2500 or more annually)

Neal Finley Aulick, II, MD, FACEP
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Carrie de Moor, MD, FACEP
Irv Edwards, MD, FACEP
William Basil Felegi, DO, FACEP
Clifford Findeiss, MD
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Howard K Mell, MD, MPH, CPE, FACEP
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Ten Year "Give-a-Shift" Donors

These members have donated at the Give-a-Shift level annually for the past ten years.

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Five Year "Give-a-Shift" Donors.
These members have donated at the Give-a-Shift level annually for the past five to nine years.

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Outstanding EM Group Contributors

The ACEP Board of Directors and the NEMPAC Board of Trustees recognizes the following EM physician groups for their efforts to encourage their ACEP member physicians to contribute to NEMPAC to unify and strengthen the voice of emergency medicine in the political process.

Large Group Practices
CEP America
USACS
TeamHealth

Small/Mid-Size Group Practices
Eastside Emergency Physicians
Emergency Medical Associates of Tampa Bay
Mid-Atlantic Emergency Medicine Association (MEMA)
Northeast Emergency Medicine Specialists (NEMS)
Northside Emergency Associates (NEA)
Wake Emergency Physicians, PA

Physician PAC Rankings as of 6/30/2018 (most recent filing date)

Cycle	2018		2016		2014		2012		2010		2008	
Specialty Society	**Contributions**	**Rank**	**Contributions**	**Rank**	**Contributions**	**Rank**	**Contributions**	**Rank**	**Contributions**	**Rank**	**Contributions**	**Rank**
	6/30/2018											
American Medical Association***	$1,616,861		$2,099,957		$2,265,084		$1,896,418		$2,311,111		$3,150,025	
Anesthesiologists (ASA)	$3,197,790	1	$3,959,260	1	$3,784,215	1	$3,469,122	1	$3,204,617	1	$2,235,776	2
Orthopaedic Surgeons (AAOS)	$2,150,706	2	$2,569,244	3	$2,507,288	3	$2,751,640	3	$2,956,230	2	$2,277,051	1
Radiologists (ACR)	$1,933,338	3	$2,667,802	2	$2,666,582	2	$2,808,129	2	$2,345,139	3	$1,681,740	3
Emergency Physicians (ACEP)	***$1,498,911***	***4***	***$1,947,679***	***4***	***$1,923,767***	***4***	***$1,873,220***	***4***	***$1,963,412***	***4***	***$1,654,851***	***4***
Dermatologists (AAD)	$1,218,980	5	$1,423,564	5	$1,360,849	5	$982,563	8	$627,994	13	$624,794	12
Ob-GYNs (ACOG)	$964,723	6	$1,191,575	6	$1,234,244	7	$1,014,636	7	$902,475	9	$651,021	11
Ophthalmologists (AAO)	$837,642	7	$1,097,044	8	$1,336,508	6	$1,391,717	5	$1,576,136	5	$1,641,764	5
Surgeons (ACS)	$769,631	8	$1,142,818	7	$1,036,958	8	$1,135,135	6	$1,052,964	7	$1,064,574	7
Family Physicians (AAFP)	$750,851	9	$903,409	9	$861,120	9	$875,060	11	$693,452	12	$775,735	9
Neurologists (AAN)	$650,060	10	$692,162	12	$598,455	13	$526,539	15	$312,004	20	$97,273	26
Cardiologists (ACC)	$634,635	11	$717,771	11	$848,066	10	$976,579	9	$1,004,135	8	$768,052	10
Osteopaths (AOA)	$505,667	12	$760,031	10	$831,493	11	$826,484	12	$839,652	10	$862,982	8
NeurosurgeryPAC	$377,694	13	$348,091	16	$368,752	17	$503,650	16	$489,352	14	$490,280	15
Psychiatrists (APA)	$354,449	14	$494,376	14	$377,965	16	$367,212	17	$396,521	17	$617,721	13
Pathologists (CAP)	$338,996	15	$488,253	15	$450,281	14	$904,962	10	$1,299,011	6	$1,071,033	6
Plastic Surgeons (ASPS)	$290,493	16	$306,115	17	$323,804	20	$318,799	20	$347,648	18	$328,847	19
Radiation Oncologists (ASTRO)	$279,641	17	$299,685	19	$304,798	21	$348,410	19	$296,501	21	$147,868	22
Otolaryngologists (ENTs)	$256,659	18	$301,606	18	$341,637	18	$366,648	18	$411,391	16	$363,527	18
Internists (ACP)	$251,034	19	$256,305	22	$323,824	19	$302,403	21	$245,667	22	$251,150	20
Oral Surgeons (AAOMS)	$244,396	20	$540,640	13	$686,569	12	$534,480	14	$482,144	15	$492,795	14
Thoracic Surgeons (STS)	$229,990	21	$268,078	21	$208,094	22	$236,582	22	$321,970	19	$405,502	17
Spine Specialists (NASS)	$215,079	22	$183,612	25	$100,611	27	$114,775	27	$225,851	23	$134,891	24
Cataract Surgeons (ASCRS)	$212,955	23	$115,285	27	$125,010	26	$140,394	25	$157,531	24	$191,180	21
Renal Physicians (RPA)	$142,065	24	$116,755	26	$130,683	25	$122,049	26	$135,126	27	$60,450	28
Urologists (AACU)	$125,817	25	$288,816	20	$442,718	15	$663,692	13	$822,126	11	$444,973	16
Gastroenterologists (AGA)	$112,397	26	$195,059	23	$194,733	24	$172,288	24	$145,006	26	$138,728	23
Vascular Surgeons (SVS)	$105,055	27	$185,721	24	$206,714	23	$194,783	23	$148,844	25	$85,835	27
Interventional Radiology (SIR)	$101,270	28	$73,577	28	$98,693	28	$109,360	28	$108,105	28	$108,504	25
TOTAL (Not including AMA)	**$18,750,924**		**$23,534,333**		**$23,674,431**		**$24,031,311**		**$23,511,004**		**$19,668,897**	

* Per Federal Election Commission Records Line 11(d); does not include "soft" money or other income.
** Election Cycles are 2 Years
*** Not included in rankings

The 911 Legislative Network

Along with NEMPAC, the 911 Legislative Network plays a significant role in promoting ACEP's legislative agenda to Congress. When ACEP recognized that it was competing for federal legislators' time and attention in an environment burgeoning with important legislative issues, ACEP's Federal Government Affairs Committee and the Board of Directors voted to create a technically sophisticated grassroots network. Launched in April 1998, the 911 Legislative Network encourages ACEP members to cultivate relationships with their federal legislators for long term, ongoing lobbying and educational efforts. The goal is to have emergency physicians across the country available as resources and healthcare issue experts for federal legislators. As "citizen lobbyists," 911 Network members carry ACEP's concerns directly to policy makers and staff to explain how legislation or regulation affects medical care provided in an emergency department. ACEP provides the tools and the training to help 911 Legislative Network members effectively communicate with their legislators. More than 4,000 ACEP members currently participate in the 911 Network.

Hosting an ED Visit for Your Legislator

An important component of the 911 Network is the ED visit program for legislators. Throughout the past three years, ACEP staff has worked with Soapbox Consulting to increase the number of targeted, coordinated ED visits hosted by ACEP members for members of Congress and their staff resulting in a 30% increase. As of September 1, ACEP members hosted 21 visits with a goal of 41.

We expect 60-80 new members of congress will be coming to Washington DC as a result of the midterm elections. In December and early 2019, we will be conducting an aggressive push to meet these new members back home through ED visits and meetings with local ACEP members to educate them on emergency medicine and the challenges faced in providing emergency care today.

The program is ongoing and we urge you to contact the ACEP Washington DC office if you would like to host a visit for your federal legislator.

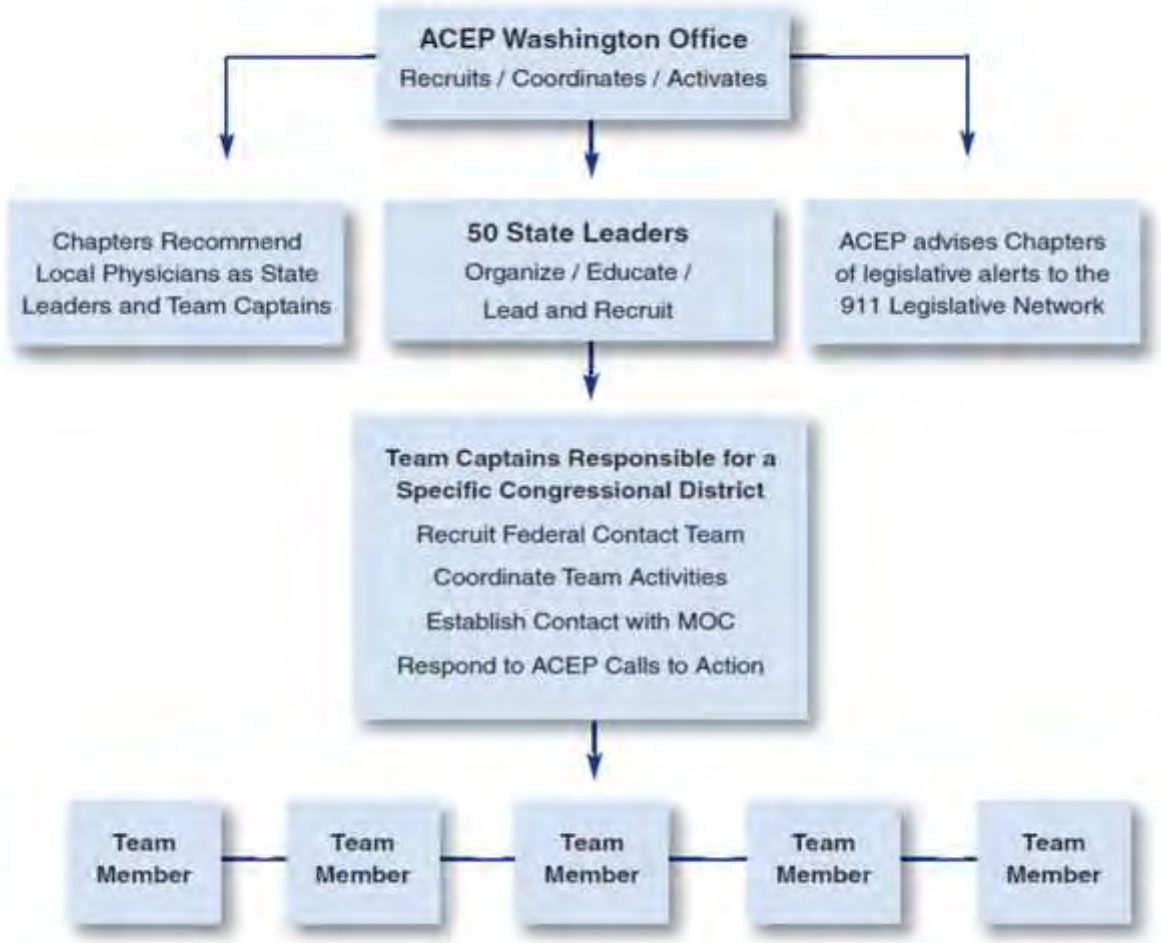
911 Network Member of the Year

Each year, a "911 Network Member of the Year" is selected from among the most active advocates in the Network based on an accrued point system which includes attending events, hosting ED visits, responding to action alerts and recruiting new members to the Network. **The 2018 winners were Dr. Jonathan Heidt from Missouri and Dr. Anne Zink from Alaska.**

As leaders of ACEP, it is important that members of the Council participate in the 911 Legislative Network. Councillors are well informed about the issues facing emergency medicine and ACEP's efforts to promote the specialty. This makes members of the Council the perfect spokes persons to carry ACEP's message to their legislators. **ACEP's goal is to achieve 100% Councillor participation in the ACEP 911 Network.**

NEMPAC and the 911 Legislative Network help promote the specialty of emergency medicine. We thank the Councillors for their past support and encourage all members of the Council to contribute to NEMPAC and sign up for the 911 Legislative Network. Your participation will help ensure the future of our specialty and our patients.

ACEP's ASAE Award Winning
911 Legislative Grassroots Network



NEMPAC 2018 Council Challenge

"Give-a-Shift" to the Future of Emergency Medicine

What Has NEMPAC Done for You Lately?

NEMPAC is an important tool to help us educate legislators. Look what we have already accomplished this year:

- ACEP Legislation to Address Opioid Crisis Passes the House of Representatives (POWER Act & ALTO Act)
- ACEP-led congressional letter drives establishment of FDA Drug Shortages Task Force
- ACEP Tele-Town Hall on Gun Violence and Injury Prevention with Rep. Seth Moulton
- Partnered with legislators in states where Anthem is violating prudent layperson standard to expose and halt these dangerous practices
- Secured repeal of IPAB, 10 years of CHIP funding, and extension of the GPCI Work Floor in congressional budget deal
- Emergency Physician Due Process Legislation Introduced in House
- ACEP language requiring DoD to share prescribing information of TRICARE beneficiaries with state PDMPs included in FY2019 NDAA

NEMPAC is the voice of emergency physicians' in the political process. Only ACEP Members are eligible to donate.

Why Should ACEP Councillors "Give-a-Shift"?

All ACEP Board members and NEMPAC Board members are Give-a-Shift donors.

In honor of 50 years of ACEP and nearly 40 years of NEMPAC, we challenge the Council to reach 100% participation for the first time since the Council Challenge began in the 1980's.

The support of ACEP Councillors sends a strong message to all ACEP members about the need to remain in the top tier of all medical PACs and increase our "political clout" in Washington, D.C.






NEMPAC "Give-a-Shift" Options

$2,500 PLATINUM (one-time donation, $210/monthly or $625/quarterly)
$1,200 GIVE-A-SHIFT (one-time donation, $100/monthly or $300/quarterly)
$365 GIVE-A-SHIFT (one-time donation, $30/monthly or $90/quarterly)
(Available only to retired physicians and physicians up to three years out of Residency)
$120 RESIDENT GIVE-A-SHIFT (one-time donation, $10/monthly or $30/quarterly)
**Contributions or gifts to NEMPAC are voluntary and not tax deductible for federal income tax purposes. The amount given or refusal to donate will not benefit or disadvantage you.*

NEMPAC at ACEP18

NEMPAC VIP Donor Reception

Donors contributing at the Platinum, 10-Year and 5-Year "Give-a-Shift" level are invited and may bring one guest.
Monday/5:00 – 6:30 pm
San Diego Wine and Culinary Center

NEMPAC Donor Celebration

Donors contributing $500 or more ($50 for Residents and Med Students, $365 for Retired and Transitioning Members) are invited. Platinum and "Give-a-Shift" donors may bring one guest.
Monday/6:30 – 8:30 pm
USS Midway
Shuttle Service Provided from the San Diego Convention Center

NEMPAC "Give-a-Shift" Donor Lounge

Open to Platinum and "Give-a-Shift" donors
Monday – Wednesday/8:00 am – 4:00 pm
San Diego Convention Center, Sails Pavilion
Complimentary breakfast, lunch, & snacks provided along with professional shoulder/neck massage and complimentary use of computers, printers, and television.

AMERICAN BOARD OF EMERGENCY MEDICINE

ANNUAL REPORT

2017-2018

ABEM'S MISSION

TO ENSURE THE HIGHEST STANDARDS IN THE SPECIALTY OF EMERGENCY MEDICINE.

ABEM'S PURPOSES[1]

To improve the quality of emergency medical care

To establish and maintain high standards of excellence in Emergency Medicine and its subspecialties

To enhance medical education in the specialty of Emergency Medicine and related subspecialties

To evaluate physicians and promote professional development through initial and continuous certification in Emergency Medicine and its subspecialties

To certify physicians who have demonstrated special knowledge and skills in Emergency Medicine and its subspecialties

To enhance the value of certification for ABEM diplomates

To serve the public and medical profession by reporting the certification status of the diplomates of the American Board of Emergency Medicine

[1]ABEM holds the interests of patients and their families in the highest standing, particularly with regard to the provision of the safest and highest-quality emergency care. ABEM addresses its commitment to patients by supporting the physicians who provide care to the acutely ill and injured, and by working to transform the specialty of Emergency Medicine.

TABLE OF CONTENTS

PRESIDENT'S MESSAGE

They always say time changes things, but you actually have to change them yourself.

~ Andy Warhol

It's only after you've stepped outside your comfort zone that you begin to change, grow, and transform.

~ Roy T. Bennett

Terry Kowalenko, M.D.

This past year has been one of tremendous change for ABEM and the way we approach Continuing Certification (MOC), and specifically, the ConCert™ Examination (ConCert). To find out what was working and what might improve the examination, ABEM reached out to ABEM-certified physicians on a number of occasions.

ABEM initially spoke with leaders and members of Emergency Medicine organizations. In the fall of 2017, ABEM began discussions about the ABEM MOC Program with ACEP state chapters and convened a ConCert Summit that included representatives of all Emergency Medicine organizations. We also examined comments from over 20,000 responses from surveys that follow each LLSA test and ConCert from the previous year.

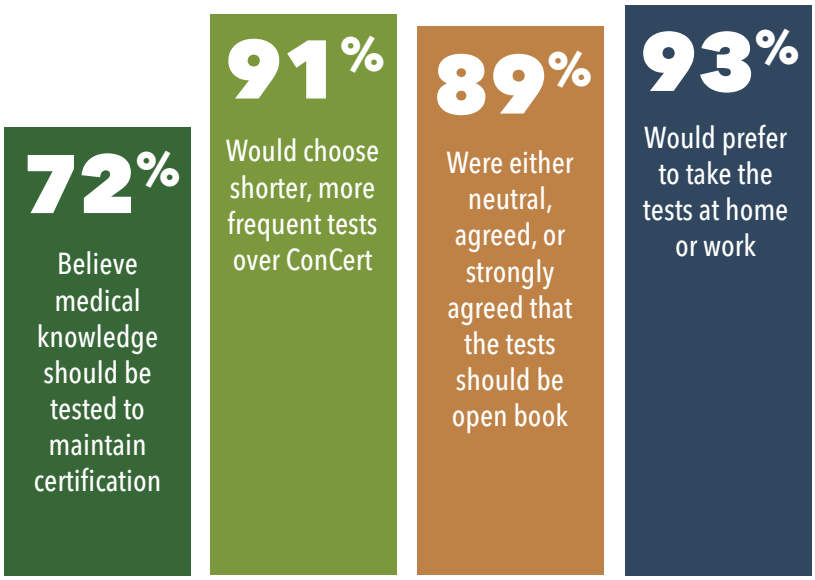
At this point, opinions about how the exam might be changed were fairly consistent: more flexibility, enhanced relevance, and a reduction in the high-stakes nature of the exam. Another common theme was that because of the speed of advances in the specialty, ten years between exams is probably too long. Above all, we heard that ABEM certification must retain its strength as a credential.

After careful analysis, ABEM decided to administer ConCert twice per year beginning in 2019, which provides additional opportunities to take the exam, thereby reducing some of its high-stakes nature.

In tandem, the development of an alternative to ConCert began to take shape. Initial thoughts were that the alternative would focus on shorter, more-frequent assessments, with the ability to retake the test sooner, if needed. Test topics would be more presentation based, such as difficulty breathing or abdominal pain. We also identified remote access and the use of some form of medical references as desirable for the alternative. The overall goal is to make it look more like your everyday work.

All-physician Survey

To gauge how closely the initial thoughts about the ConCert alternative resonated with emergency physicians, and to gather additional input about the Continuing Certification process, ABEM sent a survey to 35,247 ABEM-certified physicians. The survey was available from June 14 to June 29, 2018. ABEM received 12,800 responses (36 percent response rate). Key results are illustrated in the graphic, on the next page.



Through a new testing format, ABEM is pursuing a Continuing Certification process that could integrate many of the ideas expressed on the survey. The alternative, which will begin being phased in in 2020, will have a stronger emphasis on physician learning and integrating medical advances into practice. Again, these changes will increase the relevancy and flexibility of the process and decrease the high-stakes nature of the exam. We are grateful for all input provided by ABEM-certified physicians, either in response to a survey, attending a summit, or participating in conference calls. We appreciate the time you've taken to share your ideas.

Increasing the Value of Certification

We have also been working on ways to add value to your certification. One example is the availability of a letter refuting the need for merit badge courses. The letter, the result of the interorganizational Coalition to Oppose Medical Merit Badges (COMMB), is available to any ABEM-certified physician participating in MOC. COMMB is working to provide this information to other organizations, such as hospital-based management groups. Another example is the recognition by the American College of Surgeons (ACS) that ABEM MOC activities eliminate the need for ACS trauma-related CME credits to fulfill ACS trauma center verification requirements.

Other improvements include eliminating the MOC requirement to participate in patient satisfaction surveys.

Moving Forward

We continue to work on the details of the ConCert alternative. A dedicated team of ABEM directors and staff is committed to finalizing the details as quickly as possible, and we will provide additional specifics as they are decided. Our goal is to align our activities with your efforts to become a better doctor and ensure the public that no matter what emergency department they might enter, if they see an ABEM-certified physician they can be confident that they will receive the highest-quality care, 24/7/365. We believe your ABEM certification provides that assurance.

Together we will continue to support the ABEM mission "to ensure the highest standards in the specialty of Emergency Medicine."

Thank you for all you do.

LEADERSHIP

Board of Directors

Executive Committee

Terry Kowalenko, M.D., *President*
Robert L. Muelleman, M.D., *President-Elect*
Michael L. Carius, M.D., *Immediate-Past-President*
Jill M. Baren, M.D., *Secretary-Treasurer*
O. John Ma, M.D., *Member-at-Large*
Kerryann B. Broderick, M.D., *Senior-Member-at-Large*

Directors

Michael S. Beeson, M.D.
Wallace A. Carter, M.D.
Carl R. Chudnofsky, M.D.
Marianne Gausche-Hill, M.D.
Deepi G. Goyal, M.D.
Leon L. Haley, Jr., M.D.
Ramon W. Johnson, M.D.
Samuel M. Keim, M.D.
Mary Nan S. Mallory, M.D.
Catherine A. Marco, M.D.
Lewis S. Nelson, M.D.
James D. Thomas, M.D.
Robert P. Wahl, M.D.

Executive Staff

Earl J. Reisdorff, M.D., *Executive Director*
Melissa A. Barton, M.D., *Director of Medical Affairs*
Susan K. Adsit, *Associate Executive Director, Certification and Organizational Services*
Anne L. Harvey, Ph.D., *Associate Executive Director, Evaluation and Research*
Jennifer L. Kurzynowski, *Associate Executive Director, Operations*
Timothy J. Dalton, *Director, Examination Development and Administration*
Michele C. Miller, *Director, Certification Services*

Front row, left to right: O. John Ma, M.D.; Michael L. Carius, M.D.; Catherine A. Marco, M.D.; Jill M. Baren, M.D.; Deepi G. Goyal, M.D.; Leon L. Haley, Jr., M.D.
Second row: Michael S. Beeson, M.D.; Mary Nan S. Mallory, M.D.; Ramon W. Johnson, M.D.; Marianne Gausche-Hill, M.D.; Kerryann B. Broderick, M.D.; Wallace A. Carter, M.D.
Third row: Samuel M. Keim, M.D.; Lewis S. Nelson, M.D.; Carl R. Chudnofsky, M.D.; Terry Kowalenko, M.D.; Robert P. Wahl, M.D.
Back row: James D. Thomas, M.D.; Robert L. Muelleman, M.D.

VOLUNTEERS

ABEM could not operate without its over 500 physician volunteers. Hundreds of examiners attend each of the spring and fall Oral Exam administrations. Sixty item writers produce new questions for multiple choice tests each year, for both Emergency Medicine certification and recertification exams, and subspecialty exams. Others volunteer on standard-setting committees, which involves reviewing each multiple choice question or oral exam case, rating its difficulty, and assessing its importance to the certification of emergency physicians. And there are other task forces and advisory groups that assist in the certification and recertification processes.

Each of these clinically active physicians donates their time and effort to help assure that anyone certified or recertified in Emergency Medicine or any of its subspecialties meets the high standards expected of our specialty. Thank you!

The names of all ABEM volunteers are available on the ABEM website.

474 Oral Examiners

60 Item Writers and Editors

59 Standard Setting Panel Participants

21 Subboards and Exam Committees

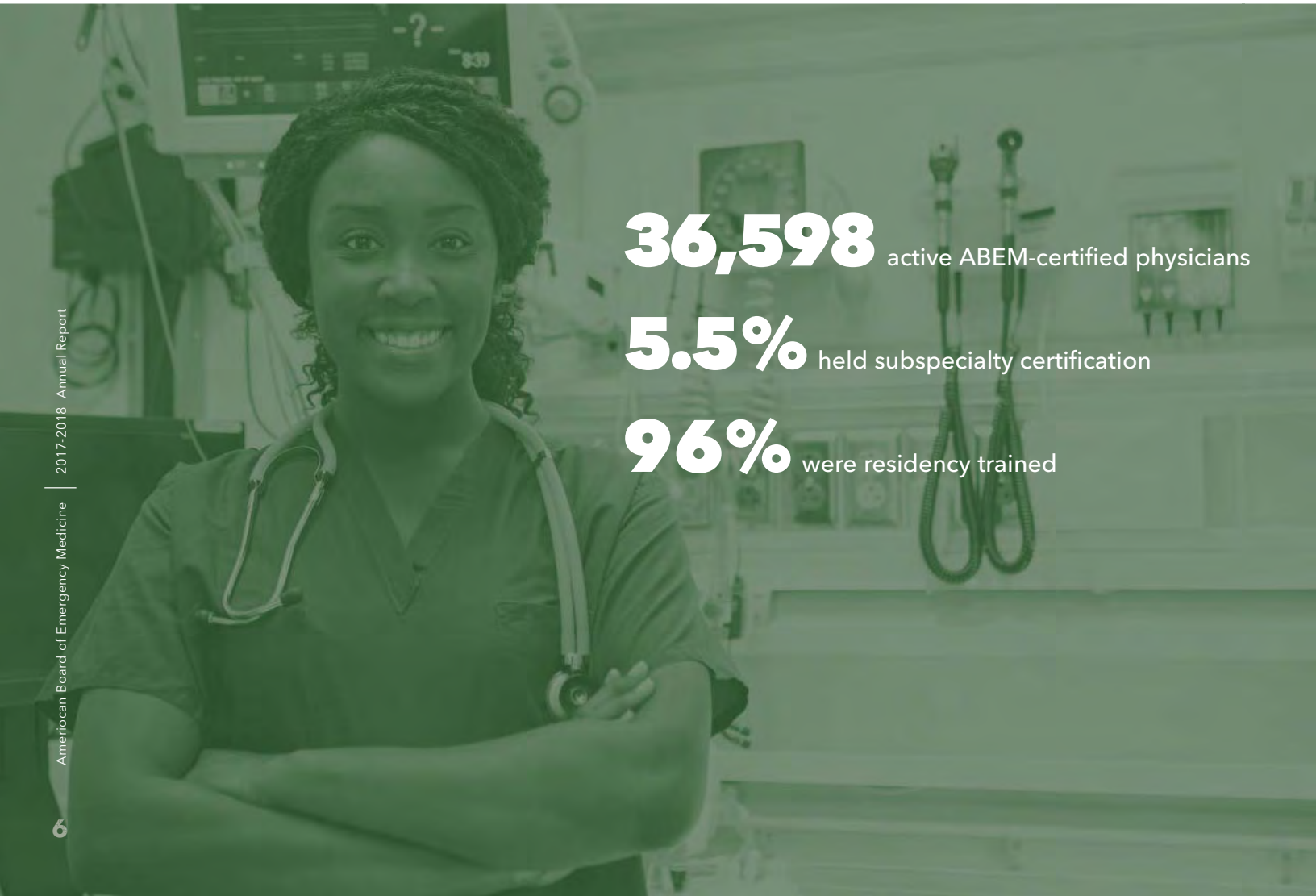
26 Task Force, Advisory Groups, etc.

19 Board of Directors

Pictured right: oral examiners
Pictured bottom left to right: item writers,
EMS Standard Setting Panel (caption at end of document)

ABEM-CERTIFIED PHYSICIANS

As of June 2018, there were 36,598 active ABEM-certified physicians. Of these, 2,001 (5.5%) held subspecialty certification. As Emergency Medicine matures, the number of residency-trained ABEM physicians rises; in 2017 nearly all (90%) were residency trained. A large majority (76%) practice in a community setting, while 57% are involved in teaching medical students and residents.

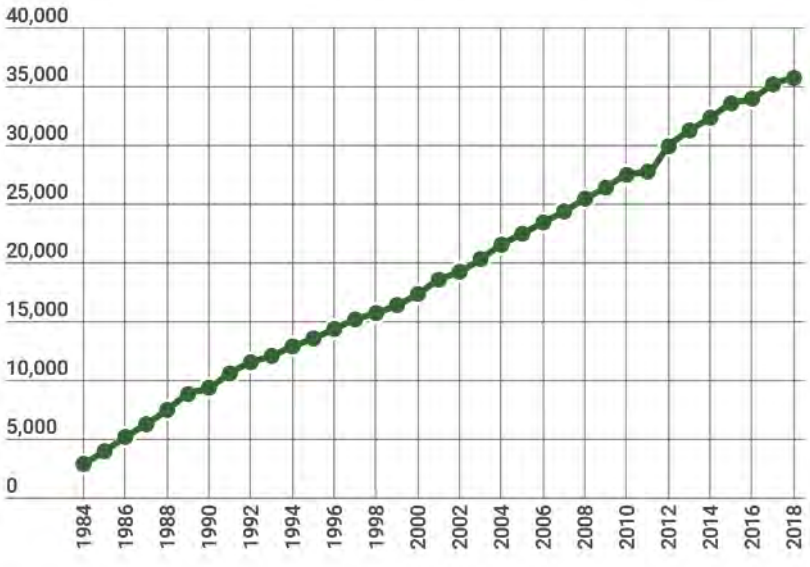


36,598 active ABEM-certified physicians

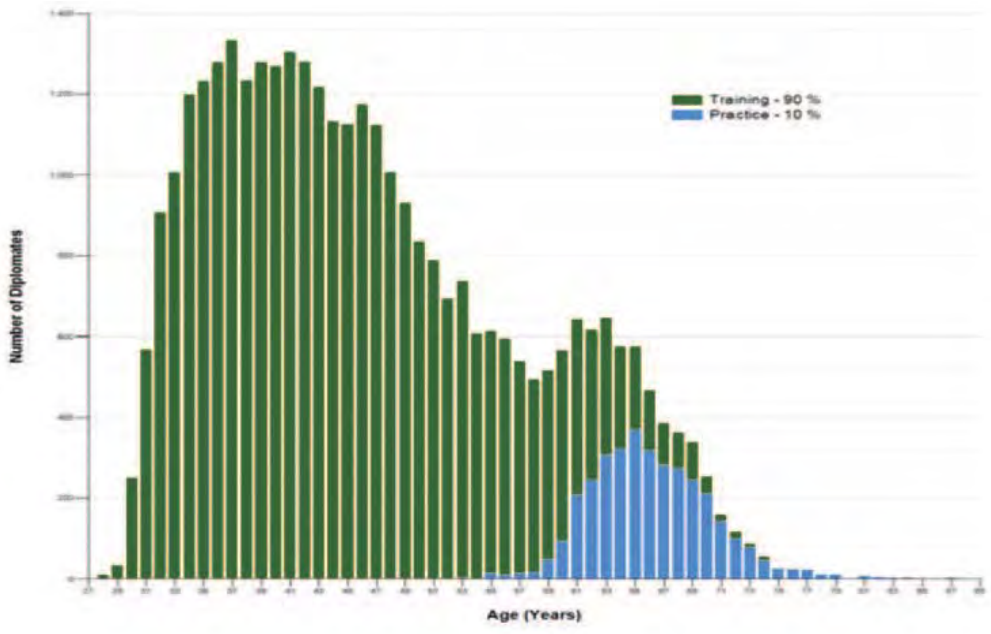
5.5% held subspecialty certification

96% were residency trained

Number of Active ABEM-certified Physicians



Distribution by Age and Training



EXAMINATION ACTIVITY

One way that ABEM achieves its mission, to ensure the highest standards in the specialty of Emergency Medicine, is through its testing and continuing certification activities. In 2017-2018, over 14,000 proctored examinations were administered, and over 24,000 LLSA tests were completed.

2,215
took the Qualifying Exam

among first-time test takers

1,952
took the Oral Certification Exam

among first-time test takers

2,799
took the ConCert Exam

among ABEM-certified physicians

7,536
took the In-training Exam

1,818
Newly Certified Physicians

87
Regained Certification

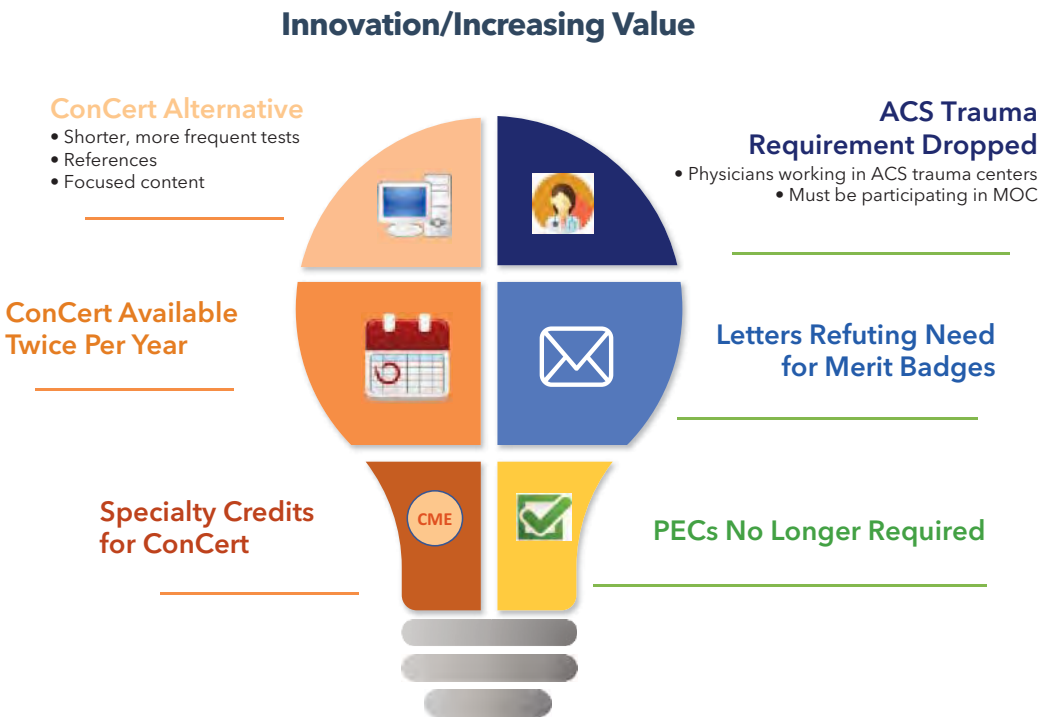
Detailed, longitudinal statistics are available in the tables beginning on page 19, and on the ABEM website.

MAINTENANCE OF CERTIFICATION

ABEM began rethinking ConCert in fall 2017 by asking a number of ABEM-certified physicians their opinions of the exam. Leaders of EM organizations, ACEP state chapters, and a survey sent to all ABEM-certified physicians helped guide the development of an alternative to the exam. The new assessment will be shorter, more frequent exams, composed of presentation-based content, and include the availability of some references. The pilot will begin in 2020. In the meantime, the current ConCert Exam will be offered twice per year—once in the spring and again in the fall—beginning in 2019. ABEM will provide additional information as it becomes available; the ABEM website is a great source for the most recent updates.

Other developments in 2017 that add value to ABEM certification included:

- The Coalition to Oppose Medical Merit Badges continued its work to leverage MOC activities against mandatory completion of short courses or additional certifications; a letter was made available for ABEM-certified physicians to download and provide to hospital administrators
- The American College of Surgeons (ACS) ruled that ABEM-certified physicians participating in MOC and working in ACS-designated trauma centers no longer need to acquire trauma-related CME credits to fulfill ACS trauma center verification requirements. This change applies only to CME requirements housed under the ACS designation.
- The communications/professionalism requirement (PECS survey) was eliminated.
- Specialty-designated credits are now available with ConCert; for the 2017 exam, 9.5 credits are designated as pediatrics, 2.0 as stroke, and 10.25 as trauma.



Lifelong Learning and Self-Assessment

The Lifelong Learning and Self-Assessment (LLS) component of ABEM's MOC Program promotes continuous learning with two aspects: LLSA tests and CME requirements.

24,282
LLSA tests completed

17,440
LLSA CME activities completed

Practice Improvement Measures

The Improvement in Medical Practice (IMP) component of ABEM's MOC Program focuses on practice-based learning and improvement in areas like patient care, communication, and more. Emergency physicians are committed to raising the quality of care for their patients by participating in practice improvement projects. Those who participate can get IMP credit for what they are already doing. Others can design a project that follows the four required steps: measuring, comparing to a standard, implementing an improvement, and re-measuring.

2017 Distinct Number of PI Attestations

1,267	Time-related (throughput time, ED length-of-stay, and other process time measures)
633	Stroke-related
554	Infectious Disease-related
399	Communication – Patient Care
575	Other
5,168	**Total PI Attestations**

SUBSPECIALTY CERTIFICATION

There were 275 subspecialty certificates in seven subspecialties issued in 2017. The number of certificates per subspecialty ranged from 183 for Emergency Medical Services, to one for Pain Medicine.

ABEM-certified physicians also have access to subspecialty certification in Addiction Medicine, Brain Injury Medicine, Clinical Informatics, and Surgical Critical Care.

Subspecialty	**Certificates Issued in 2017**	**Total Active Subspecialists**
Emergency Medical Services	183	626
Medical Toxicology*	0	409
Pediatric Emergency Medicine	27	255
Sports Medicine	17	189
Internal Medicine-Critical Care Medicine	34	170
Undersea and Hyperbaric Medicine	2	157
Hospice and Palliative Medicine*	0	138
Anesthesiology-Critical Care Medicine	11	49
Pain Medicine	1	8
Total	**275**	**2,001**

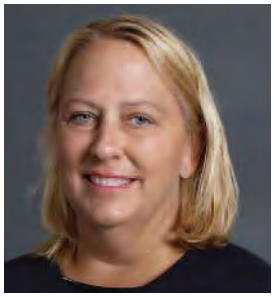
* Certification examination not offered in 2017. Data are for the 2017 calendar year.

2017-2018 HIGHLIGHTS

Newly Elected Directors

The Board of Directors of the American Board of Emergency Medicine (ABEM) recently elected two new members: Felix K. Ankel, M.D., and Diane L. Gorgas, M.D. Their terms begin at the close of the summer 2018 Board of Directors meeting.

Felix K. Ankel, M.D.



Diane L. Gorgas, M.D.

New Website

In spring 2018, ABEM launched a new public website (www.abem.org). The look and feel have been refreshed and the navigation updated to help users more easily locate information. We welcome your questions, comments, and suggestions, which can be shared with communications@abem.org.

Diplomate Recognitions

ABEM recognizes physicians who mark 30 years of being board certified in Emergency Medicine with a special certificate. This year's recipients included 649 physicians who had been board certified for 30 years as of December 31, 2017. A list of the 2018 recipients is posted on the ABEM website. Certificates are awarded annually to diplomates who achieve this milestone. ABEM applauds these physicians who have demonstrated a career-long commitment to excellence.

2017-19 ABEM NAM Fellow

The National Academy of Medicine recently named Mahshid Abir, M.D., M.Sc., the 2017-19 ABEM Fellow. Dr. Abir is an assistant professor in the Department of Emergency Medicine at the University of Michigan, and director of the acute care research unit at the Institute for Healthcare Policy & Innovation in Ann Arbor, Michigan.

Mahshid Abir, M.D.

Coalition to Oppose Medical Merit Badges

The Coalition believes that board-certified emergency physicians who actively maintain their board certification should not be required to complete short-course certifications in, for example, advanced resuscitation, trauma care, stroke care, cardiovascular care, or pediatric care in order to obtain or maintain medical staff privileges to work in an emergency department.

ABEM-certified physicians can now download a letter of support that may be submitted to hospital administrators to forego the mandatory completion of short courses or additional certifications often needed for hospital privileges. The letter is available from physicians' Personal Pages on the ABEM portal. Go to the following link for more information: https://www.abem.org/public/news-events/news/2018/03/19/commb-letters_press-release.

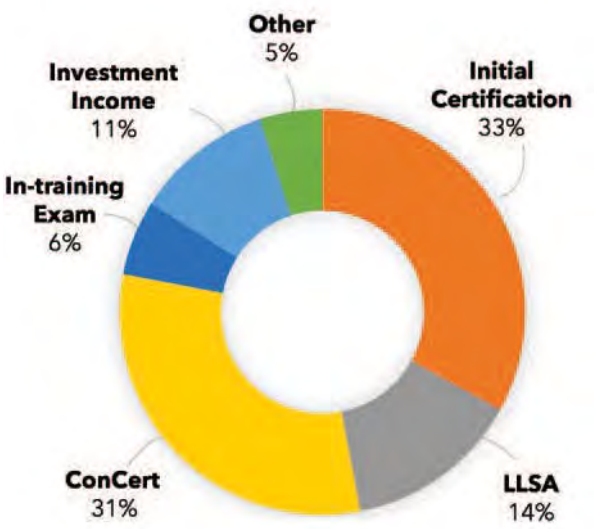
FINANCES

As reported on ABEM's 990, net revenue in 2017 totaled $1,350,361, of which $1,337,655 came from investment income, leaving net revenue from operations of $12,696.

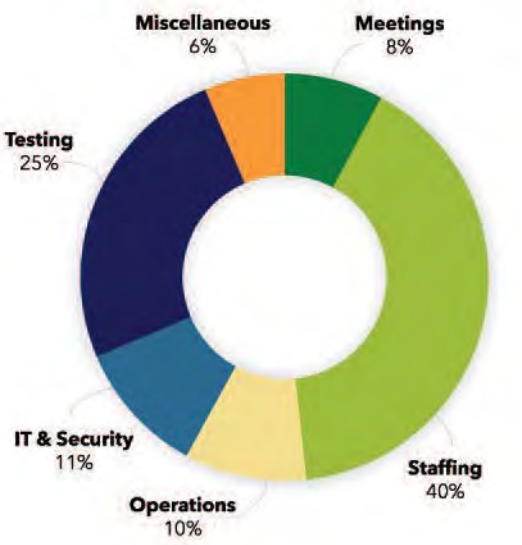
ABEM has been able to operate and **keep fees fixed** for the sixth consecutive year because of asset gains accumulated during the recent market expansion and realized gains from net assets.

Asset growth has allowed fees to remain fixed for six years.

Revenue by Category
2017-2018*



Spending by Category
2017-2018*



* Unaudited data

Spending by Category

Staffing: 40%

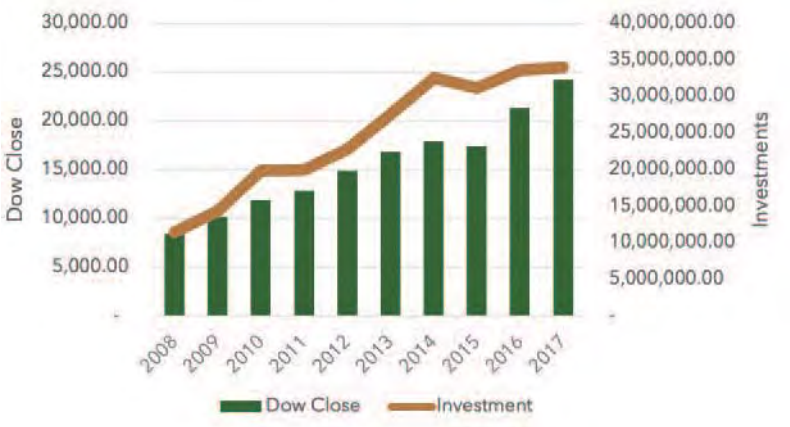
- Skilled professional staff (physicians, psychometricians, M.B.A.s, etc.)
- Staff supports all testing activities
- Supports physicians during initial certification and ongoing certification processes

Testing: 25%

- Leader in physician assessment
- Constantly advancing and innovating
- Robust research and development
- Exams developed, administered, scored, and reported

Change in Dow Closing Average and Investment Growth

ABEM assets largely the result of market growth since 2008



Audited Statement of Financial Position

June 30, 2017

Assets	
Current assets	
Cash and cash equivalents	$ 1,534,720
Accrued investment income	85,780
Investments	35,616,335
Prepaid expenses	101,411
Total current assets	37,338,246
Property, equipment, and software	8,575,537
Less: accumulated depreciation and amortization	(3,891,037)
Net property, equipment, and software	4,684,500
Other assets	
Deposits	37,000
Total assets	**$ 42,059,746**
Liabilities and Net Assets	
Current liabilities	
Accounts payable	$ 99,403
Accrued payroll	114,834
Accrued payroll tax	7,879
Deferred revenue	4,168,996
Current portion of capital lease payable	19,371
Current portion of note payable	667,841
Total current liabilities	5,078,324
Long-term liabilities	
Compensated absences	468,932
Capital lease payable, net of current portion	9,362
Note payable, net of current portion	964,376
Total long-term liabilities	1,442,670
Total liabilities	6,520,994
Net assets	
Unrestricted and undesignated	35,538,752
Total liabilities and net assets	**$ 42,059,746**
Revenues	**$14,779,149**
Expenses	
Direct Certification Expense	$6,100,024
Governance	1,757,777
International	15,183
Office administration	2,558,430
Outreach/liaison	1,214,183
Program development	959,560
Research	194,647
Subspecialties	618,848
Training/academic relations	833,229
Miscellaneous	50,415
Total expenses	**$14,302,296**
Change in net assets*	**476,853**
Other income (expense)	**2,555,634**
Change in net assets	3,032,487
Net assets, at beginning of year	$32,506,265
Net assets, at end of year	**$35,538,752**

* Before other income and gains

REPRESENTATIVES ON SUBBOARDS AND EXAMINATION COMMITTEES

EMS Examination Committee

Debra G. Perina, M.D., Chair
Jane H. Brice, M.D.
Carol A. Cunningham, M.D.
Theodore R. Delbridge, M.D.
Alexander P. Isakov, M.D.
Douglas F. Kupas, M.D.
Vincent N. Mosesso, Jr., M.D.
Peter T. Pons, M.D.,
Kathy J. Rinnert, M.D.
Ritu Sahni, M.D.
Marianne Gausche-Hill, M.D., ABEM Liaison

Medical Toxicology Subboard

Theodore C. Bania, M.D.
Sean M. Bryant, M.D.
Robert G. Hendrickson, M.D.
Michael G. Holland, M.D.
Anne-Michelle Ruha, M.D.
Joshua G. Schier, M.D.
Daniel L. Sudakin, M.D.
Lewis S. Nelson, M.D., ABEM Liaison

Pediatric Emergency Medicine Subboard

Robert L. Cloutier, M.D.
Timothy Horeczko, M.D.
Paul T. Ishimine, M.D.
Stacy L. Reynolds, M.D.
Larry B. Mellick, M.D.
Ramon W. Johnson, M.D.

Sports Medicine Examination Committee

Moria Davenport, M.D.
Andrew P. Perron, M.D.

Undersea and Hyperbaric Medicine Examination Committee

Charles S. Graffeo, M.D.
Tracy L. LeGros, M.D.

Captions at end of document

SENIOR DIRECTORS

Thank you for your legacy and contributions to the specialty of Emergency Medicine.

Gail V. Anderson, Sr., M.D. 1976–1989
Walter R. Anyan, Jr., M.D. 1995–2003
William G. Barsan, M.D. 1993–2001
Carol D. Berkowitz, M.D. 2003–2006
Howard A. Bessen, M.D. 2002–2010
Michael D. Bishop, M.D. 1988–1996
Brooks F. Bock, M.D. 1995–2004
G. Richard Braen, M.D. 1988–1996
Glenn D. Braunstein, M.D. 2002–2006
Dick D. Briggs, Jr., M.D. 1994–2002
Paul D. Bruns, M.D. 1980–1983
Joseph E. Clinton, M.D. 1986–1994
Robert E. Collier, M.D. 2004–2012
Lily C. A. Conrad, M.D. 2002–2010
Francis L. Counselman, M.D. 2008–2016
Rita Kay Cydulka, M.D. 2002–2010
Robert H. Dailey, M.D. 1976–1982
Daniel F. Danzl, M.D. 1991–1999
Steven J. Davidson, M.D. 1986–1995
John H. Davis, M.D. 1979–1984
Richard E. Dean, M.D. 1991–1994
James J. Dineen, M.D. 1976–1980
Frank A. Disney, M.D. 1979–1980
Lynnette Doan-Wiggins, M.D. 1999–2008
E. John Gallagher, M.D. 1995–2003
Joel M. Geiderman, M.D. 2003–2011
William E. Gotthold, M.D. 1994–2003
Jeffrey G. Graff, M.D. 1996–2005
Harris B. Graves, M.D. 1980–1987
R. R. Hannas, Jr., M.D. 1976–1988
Gerald B. Healy, M.D. 1988–1992
Robert S. Hockberger, M.D. 1995–2004
Gwendolyn L. Hoffman, M.D. 1994–2003
Leonard D. Hudson, M.D. 1990–1994
Bruce D. Janiak, M.D. 1986–1995
Carl Jelenko, III, M.D. 1976–1980
James H. Jones, M.D. 2005–2015
R. Scott Jones, M.D. 1988–1991
Allen P. Klippel, M.D. 1976–1982
Robert K. Knopp, M.D. 1988–1993
David A. Kramer, M.D. 2009–2013
Ronald L. Krome, M.D. 1976–1988
Jo Ellen Linder, M.D. 2004–2012
Louis J. Ling, M.D. 1997–2007
Mark A. Malangoni, M.D. 1998–2002
Vincent J. Markovchick, M.D. 1994–2002
M. J. Martin, M.D. 1990–1994, 1996–1998
John B. McCabe, M.D. 1996–2006
Henry D. McIntosh, M.D. 1979–1986
W. Kendall McNabney, M.D. 1982–1986
Harvey W. Meislin, M.D. 1986–1994
J. Mark Meredith, M.D. 2004–2012
Sheldon I. Miller, M.D. 1999–2006
James D. Mills, M.D. 1976–1988
John C. Moorhead, M.D. 2004–2014
John F. Murray, M.D. 1986–1989
Robert C. Neerhout, M.D. 1986–1994
Richard N. Nelson, M.D. 2004–2013
Michael S. Nussbaum, M.D. 2002–2006
Thomas K. Oliver, Jr., M.D. 1980–1981
Debra G. Perina, M.D. 2003–2011
Nicholas J. Pisacano, M.D. 1979–1986
Roy M. Pitkin, M.D. 1990–1998
George Podgorny, M.D. 1976–1988
Peter T. Pons, M.D. 1996–2004
J. David Richardson, M.D. 1994–1998
Leonard M. Riggs, Jr., M.D. 1981–1986
Frank N. Ritter, M.D. 1979–1988
Peter Rosen, M.D. 1976–1986
Robert J. Rothstein, M.D. 1996–2004
Douglas A. Rund, M.D. 1988–1997
Earl Schwartz, M.D. 1994–2002
Richard I. Shader, M.D. 1980–1990
Roger T. Sherman, M.D. 1984–1988
Rebecca Smith-Coggins, M.D. 2007–2015
Mark T. Steele, M.D. 2003–2012
Richard M. Steinhilber, M.D. 1979–1980
Richard L. Stennes, M.D. 1988–1996
Robert W. Strauss, M.D. 2007–2015
Henry A. Thiede, M.D. 1979–1980, 1984–1990
Harold A. Thomas, M.D. 2001–2010
Judith E. Tintinalli, M.D. 1982–1991
Robert Ulstrom, M.D. 1982–1986
Michael V. Vance, M.D. 1986–1995
David K. Wagner, M.D. 1976–1988
Edward E. Wallach, M.D. 1998–2006
Gerald P. Whelan, M.D. 1988–1998
John G. Wiegenstein, M.D. 1976–1986

EXAMINATION STATISTICS

Certification

		Qualifying Examination						Oral Certification Examination					
		EM Residency-eligible First-time Takers			Total Candidates[3]			EM Residency-eligible First-time Takers			Total Candidates[3]		
Date	App's Rec'd	# Took	# Pass	% Pass	# Took	# Pass	% Pass	# Took	# Pass	% Pass	# Took	# Pass	% Pass
1980 and prior	1,875	-	-	-	1,496	998	67	-	-	-	399	248	62
1981	1,035	-	-	-	1,142	825	72	-	-	-	548	356	65
1982	1,149	-	-	-	1,254	869	69	-	-	-	998	571	57
1983	1,242	-	-	-	1,335	885	66	-	-	-	1,293	766	59
1984	1,399	-	-	-	1,694	1,108	65	-	-	-	1,339	912	68
1985	1,600	-	-	-	2,016	1,274	63	-	-	-	1,066	801	75
1986	1,709	-	-	-	2,147	1,124	52	-	-	-	1,425	993	70
1987	1,977	-	-	-	2,479	1,429	58	-	-	-	1,503	1,192	79
1988	2,915	-	-	-	2,607	1,375	53	-	-	-	1,602	1,227	77
1989	886	Postponed to 5/30/90						-	-	-	1,627	1,266	78
1990	1,069	-	-	-	3,446	1,953	57	-	-	-	1,350	1,059	78
1991	624	-	-	-	1,510	853	56	-	-	-	1,464	1,185	81
1992	742	-	-	-	1,396	820	59	-	-	-	1,446	1,146	79
1993	964	-	-	-	1,281	822	64	-	-	-	977	753	76
1994	785	-	-	-	1,329	781	59	-	-	-	1,095	894	82
1995[1]	847	753	664	88	1,249	769	62	692	669	97	1,028	890	87
1996	860	839	756	90	1,290	899	70	703	658	94	968	808	84
1997	943	920	811	89	1,335	903	68	795	711	89	934	795	85
1998	1,005	1,003	909	91	1,426	1,036	73	864	788	91	1,059	895	85
1999	1,099	1,092	972	89	1,457	1,053	72	988	851	86	1,083	901	83
2000	1,108	1,087	985	91	1,488	1,085	73	1,040	957	92	1,272	1,124	88
2001	1,173	1,155	1,026	89	1,471	1,135	77	1,064	1,000	94	1,257	1,133	90
2002	1,171	1,176	1,057	90	1,516	1,181	78	1,142	1,040	91	1,291	1,140	88
2003	1,198	1,179	1,092	93	1,496	1,205	81	1,158	1,058	91	1,278	1,140	89
2004	1,256	1,242	1,099	88	1,490	1,188	80	1,204	1,142	95	1,335	1,237	93
2005	1,299	1,287	1,164	90	1,593	1,283	81	1,197	1,132	95	1,325	1,233	93
2006	1,329	1,302	1,200	92	1,606	1,344	84	1,239	1,166	94	1,289	1,204	93
2007	1,411	1,408	1,267	90	1,645	1,363	83	1,328	1,254	94	1,431	1,340	94
2008	1,387	1,366	1,246	91	1,638	1,371	84	1,357	1,288	95	1,434	1,353	94
2009	1,448	1,430	1,295	91	1,717	1,429	83	1,408	1,337	95	1,484	1,397	94
2010	1,517	1,519	1,381	91	1,779	1,515	85	1,416	1,335	94	1,470	1,378	94
2011	1,584	1,560	1,417	91	1,827	1,540	84	1,534	1,487	97	1,665	1,603	96
2012	1,612	1,615	1,511	94	1,898	1,653	87	1,548	1,515	98	1,643	1,599	97
2013	1,711	1,704	1,520	89	1,952	1,617	83	1,704	1,675	98	1,712	1,678	98
2014	1,739	1,709	1,536	90	2,028	1,676	83	1,620	1,559	96	1,638	1,571	96
2015	1,811	1,807	1,639	91	2,118	1,788	84	1,684	1,648	98	1,729	1,682	97
2016	1,867	1,853	1,732	93	2,129	1,893	89	1,765	1,722	98	1,827	1,778	97
2017	1,986	1,975	1,834	93	2,215	1,961	89	1,894	1,818	96	1,952	1,868	96
Total	**51,332**	**30,981**	**28,113**	**91[2]**	**63,495**	**46,003**	**72[2]**	**29,344**	**27,810**	**95[2]**	**50,236**	**43,116**	**86[2]**

[1] 1995 was the first year that a reference group of EM residency-eligible, first-time test takers was used to construct the written certification examination, now known as the qualifying examination.

[2] Number indicates the percent of the total that passed.

[3] Candidates do not include former diplomates attempting to regain certification through the qualifying and/or oral examination.

Subspecialty Certification

Year	ACCM	EMS	HPM	IM-CCM	Med Tox	Pain	Ped EM	SPM	UHM	**Total**
1993							38	8		46
1994							23	0		69
1995					51		0	12		134
1996					0		0	0		132
1997					32		39	8		213
1998					0		0	0		213
1999					42		20	8		283
2000					24		0	0		307
2001					0		23	4	7	341
2002					30		0	2	7	380
2003					0		12	2	11	405
2004					30		19	3	42	499
2005					0		0	3	17	519
2006					39		10	12	7	587
2007					0		0	5	6	598
2008			12		31		0	12	12	665
2009			0		0	1	19	9	21	715
2010			23		39	2	0	13	38	830
2011			0		0		26	14	15	885
2012			60	25	38	1	0	11	5	1,024
2013		225	0	19	0	2	35	16	5	1,326
2014	12	0	20	25	48	0	0	14	4	1,449
2015	9	220	0	28	0	1	30	16	3	1,756
2016	17	0	32	40	53	0	0	26	6	1,930
2017	11	183	0	34	0	1	27	17	2	2,205
Total Certificates Issued	**49**	**628**	**146**	**171**	**459**	**8**	**321**	**215**	**208**	**2,205**
Total Active Diplomates	**49**	**626**	**138**	**170**	**409**	**8**	**255**	**189**	**157**	**2,001**

ACCM: Anesthesiology Critical Care Medicine
EMS: Emergency Medical Services
HPM: Hospice and Palliative Medicine
IM-CCM: Internal Medicine – Critical Care Medicine
MedTox: Medical Toxicology
Pain: Pain Medicine
PedEM: Pediatric Emergency Medicine
SPM: Sports Medicine
UHM: Undersea and Hyperbaric Medicine

Statistics are reported by calendar year.

ConCert™ Examination

	Diplomates			Former Diplomates		
Year	**# Took**	**# Pass**	**% Pass**	**# Took**	**# Pass**	**% Pass**
2004	1,264	1,169	92	127	60	47
2005	1,407	1,295	92	157	92	59
2006	1,367	1,296	95	206	129	63
2007	1,569	1,483	95	135	81	60
2008	1,778	1,687	95	138	104	75
2009	1,657	1,576	95	119	82	69
2010	1,955	1,897	97	121	94	78
2011	2,022	1,943	96	147	99	67
2012	1,762	1,681	95	154	100	65
2013	1,971	1,895	96	189	132	70
2014	2,391	2,335	98	61	19	31
2015	2,503	2,412	96	124	74	60
2016	2,582	2,478	96	136	78	57
2017	2,653	2,535	96	146	79	54
Total	**26,881**	**25,682**	**96**[1]	**1,814**	**1,306**	**64**[1]

[1] Number indicates the percent of the total who passed.

Statistics are reported by calendar year. The statistics accurately reflect the examinations administered during the designated periods, and all examination data are included. Candidates who took more than one examination are included more than once.

Total number of active diplomates on 12/31/2017 was 36,166.

Page 5, EMS Standard Setting Panel: Michael W. Dailey, M.D.; Francis X. Guyette, M.D.; Sean W. Marquis, M.D.; Ross E. Megargel, D.O.; Juan A. March, M.D.; Peter T. Pons, M.D. (exam co-editor); Douglas F. Kupas, M.D. (exam committee member); Gerard DeMers, D.O.; Josef Schenker, M.D.; Andrew M. McCoy, M.D.; Wendy J. Wilcoxson, D.O.; Buddy G. Kozen, M.D.; Jocelyn M. DeGuzman, M.D.; Joanna L. Adams, M.D.; Rachel E. Semmons, M.D.; Mohamud R. Daya, M.D.; Daniel S. Schwartz, M.D.; Katie L. Tataris, M.D.; Heidi J. Lako-Adamson, M.D.; Marilyn McLeod, M.D.

Page 17, EMS Examination Committee: Standing, left to right: Vincent N. Mosesso, Jr., M.D.; Douglas F. Kupas, M.D.; Peter T. Pons, M.D.; Theodore R. Delbridge, M.D.; Alexander P. Isakov, M.D.; Carol A. Cunningham, M.D.; and ABEM Liaison Marianne Gausche-Hill, M.D. Seated, left to right: Debra G. Perina, M.D.; Kathy J. Rinnart, M.D.; Ritu Sahni, M.D. Not pictured: Jane H. Brice, M.D.

Page 17, Medical Toxicology Subboard: Standing, left to right: Christopher J. Ondrula, J.D. (ABPM Executive Director); Theodore C. Bania, M.D.; Sean M. Bryant, M.D.; Michael G. Holland, M.D.; Daniel L. Sudakin, M.D.; Benson S. Munger, Ph.D. (ABPM Liaison); Lewis S. Nelson, M.D. (ABEM Liaison). Seated left to right: Daniel A. Goldstein, M.D.; Joshua G. Schier, M.D.; and Michele Burns, M.D. Not pictured: Carl R. Baum, M.D.; Diane P. Calello, M.D.; Michael I. Greenberg, M.D.; Robert G. Hendrickson, M.D.; and Gail A. McGuinness, M.D. (ABP Liaison).

American Board of Emergency Medicine
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This item will be provided as soon as it is available.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Memorandum

To: 2018 Council

From: Stephen H. Anderson MD, FACEP
Secretary-Treasurer

Date: September 12, 2018

Subj: FY 2017-18 Financial Report

This report of the FY 2017-18 encompasses the College's activities from July 1, 2017, through June 30, 2018. Additional details can be found in the June 30, 2018 Financial Statements.

Membership

Total membership increased by 1,050 to a total of 38,347 (2.82%). Active membership increased by 104 to 20,778 (0.5%). Candidate membership increased by 920 to 13,368 (7.3%). International membership increased by 136 to 1,097 (11.32%). Life membership decreased by 109 to 2,966 (-3.54%). Honorary membership decreased by 1 to 34 (-2.86%).

Revenue

Total revenue was $38,480,803. Membership dues accounted for $13,433,859 (35% of the total revenue). Meetings, sale of products, and royalties generated $18,125,087 (47% of the total revenue). Grants, investments, sale of the building, CEDR, and other contributions accounted for $6,921,857 (18% of total revenue).

Expenses

Total expenses were $37,213,203. Salaries and accrued vacations were $13,056,558 (35% of expenses). Facility and meal costs were $6,424,148 (17% of expenses). Consulting and legal fees were $4,085,342 (11% of expenses). Staff benefits were $4,036,768 (11% of expenses).

Net from Operations

Revenue	$38,480,803
Expenses	$37,213,203
Net	$1,267,600

Liquid Reserve

Liquid reserve represents the amount of cash on hand minus the amount due to chapters and deferred revenue.

Cash equivalents	$22,630,130
Due to chapters	$2,190,886
Deferred revenue	$12,669,927
Liquid reserve	$7,769,317 (20% of operating budget)

ACEP's policy is to have at least 15% of the operating budget in liquid reserves. The FY 2017-18 operating budget was $39,526,097 and 15% would equal $5,928,914. Therefore, we have excess liquid reserves of $1,840,402.

HEADQUARTERS
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Irving, TX 75063-2524

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Contributions to Equity and Staff Bonuses
The amount available is calculated from the net revenue after realized gains and the net budget is subtracted. This year that totaled $303,367. 40% was allocated to the staff bonus pool, and 60% was allocated to member equity. The operating revenue over expense below excludes the in-kind revenue of $254,151 and the in-kind depreciation expense of $8,472.

Adjusted Operating Revenue Over Expense	$1,021,922
Less Positive Realized Gains Variance	($769,298)
Less Target Budgeted Net	($50,743)
Adjusted Excess	$303,367

Equity
Current member's equity is $22,261,217. The total contribution to equity this year was $879,483, which is a $2,439,908 decrease over last year.

Assets	$45,086,086
Liabilities	$22,824,869
Equity	$22,261,217

Equity per regular member is a useful means to measure growth in equity. Equity per regular member this fiscal year was $1,071, an increase of $37, a 3.5% gain.

Staff Bonuses
$121,346 was distributed to the staff bonus award pool, a decrease of $753,048 or 86% over last year. After taxes were paid (7.65%) the bonus award pool was $112,723.

Investment Portfolio
Additional details can be found in the June 30, 2018, Financial Statements. The current distribution is approximately 43% in equities and 57% in fixed income investments. The fiscal year return was 5.29%. Since the fund was created in 2009, the average annual return has been 11.53%.

2017-18 Activity Highlights

ACEP.org Website Redesign
In FY 2016-2017 the College began working on the website redesign project including feedback from 250 members, deep dive interviews with 7 task force members, stats on most used pages and searched words and phrases, and best practices for websites in 2018. In May 2018, the soft launch of the website was released and offered several important features such as enhanced search performance, content organized by topic, streamlined design of the content for better visibility on mobile devices, and section content is no longer behind a members-only restriction.

Geriatric Emergency Department Accreditation Program
In early 2017, the Board of Directors approved a new program to accredit emergency departments as geriatric emergency departments (GEDs) recognizing that they demonstrate exemplary emergency care of older adults. Most of these EDs will not have separate spaces for older adults, but will demonstrate dedicated programs of care for older adults. Accreditation is granted on three levels. ACEP launched the GED Accreditation program at *ACEP17* and began receiving applications in 2018. By recognizing EDs publicly as having enhanced models of care for older adults, ACEP hopes to support these EDs in acquiring the resources needed to evolve their care to meet the needs of growing numbers of frail older adults. Once again, ACEP is helping lead the US Health Care System in its needed evolution to meet the needs of our shared patients.

Clinical Qualified Data Registry
ACEP's new quality portfolio is becoming part of the national quality movement to redefine and rebrand emergency care. The quality line of service was re-structured to provide cross-functional member interaction and best practice development-related quality data tracking and reporting: Quality Collaboration, Policy, Patient Safety, Informatics, Performance Measurement, Quality Improvement, Health Information Technology, Analytics, Research, Innovation, Education, Training, and Quality Strategy. With a humble beginning in FY 2015-16, the Clinical Emergency Department Data Registry (CEDR) started with five emergency medicine groups representing 14 EDs, and has grown rapidly in FY 2017-18 to 145 emergency medicine groups representing 700+ EDs. CEDR has is now sustainable financially and is likely to be a significant driver for ACEP's financial diversity and membership growth and satisfaction.

American College of Emergency Physicians

Independent Auditor's Report and Consolidated Financial Statements

June 30, 2018 and 2017

BKD
CPAs & Advisors

American College of Emergency Physicians

June 30, 2018 and 2017

Contents

BKD
CPAs & Advisors

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Independent Auditor's Report

Board of Directors
American College of Emergency Physicians
Irving, Texas

We have audited the accompanying consolidated financial statements of American College of Emergency Physicians (College) and National Emergency Medicine Political Action Committee (NEMPAC), which comprise the consolidated statements of financial position as of June 30, 2018 and 2017, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the College and NEMPAC as of June 30, 2018 and 2017, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

BKD, LLP

Dallas, Texas
September 25, 2018

American College of Emergency Physicians
Consolidated Statement of Financial Position
June 30, 2018

	2018		
	ACEP	NEMPAC	Total
Assets			
Cash and cash equivalents	$ 5,067,183	$ 182,162	$ 5,249,345
Assets in 457b plan	1,254,661	-	1,254,661
Investments	16,308,286	-	16,308,286
Accounts receivable	1,621,212	-	1,621,212
Inventories	366,506	-	366,506
Prepaid expenses	681,460	-	681,460
Deferred expenses	1,438,356	-	1,438,356
Property and equipment, net	18,334,446	-	18,334,446
Deposits	13,991	-	13,991
Total assets	$ 45,086,101	$ 182,162	$ 45,268,263
Liabilities and Net Assets			
Liabilities			
Accounts payable	$ 1,617,388	$ 1,363	$ 1,618,751
Accrued compensation	1,238,954	-	1,238,954
Liability in 457b plan	1,254,661	-	1,254,661
Other accrued expenses	498,301	-	498,301
Deferred revenue	12,669,927	-	12,669,927
Amounts held on behalf of chapter affiliates	2,190,880	-	2,190,880
Note payable to bank	3,354,803	-	3,354,803
Total liabilities	22,824,914	1,363	22,826,277
Unrestricted net assets	22,261,187	180,799	22,441,986
Total liabilities and net assets	$ 45,086,101	$ 182,162	$ 45,268,263

American College of Emergency Physicians
Consolidated Statement of Financial Position
June 30, 2017

	2017		
	ACEP	NEMPAC	Total
Assets			
Cash and cash equivalents	$ 5,479,742	$ 327,134	$ 5,806,876
Assets in 457b plan	1,116,011	-	1,116,011
Investments	18,306,836	-	18,306,836
Accounts receivable	1,615,656	-	1,615,656
Inventories	554,747	-	554,747
Prepaid expenses	534,691	-	534,691
Deferred expenses	933,731	-	933,731
Property and equipment, net	18,151,911	-	18,151,911
Deposits	13,991	-	13,991
Total assets	$ 46,707,316	$ 327,134	$ 47,034,450
Liabilities and Net Assets			
Liabilities			
Accounts payable	$ 2,246,932	$ 56	$ 2,246,988
Accrued compensation	2,004,561	-	2,004,561
Liability in 457b plan	1,116,011	-	1,116,011
Other accrued expenses	342,521	-	342,521
Deferred revenue	12,568,423	-	12,568,423
Amounts held on behalf of chapter affiliates	2,296,010	-	2,296,010
Note payable to bank	4,751,154	-	4,751,154
Total liabilities	25,325,612	56	25,325,668
Unrestricted net assets	21,381,704	327,078	21,708,782
Total liabilities and net assets	$ 46,707,316	$ 327,134	$ 47,034,450

American College of Emergency Physicians
Consolidated Statement of Activities
Year Ended June 30, 2018

	2018		
	ACEP	NEMPAC	Total
Revenues			
Membership	$ 16,581,383	$ -	$ 16,581,383
Education, professional products and meetings	15,539,803	-	15,539,803
Policy	1,456,274	-	1,456,274
Federal awards	1,021,311	-	1,021,311
Public affairs	847,177	970,452	1,817,629
Quality	1,634,479	-	1,634,479
Leadership	181,081	-	181,081
Investment return	952,527	68	952,595
Total revenues	38,214,035	970,520	39,184,555
Program and Service Expenses			
Membership	6,674,785	-	6,674,785
Education, professional products and meetings	8,790,969	-	8,790,969
Policy	3,843,208	-	3,843,208
Federal awards	1,021,311	-	1,021,311
Public affairs	4,319,593	1,116,799	5,436,392
Quality	1,705,381	-	1,705,381
Leadership	3,366,546	-	3,366,546
Total program and service expenses	29,721,793	1,116,799	30,838,592
Administrative Expenses			
College administration	7,491,413	-	7,491,413
Bonus award program	121,346	-	121,346
Total administrative expenses	7,612,759	-	7,612,759
Total expenses	37,334,552	1,116,799	38,451,351
Change in Unrestricted Net Assets	879,483	(146,279)	733,204
Unrestricted Net Assets, Beginning of Year	21,381,704	327,078	21,708,782
Unrestricted Net Assets, End of Year	$ 22,261,187	$ 180,799	$ 22,441,986

American College of Emergency Physicians
Consolidated Statement of Activities
Year Ended June 30, 2017

	2017		
	ACEP	NEMPAC	Total
Revenues			
Membership	$ 16,474,716	$ -	$ 16,474,716
Education, professional products and meetings	17,010,227	-	17,010,227
Policy	1,944,925	-	1,944,925
Federal awards	721,682	-	721,682
Public affairs	682,054	1,008,256	1,690,310
Quality	555,421	-	555,421
Leadership	172,014	-	172,014
Gain on disposal of equipment	2,164,314		2,164,314
Investment return	1,780,110	6	1,780,116
Total revenues	41,505,463	1,008,262	42,513,725
Program and Service Expenses			
Membership	6,860,613	-	6,860,613
Education, professional products and meetings	9,860,343	-	9,860,343
Policy	5,840,083	-	5,840,083
Federal awards	739,656	-	739,656
Public affairs	5,031,032	962,969	5,994,001
Quality	3,666,258	-	3,666,258
Leadership	4,194,329	-	4,194,329
Total program and service expenses	36,192,314	962,969	37,155,283
Administrative Expenses			
College administration	1,119,403	-	1,119,403
Bonus award program	874,394	-	874,394
Total administrative expenses	1,993,797	-	1,993,797
Total expenses	38,186,111	962,969	39,149,080
Change in Unrestricted Net Assets	3,319,352	45,293	3,364,645
Unrestricted Net Assets, Beginning of Year	18,062,352	281,785	18,344,137
Unrestricted Net Assets, End of Year	$ 21,381,704	$ 327,078	$ 21,708,782

American College of Emergency Physicians
Consolidated Statements of Cash Flows
Years Ended June 30, 2018 and 2017

	2018	2017
Operating Activities		
Change in net assets	$ 733,204	$ 3,364,645
Items not requiring (providing) cash		
Depreciation	1,294,597	1,181,686
Net unrealized and realized gains on investments	(424,614)	(1,303,399)
Gain on disposal of fixed assets	-	(2,164,314)
Changes in		
Accounts receivable	(5,556)	(651,796)
Inventories	188,241	(235,163)
Prepaid expenses	(146,769)	(67,042)
Deferred expenses	(504,625)	201,422
Accounts payable	(628,237)	(1,057,356)
Accrued compensation	(765,607)	594,947
Other accrued expenses	155,780	(42,531)
Deferred revenue	101,504	(1,388,577)
Amounts held on behalf of chapter affiliates	(105,130)	45,273
Net cash used in operating activities	(107,212)	(1,522,205)
Investing Activities		
Purchases of investments	(5,375,133)	(5,923,095)
Proceeds from sales of investments	7,798,297	5,737,012
Purchases of property and equipment	(1,477,132)	(6,173,512)
Proceeds from sale of building	-	2,875,000
Net cash provided by (used in) investing activities	946,032	(3,484,595)
Financing Activities		
Payments of note payable to bank	(1,396,351)	-
Proceeds from issuance of note payable to bank	-	4,249,523
Net cash provided by (used in) financing activities	(1,396,351)	4,249,523
Decrease in Cash and Cash Equivalents	(557,531)	(757,277)
Cash and Cash Equivalents, Beginning of Year	5,806,876	6,564,153
Cash and Cash Equivalents, End of Year	$ 5,249,345	$ 5,806,876
Supplemental Cash Flows Information		
Cash paid for interest	$ 128,017	$ 73,636
Accounts payable incurred for purchase of property and equipment	$ -	$ 268,221

American College of Emergency Physicians
Notes to Consolidated Financial Statements
June 30, 2018 and 2017

Note 1: Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

The consolidated financial statements of American College of Emergency Physicians (College) include the accounts of the College and National Emergency Medicine Political Action Committee (NEMPAC). The College has control of NEMPAC by appointment authority of a majority of the Board of Directors (Board). Economic interest only exists to the extent that the NEMPAC supports candidates for federal office who support positions that benefit emergency physicians. Under law, the funds available to NEMPAC may not be used by the College and are, as required, kept in a segregated fund for allowable NEMPAC activities.

The College is a Texas not-for-profit corporation that provides continuing education in emergency medicine through various programs, publications and updates on developments in emergency medicine. The College receives its primary funding from annual membership dues and charges for education, professional products, and meetings. Additionally, the College provides administrative support for certain chapter activities. The College manages other organizations with related purposes for fees established by the Board.

Basis of Presentation

The accompanying consolidated financial statements of the College have been prepared in accordance with accounting principles generally accepted in the United States of America for not-for-profit organizations. Resources are classified into three net asset categories according to the existence or absence of donor-imposed restrictions. Accordingly, net assets of the College and changes therein are classified and reported as follows:

- **Unrestricted Net Assets** – Net assets that are not subject to donor-imposed restrictions and which may be used for any operating purpose of the College.

- **Temporarily Restricted Net Assets** – Net assets that are subject to donor-imposed stipulations that require the passage of time or the occurrence of a specific event. When a donor restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the accompanying consolidated statements of activities as net assets released from restrictions. The College has no temporarily restricted net assets as of June 30, 2018 and 2017.

- **Permanently Restricted Net Assets** – Net assets required to be maintained in perpetuity due to donor-imposed restrictions. Generally, the donors of these assets permit the use of all or part of the income earned on the related investments for general or specific purpose. The College has no permanently restricted net assets as of June 30, 2018 and 2017.

Cash and Cash Equivalents

The College considers all liquid investments with original maturities of three months or less to be cash equivalents. At June 30, 2018 and 2017, cash equivalents consisted primarily of money market accounts.

At June 30, 2018 and 2017, the College's cash accounts exceeded federally insured limits by approximately $3,800,000 and $4,300,000, respectively.

Investments and Investment Return

Investments in exchange traded funds, corporate debentures, and mutual funds are carried at fair value. Other investments are valued at the lower of cost (or fair value at time of donation, if acquired by contribution) or fair value. Investment return includes dividend, interest and other investment income; realized and unrealized gains and losses on investments carried at fair value; and realized gains and losses on other investments.

Accounts Receivable

The College's accounts receivable are due from members, nonmembers, other organizations and institutions. Accounts receivable are due upon receipt of the invoice. Receivables are stated at amounts due net of an allowance for doubtful accounts. Accounts are considered past due after 30 days. The College determines its allowance based on past due accounts. The College reserves a percentage of accounts receivable in anticipation of disputed invoices based on historical experience. Significantly past due invoices are charged to the allowance for uncollectible accounts and payments subsequently received on such receivables are credited to the revenue accounts. Customers whose accounts are not current are not allowed to make additional purchases or to register for meetings. There was no allowance for doubtful accounts at June 30, 2018 and 2017.

Inventories

Inventories consist primarily of publications held for sale and are valued at the lower of cost or net realizable value. Cost is determined using the average cost method.

Property and Equipment

Property and equipment are stated at cost less accumulated depreciation. Depreciation is charged to expense using the straight-line method over the estimated useful life of each asset. The College generally capitalizes all expenditures for property and equipment in excess of $2,500.

The estimated useful lives for each major depreciable classification of property and equipment are as follows:

Headquarters building	30 years
Building fixtures	5 years
Furniture and equipment	3 – 10 years
Data processing software	2 – 5 years
Quality measures	5 years

Deferred Revenue

Revenue from various sources is deferred and recognized over the periods to which the revenue relates.

Revenue and Expense Recognition

Membership revenues and expenses relate to the planning, production and implementation of membership recruitment and retention programs, including the provision of certain newsletters and other publications to the membership. Revenue from annual membership dues and subscriptions are recognized on a pro rata basis over the related membership and subscription terms.

Revenues and expenses from educational meetings relate to the development and implementation of educational programs. Revenues and expenses from educational and professional products relate to the development and production of publications and the operation of a bookstore during educational programs. Revenues and expenses relating to educational meetings and professional products are recognized at the time the meetings occur or publications are sold.

Revenues and expenses relating to certain projects not completed at the end of each year are deferred. Such revenues and expenses are subsequently recognized upon completion of the related projects.

Revenues from sponsorships are deferred until the sponsored event occurs. These revenues are included in the accompanying consolidated statements of activities in the educational meetings or policy revenue.

Revenues and expenses described as policy relate to emergency medical service issues, research in emergency medicine and aspects of emergency medicine practice at the state and federal levels.

Revenues and expenses described as public affairs relate to governmental relations and public affairs activities, contributions received from corporations for the benefit of NEMPAC and contributions in support of public policy research and related activities.

Revenues and expenses described as quality relate to facilitating emergency care research through the identification of practice patterns, trends and outcomes in emergency care which will allow for physician groups and hospitals to identify areas of improvement. Quality performance measures have also been developed which involves identifying the clinical area to evaluate, evidence to support the measure (i.e. literature), variations in care/gaps in quality, feasibility and testing.

Revenues and expenses from leadership relate to the continued development and refinement of emergency medicine and foster interchange of information with its members.

Functional Allocation of Expense

The costs of supporting the various programs and other activities have been summarized on a functional basis in the accompanying consolidated statements of activities. Certain costs have been allocated among the program and service and administrative categories based on the actual usage or estimate of usage applicable and other methods.

Contributed Services

Contributions of services are recognized as revenue at their estimated fair value only when the services received create or enhance nonfinancial assets or require specialized skills possessed by the individuals providing the service and the service would typically need to be purchased if not donated. The College receives valuable donated services from member volunteers who provide teaching and writing on specific topics; however, these are not reflected in the accompanying consolidated statements of activities since these services do not create or enhance nonfinancial assets.

Government Grants

Support funded by grants is recognized as the College performs the contracted services or incurs outlays eligible for reimbursement under the grant agreements. Grant activities and outlays are subject to audit and acceptance by the granting agency and, as a result of such audit, adjustments could be required.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the College and NEMPAC, whose governing body is appointed by the College. All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, and disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains, losses and other changes in net assets during the reporting period. Actual results could differ from those estimates.

Income Taxes

The College is exempt from income taxes under Section 501(c)(6) of the Internal Revenue Code (IRC). However, the College is subject to federal income tax on any unrelated business taxable income. NEMPAC is a separate segregated fund of the College and is therefore, subject to tax as a political organization under Section 527(f)(3).

The College and NEMPAC file tax returns in the U.S. federal jurisdiction.

With a few exceptions, the College is no longer subject to U.S. federal examinations by tax authorities for years before 2015.

Note 2: Investments and Investment Return

Investments consist of the following at June 30:

	2018	2017
Exchange traded funds	$ 8,677,354	$ 10,799,503
Corporate debentures	7,207,032	7,507,333
Mutual funds	423,900	-
	$ 16,308,286	$ 18,306,836

Total investment return is comprised of the following for the years ended June 30:

	2018	2017
Interest and dividend income	$ 527,981	$ 476,717
Net unrealized gain (loss) on investments reported at fair value	(266,771)	1,205,425
Net realized gain on investments reported at fair value	691,385	97,974
	$ 952,595	$ 1,780,116

Note 3: Property and Equipment

Property and equipment consists of the following at June 30:

	2018	2017
Land	$ 2,667,142	$ 2,667,142
Headquarters building	11,613,907	11,613,907
Building fixtures	45,312	45,312
Furniture and equipment	3,919,735	3,541,940
Data processing software	4,637,543	3,608,031
Quality measures	595,697	264,045
Construction in progress – Furniture and equipment	2,863	-
Construction in progress – Data processing	-	268,221
	23,482,199	22,008,598
Less accumulated depreciation	(5,147,753)	(3,856,687)
	$ 18,334,446	$ 18,151,911

Note 4: Deferred Revenue

Deferred revenue consists of the following at June 30:

	2018	2017
Membership dues	$ 5,949,854	$ 6,584,093
Emergency Medicine Action Fund	449,023	694,212
Scientific assembly revenues	3,340,484	3,084,133
Subscription revenue	452,638	654,299
Fellow application fees	58,730	43,750
Publication and meeting revenues	340,968	382,451
Sponsorships and other	2,078,230	1,125,485
	$ 12,669,927	$ 12,568,423

Note 5: Amounts Held on Behalf of Chapter Affiliates

The College collects dues on behalf of chapter affiliates. The College's chapter affiliates may elect to have the College pay expenses on their behalf or have funds disbursed to the chapter. The College was holding a total of $2,190,880 and $2,296,010 for such purposes at June 30, 2018 and 2017, respectively. Chapters were paid interest on the balances maintained by the College at an average annual rate of 1.33% and 0.47% during the years ended June 30, 2018 and 2017, respectively. Interest is computed monthly using the 90-day T-bill rate in accordance with the Board policy.

Note 6: Note Payable to Bank

The College had a $1,000,000 revolving line of credit with iBERIABANK that expired on May 26, 2017. Effective May 26, 2017, the line of credit was extended until May 26, 2019. At June 30, 2018 and 2017, there was $0 borrowed against this line of credit. The line of credit is collateralized by substantially all of the College's assets. The interest rate was the Wall Street Journal Prime Rate.

The College had a $10,000,000 construction note with iBERIABANK for the construction of the new headquarters facility. This construction note was converted to a term loan in March 2017. At June 30, 2018 and 2017, there was $3,354,803 and $4,751,154, respectively, borrowed against this note. The note is collateralized by the new property and building. The interest rate is fixed at 3.5% maturing May 28, 2035. Interest expense for the fiscal years ended June 30, 2018 and 2017, was $128,017 and $73,636, respectively. In connection with this note payable to bank, the College is required, among other things, to maintain certain financial conditions, including unrestricted liquid assets of at least $3,000,000.

Annual maturities of the note are as follows at June 30, 2018:

2019	$ 413,565
2020	428,275
2021	443,507
2022	459,281
2023	475,617
Thereafter	1,134,558
	$ 3,354,803

Note 7: Retirement Plans

The College has a 401(k) profit-sharing plan covering substantially all employees. Under this plan, there is no fixed dollar amount of retirement benefits. Actual retirement benefits depend on the amount of the participant's account at the time of their retirement. Eligibility for participation in the plan is immediate upon employment. The following types of contributions are made to the participant's account:

- **College (Profit-sharing)** – The College makes a contribution to all participants' accounts. A safe harbor contribution equal to 3% of the participant's compensation and a discretionary contribution equal to 7% of the participant's compensation are made.
- **Participant (401(k))** – A participant may elect to defer 1–75% of annual compensation, subject to limitations imposed by the IRC. The College matches 10% of each dollar that the participant contributes up to 6% of eligible compensation.

The participant is 100% vested in their contribution. Vesting in the College's discretionary and matching contributions occurs at the rate of 20% after each year of service (a consecutive 12-month period from January 1 – December 31, during which the participant completes at least 1,000 hours of service).

The participant is 100% vested in the safe harbor contribution upon two years of service (a consecutive 12-month period from January 1 – December 31, during which the participant completes at least 1,000 hours of service). No vesting of the safe harbor contribution occurs prior to two years of service. Expenses related to this plan were $1,274,290 and $1,169,108, which include safe harbor, profit sharing and 401(k) matching, during fiscal years ended June 30, 2018 and 2017, respectively, and are allocated within each functional area in the accompanying consolidated statements of activities.

Note 8: Deferred Compensation Agreement

The College has a nonqualified 457b deferred compensation plan (Plan) established for a select group of management or highly compensated employees. The assets and liabilities of the Plan are recorded at market value as deferred compensation in the assets and liabilities in the accompanying consolidated statements of financial position. Participants will direct the investment of their accounts in a variety of funds offered by the Plan, including stock, mutual and fixed income funds. The investments of the Plan are measured at fair value on a recurring basis and are measured as Level 1, using quoted prices in active markets for identical assets, within the fair value hierarchy at June 30, 2018 and 2017.

Note 9: Bonus Award Program

The College maintains (upon annual approval by the Board) a bonus award program for personnel employed by the College. All staff, except the executive director, who are employed by the College by the first working day of the calendar year and continuing through June 30 are eligible. Those staff employed by the College for longer than six months and less than 12 months receive a pro-rated bonus (1/12 of the total amount for each full month worked). Unless changed by the Board, 40% of the excess of revenues over expenses for a fiscal year that exceeds an objective established by the Board is available as bonus compensation for employees who meet certain performance criteria. Any budget variance attributable to realized or unrealized gain or loss on investments or dividend and interest income shall not be included in the calculation of the staff bonus plan. The College met the objectives established for the fiscal years ended June 30, 2018 and 2017, and expenses related to this plan were $121,346 and $874,394, respectively.

Note 10: Management Service Agreements

Emergency Medicine Foundation (EMF)

The College provides management services at no cost to EMF. During the years ended June 30, 2018 and 2017, the College provided services to the EMF valued at $240,135 and $227,678, respectively. Additionally, the College made contributions to EMF in the amount of $100,000 and $200,000 during the years ended June 30, 2018 and 2017, respectively. These expenses are reflected in the accompanying consolidated statements of activities of the College as membership expenses. The activities of EMF are not designed, restricted nor intended to benefit the College or its members.

The primary beneficiaries of these activities are those members of the general public which seek medical care in emergency medicine facilities. The College includes as one of its purposes, the support of research in emergency medicine. The College has determined that it can best achieve part of this objective by providing services in support of certain activities of EMF. There are no direct or indirect requirements placed on the EMF to provide services to the College in return for this support. The College has no commitment to guarantee debt of the EMF, but is contracted to provide management services and other support. Such allocations of the College's resources are considered annually as a part of its budgeting process. Additionally, the resources of the EMF are not required to be used for the exempt purposes of ACEP. Accordingly, EMF is not required to be consolidated as the College does not have both control and economic interest. ACEP does not have control of EMF's Board. Management of ACEP does not believe that ACEP has an economic interest in EMF because the College is not required to provide financial support to EMF.

Emergency Medicine Resident Association (EMRA)

The College has common membership with EMRA, but does not have either control or economic interest. The College provides management services under contract to EMRA. Additionally, the College provided other support, primarily as part of its liaison relationships, to EMRA in the amount of $235,000 and $270,000 during the fiscal years ended June 30, 2018 and 2017, respectively. The College collected dues on behalf of EMRA. At June 30, 2018 and 2017, $260,953 and $241,232, respectively, is due to EMRA. EMRA paid the College $992,048 and $752,526, for management services and labor for the fiscal years ended June 30, 2018 and 2017, respectively. These revenues are reflected in the accompanying consolidated statements of activities of the College as membership revenues.

Society of Emergency Physicians Association (SEMPA)

The College provides management services under contract to SEMPA and these expenses are reflected in the accompanying consolidated statements of activities of the College as membership expenses. The College does not have either control or economic interest in SEMPA. Amounts due from SEMPA to the College were $78,589 and $48,051 at June 30, 2018 and 2017, respectively. SEMPA paid the College $321,347 and $223,600 for management services for the fiscal years ended June 30, 2018 and 2017, respectively. These revenues are reflected in the accompanying consolidated statements of activities of the College as membership revenues.

Council of Emergency Medicine Residency Directors Association (CORD)

The College provides management services under contract to CORD. The College does not have either control or economic interest in CORD.

During the years ended June 30, 2018 and 2017, the College provided services to CORD valued at $310,444 and $101,401, respectively. These expenses are reflected in the accompanying consolidated statements of activities of the College as membership expenses. Amounts due from CORD to the College were $147,183 and $35,841 at June 30, 2018 and 2017, respectively. CORD paid the College $326,991 and $174,800, for management services for years ending June 30, 2018 and 2017, respectively. These revenues are reflected in the accompanying consolidated statements of activities of the College as membership revenues.

Note 11: Operating Leases and Commitments

Noncancellable operating leases for office space and equipment expire in various years through November 2020. One lease contains a renewal option for five years and requires the College to pay all executory costs (property taxes, maintenance and insurance).

At June 30, 2018, future minimum lease payments under operating leases are as follows for the fiscal years ended June 30:

2019	$	376,849
2020		385,945
2021		157,188
Thereafter		-
Total minimum lease payments	$	919,982

Expenses recorded under operating leases for the years ended June 30, 2018 and 2017, were $384,996 and $369,431, respectively.

The College contracts out facilities in connection with its assemblies. As of June 30, 2018, cancellation clauses, if activated, for future facility rental contracts through October 2027 are estimated at $14,177,000.

The College has certain commitments under employment agreements.

Note 12: Disclosures About Fair Value of Assets and Liabilities

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. There is a hierarchy of three levels of inputs that may be used to measure fair value:

Level 1 Quoted prices in active markets for identical assets or liabilities

Level 2 Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities

Level 3 Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities

Recurring Measurements

The following table presents the fair value measurements of assets recognized in the accompanying consolidated statements of financial position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at June 30, 2018 and 2017:

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
June 30, 2018				
Exchange traded funds	$ 8,677,354	$ 8,677,354	$ -	$ -
Corporate debentures	7,207,032	-	7,207,032	-
Mutual funds	423,900	423,900	-	-
Mutual funds - 457b Plan	1,254,661	1,254,661	-	-
	$ 17,562,947	$ 10,355,915	$ 7,207,032	$ -
June 30, 2017				
Exchange traded funds	$ 10,799,503	$ 10,799,503	$ -	$ -
Corporate debentures	7,507,333	-	7,507,333	-
Mutual funds - 457b Plan	1,116,011	1,116,011	-	-
	$ 19,422,847	$ 11,915,514	$ 7,507,333	$ -

The following is a description of the valuation methodologies and inputs used for assets measured at fair value on a recurring basis and recognized in the accompanying consolidated statements of financial position, as well as the general classification of such assets pursuant to the valuation hierarchy. There have been no significant changes in the valuation techniques during the years ended June 30, 2018 and 2017.

Investments

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using quoted prices of securities with similar characteristics or independent asset pricing services and pricing models, the inputs of which are market-based or independently sourced market parameters, including, but not limited to, yield curves, interest rates, volatilities, prepayments, defaults, cumulative loss projections and cash flows. Such securities are classified in Level 2 of the valuation hierarchy. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy. The College had no Level 3 investments at June 30, 2018 and 2017.

Note 13: Significant Estimates and Concentrations

Accounting principles generally accepted in the United States of America require disclosure of certain significant estimates and current vulnerabilities due to certain concentrations. Those matters include the following.

Investments

The College invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the accompanying consolidated statements of financial position.

Note 14: Change in Accounting Principle

During the fiscal year ended June 30, 2018, the College changed its method of allocating certain costs among the program and service and administrative categories. By following this new method, the College believes cost allocations will more closely approximate the functional classification of expenses. The effect of the change was to increase college administration expenses and decrease program and service expenses. Under the new method, expenses are allocated as follows for the year ended June 30:

	2018	2017
Program and Service Expenses		
Membership	6,674,785	6,045,123
Educational, professional products and meetings	8,790,969	8,129,100
Policy	3,843,208	4,632,604
Federal awards	1,021,311	739,656
Public affairs	5,436,392	5,371,579
Quality	1,705,381	3,005,163
Leadership	3,366,546	3,480,035
Total program and service expenses	30,838,592	31,403,260
Administrative Expenses		
College administration	7,491,413	6,871,426
Bonus award program	121,346	874,394
Total administrative expenses	7,612,759	7,745,820
Total expenses	38,451,351	39,149,080
Change in Unrestricted Net Assets	733,204	3,364,645
Unrestricted Net Assets, Beginning of Year	21,708,782	18,344,137
Unrestricted Net Assets, End of Year	$ 22,441,986	$ 21,708,782

Note 15: Subsequent Events

Subsequent events have been evaluated through September 25, 2018, which is the date the consolidated financial statements were available to be issued.