American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

INTRODUCTION

2017 Annual Council Meeting
Thursday Evening, October 26 through Saturday, October 28, 2017
Marriott Marquis Hotel

For all of the Council information visit the Council Meeting Web site: http://acep.myeventpartner.com/. 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. To print only certain pages of any of the PDF compendiums, please note the page numbers on the left in the "Bookmark" panel and enter the specific range of page numbers you want to print. (From the menu bar, click on File, Print, Pages from, and enter the specific page numbers.)

The ACEP staff and your Council officers have diligently prepared background information for the resolutions submitted by the deadline. In addition to this compendium of resolutions in PDF format, you will also find on the Council Meeting Web site the individual resolutions in Word file formats. Again, you can download and print this entire compendium, or only specific resolutions. 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 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 Washington, DC!

Your Council officers,

James M. Cusick, MD, FACEP
Speaker

John G. McManus, Jr., 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

Marriott Marquis
October 26-28, 2017
Washington, DC

Thursday, October 26

3:00 pm – 8:00 pm	Councillor Credentialing – *Marquis Ballroom Foyer, Meeting Level 2*
4:30 pm – 6:00 pm	Candidate Forum Subcommittee – *Mount Vernon Square, Meeting Level 3*
6:00 pm – 7:00 pm	Steering Committee Meeting – *Capitol/Congress, Meeting Level 4*
7:00 pm – 8:00 pm	Tellers, Credentials, & Elections Committee – *LeDroit Park/Shaw, Meeting Level 3*
7:00 pm – 8:00 pm	Reference Committee Briefing – *Union Station, Meeting Level 3*
8:00 pm – 9:00 pm	Councillor Orientation – *University of DC/Catholic University, Meeting Level 1*

Friday, October 27

7:30 am – 5:30 pm	Councillor Credentialing – *Marquis Ballroom Foyer, Meeting Level 2*
7:30 am – 8:00 am	Council Continental Breakfast – *Marquis Ballroom Salons 5-6, Meeting Level 2*
8:00 am – 9:15 am	Council Meeting – *Marquis Ballroom Salons 5-6, Meeting Level 2*
9:30 am – 12:30 pm	Reference Committee A – *Independence Ballroom Salons A-C, Meeting Level 4*
9:30 am – 12:30 pm	Reference Committee B – *Independence Ballroom Salon D, Meeting Level 4*
9:30 am – 12:30 pm	Reference Committee C – *Independence Ballroom Salon E, Meeting Level 4*
11:00 am – 12:30 pm	Reference Committee Boxed Luncheon – *Independence Ballroom Foyer, Meeting Level 4*
12:30 pm – 2:30 pm	Reference Committee Executive Sessions A – *Independence Ballroom Salons A-C, Meeting Level 4* B – *Independence Ballroom Salon D, Meeting Level 4* C – *Independence Ballroom Salon E, Meeting Level 4*
12:45 pm – 2:15 pm	Town Hall Meeting – *Marquis Ballroom, Meeting Level 2*
2:30 pm – 4:30 pm	Candidate Forum – *Independence Ballroom Salons A-E, Meeting Level 4*
4:45 pm – 6:00 pm	Council Reconvenes – *Marquis Ballroom, Meeting Level 2*
6:15 pm – 7:15 pm	Candidate Reception – *Marquis Ballroom, Meeting Level 2*

Saturday, October 28

7:00 am – 8:30 am	Keypad Distribution – *Marquis Ballroom Foyer, Meeting Level 2*
7:00 am – 5:30 pm	Councillor Credentialing – *Marquis Ballroom Foyer, Meeting Level 2*
7:30 am – 8:00 am	Council Continental Breakfast – *Marquis Ballroom, Meeting Level 2*
8:00 am – 12:00 pm	Council Meeting – *Marquis Ballroom, Meeting Level 2*
12:00 pm – 1:30 pm	Council Awards Luncheon – *Marquis Ballroom Salons 7-10, Meeting Level 2*
1:45 pm – 5:45 pm	Council Reconvenes – *Marquis Ballroom, Meeting Level 2*
5:10 pm – 5:40 pm	Elections – *Marquis Ballroom, Meeting Level 2*

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2017 Council Meeting

October 27-28, 2017
(Pre-Meeting Events Occur Thursday Evening, October 26, 2017, Marriott Marquis
Marquis Ballroom, Meeting Level 2
Washington, DC

TIMED AGENDA

Friday, October 27, 2017

Continental Breakfast – Marquis Ballroom		***7:30 am***
1. Call to Order A. Meeting Dedication B. Pledge of Allegiance C. National Anthem	Dr. Cusick	8:00 am
2. Introductions	Dr. Cusick	8:10 am
3. Welcome from DC Chapter President	Dr. Burke	8:12 am
4. Tellers, Credentials, & Election Committee A. Credentials Report B. Meeting Etiquette	Dr. Costello	8:14 am
5. Changes to the Agenda	Dr. Cusick	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 14-15, 2016	Dr. Cusick	8:25 am
10. Approval of Steering Committee Actions A. Steering Committee Meeting – January 18, 2017 B. Steering Committee Meeting – June 26, 2017	Dr. Cusick	
11. Call for and Presentation of Emergency Resolutions	Dr. Cusick	
12. Steering Committee's Report on Late Resolutions A. Reference Committee Assignments of Allowed Late Resolutions B. Disallowed Late Resolutions	Dr. Cusick	
13. Nominating Committee Report A. Speaker 1. Slate of Candidates 2. Call for Floor Nominations B. Vice Speaker 1. Slate of Candidates 2. Call for Floor Nominations C. President-Elect 1. Slate of Candidates 2. Call for Floor Nominations D. Board of Directors 1. Slate of Candidates 2. Call for Floor Nominations	Dr. Cusick	8:30 am

Friday, October 27, 2017 (*Continued*)

14. Candidate Opening Statements	Dr. Cusick	
A. Speaker Candidates (2 minutes each)		8:35 am
B. Vice Speaker Candidates (2 minutes each)		8:38 am
C President-Elect Candidates (5 minutes each)		8:45 am
D. Board of Directors Candidates (2 minutes each)		9:05 am
15. Reference Committee Assignments	Dr. Cusick	9:20 am
BREAK		***9:20 am – 9:30 am***
16. Reference Committee Hearings		9:30 am – 12:30 pm
A – Governance & Membership – *Independence Ballroom Salons A-C, Meeting Level 4*		
B – Advocacy & Public Policy – *Independence Ballroom Salon D, Meeting Level 4*		
C – Emergency Medicine Practice – *Independence Ballroom Salon E, Meeting Level 4*		
Lunch Available – Independence Ballroom Foyer		***11:00 am – 12:30 pm***
17. Reference Committee Executive Sessions		12:30 pm – 2:30 pm
A – *Independence Ballroom Salons A-C, Meeting Level 4*		
B – *Independence Ballroom Salon D, Meeting Level 4*		
C – *Independence Ballroom Salon E, Meeting Level 4*		
BREAK – Return to main Council meeting room.		***12:30 pm – 12:45 pm***
18. Town Hall Meeting – *Marquis Ballroom, Meeting Level 2*	Dr. McManus	12:45 pm – 2:15 pm
A. The Out-of-Network and Balance Billing Conundrum: What Can We Do About It?		
19. Candidate Forum – *Independence Ballroom Salons A-E, Meeting Level 4*		2:30 pm – 4:30 pm
Candidates rotate through Reference Committee meeting rooms.		
BREAK – Return to main Council meeting room.		***4:30 pm – 4:45 pm***
20. Speaker's Report – *Marquis Ballroom, Meeting Level 2*	Dr. Cusick	4:45 pm
A. Leadership Development Advisory Group		
B. Board Actions on 2016 Resolutions		
C. Introduction of Honored Guests		
D. Introduction of Council Steering Committee		
E. Introduction of Board of Directors		
21. In Memoriam	Dr. Cusick	5:00 pm
A. Reading and Presentation of Memorial Resolutions	Dr. McManus	5:00 pm
Adopt by observing a moment of silence.		
22. ABEM Report	Dr. Kowalenko	5:10 pm
23. Secretary-Treasurer's Report	Dr. Friedman	5:15 pm
24. EMRA Report	Dr. Kurtz	5:20 pm
25. EMF Report	Dr. House	5:25 pm
26. NEMPAC Report	Dr. Jacoby	5:30 pm
27. President's Address	Dr. Parker	5:35 pm

Candidate Reception ● 6:15 pm – 7:15 pm ● *Marquis Ballroom Salons 8-10*

Saturday, October 28, 2017

Keypad Distribution – Marquis Ballroom Foyer		***7:00 am***
Continental Breakfast – Marquis Ballroom		***7:30 am***
1. Call to Order	Dr. Cusick	8:00 am
2. Tellers, Credentials, & Elections Committee Report	Dr. Costello	8:00 am
3. Electronic Voting A. Keypad Testing/Demographic Data Collection	Dr. Costello	8:05 am
4. Executive Directors Report	Mr. Wilkerson	8:30 am
5. Video – How to Submit Amendments Electronically		8:55 am
6. Reference Committee Reports A. Reference Committee _____ B. Reference Committee _____		9:00 am
7. Awards Luncheon – *Marquis Ballroom Salons 7-10*		*12:00 pm*
A. Welcome	Dr. Cusick	12:45 pm
1. Recognition of Past Speakers and Past Presidents		
2. Recognition of Chapter Executives		
B. Award Announcements	Dr. Parker	12:55 pm
1. Wiegenstein Leadership Award – *Brian Keaton, MD, FACEP*		
2. Mills Outstanding Contribution to Emergency Medicine Award – *Wesley Curry, MD, FACEP*		
3. Outstanding Contribution in Education Award – *Francis Counselman, MD, FACEP*		
4. Outstanding Contribution in Research Award – *Edward Jauch, MD, FACEP*		
5. Outstanding Contribution in EMS Award – *Salvatore Silvestri, MD, FACEP (awarded posthumously)*		
6. Rorrie Excellence in Health Policy Award – *Nathanial, MD, JD, MBA, FACEP*		
7. Rupke Legacy Award – *Compton Broders, MD, FACEP*		
8. Honorary Membership Award – *Patty Stowe, CAE; Laura Tiberi, CAE; and Gordon Wheeler*		
9. Disaster Medical Sciences Award – *Kristi Koenig, MD, FACEP*		
C. Reading and Presentation of Commendation Resolutions	Dr. Cusick/Dr.McManus	
D. Council Award Presentations	Dr. Cusick	
1. Council Service Milestone Awards – *5, 10, 15, 20, 25, 30, 35+ Year Councillors*		
2. Council Teamwork Award – *Government Services Chapter*		
3. Council Horizon Award – *Laura Medford-Davis, MD*		
4. Council Curmudgeon Award – *Pamela Bensen, MD, FACEP*		
5. Council Meritorious Service Award – *Kelly Gray-Eurom, MD, MMM, FACEP*		
8. Luncheon Adjourns – ***Return to main Council meeting room.***		***1:30 pm***
9. Reference Committee Reports Continue C. Reference Committee ___		1:45 pm
10. President-Elect's Address	Dr. Kivela	4:45 pm
11. Installation of President	Dr. Parker/Dr. Kivela	5:05 pm
12. Elections A. Speaker B. Vice Speaker C. Board of Directors D. President-Elect	Dr. Costello	5:10 pm
13. Announcements	Dr. Cusick	5:40 pm
14. Adjourn	Dr. Cusick	5:45 pm

American College of Emergency Physicians®
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2017 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 10-26, Compensation Committee Report

Brahim Ardolic, MD, FACEP (TX), Chair
Patricia A. Bayless, MD, FACEP (AZ)
Justin Fuehrer, DO, (EMRA)
Mark Notash, MD, FACEP (CO)
Susanne J. Spano, MD, FACEP (Wilderness Section)
Arvind Venkat, MD, FACEP (PA)

Leslie Moore, JD
Cynthia Singh, MS

Reference Committee B
Advocacy & Public Policy
Resolutions 27-41

Michael Lozano, MD, FACEP (FL), Chair
Daniel Freess, MD, FACEP (CT)
Nathaniel T. Hibbs, DO, FACEP (CO)
Jeffrey F. Linzer, MD, FACEP (GA)
Heather A. Marshall, MD, FACEP (NM)
John Matheson, MD, FACEP (WA)

Harry Monroe
Ryan McBride, MPP

Reference Committee C
Emergency Medicine Practice
Resolutions 42-55

John H. Proctor, MD, MBA, FACEP (TN), Chair
Enrique R. Enguidanos, MD, FACEP (WA)
Heather A. Heaton, MD, FACEP (MN Alt)
Marianna Karounos, DO, FACEP (NJ Alt)
Michael D. Smith, MD, MBA, CPE, FACEP (LA Alt)
James M. Williams, DO, MS, FACEP (TX)

Margaret Montgomery, RN, MSN
Loren Rives, MNA

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2017 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for James M. Cusick, MD, FACEP *Colorado Chapter*	
2	Commendation for Robert E. O'Connor, MD, MPH, FACEP *Delaware Chapter* *Virginia College of Emergency Physicians*	
3	Commendation for Gordon B. Wheeler *Washington Chapter*	
4	In Memory of Charles R. Bauer, MD, FACEP *Texas College of Emergency Physicians*	
5	In Memory of Diane Kay Bollman *Michigan College of Emergency Physicians*	
6	In Memory of Aaron T. Daggy, MD, FACEP *New York Chapter*	
7	In Memory of Geoffrey Edmund Renk, MD, PhD, FACEP *South Carolina College of Emergency Physicians*	
8	In Memory of Salvatore Silvestri, MD *Florida College of Emergency Physicians*	
9	In Memory of Robert Wears, MD, FACEP *Florida College of Emergency Physicians*	
10	Chapter Bylaws Conformance Standards – Housekeeping Change – Bylaws Amendment *Bylaws Committee* *Board of Directors*	A
11	Diversity of ACEP Councillors – Bylaws Amendment *Emergency Medicine Residents' Association* *Young Physicians Section*	A
12	Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment *Florida College of Emergency Physicians* *Louisiana Chapter* *Virginia College of Emergency Physicians* *Washington Chapter* *Wisconsin Chapter*	A
13	Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment *Florida College of Emergency Physicians* *Louisiana Chapter* *Virginia College of Emergency Physicians* *Washington Chapter* *Wisconsin Chapter*	A

Resolution #	Subject/Submitted by	Reference Committee
14	Unanimous Consent – Council Standing Rules Amendment *Pennsylvania College of Emergency Physicians*	A
15	ABEM Financial Transparency *Texas College of Emergency Physicians*	A
16	ABEM Governance *Texas College of Emergency Physicians*	A
17	ACEP Membership and Status is Independent of Other Organizations *Texas College of Emergency Physicians*	A
18	ACEP Wellness Center Services *Arizona College of Emergency Physicians*	A
19	Advocacy and Support for "Scholarly Activity" Requirements for EM Residents *Emergency Medicine Research Section*	A
20	Campaign Financial Reform *Douglas Char, MD, FACEP* *Marco Coppola, DO, FACEP* *Henderson McGinnis, MD, FACEP* *Jamie Shoemaker, MD, FACEP* *Annalise Sorrentino, MD, FACEP* *Jennifer L'Hommedieu Stankus, MD, JD, FACEP* *Arlo Weltge, MD, FACEP* *Anne Zink, MD, FACEP*	A
21	Creation of an Electronic Council Forum *Emergency Medicine Informatics Section*	A
22	Emergency Medicine Residency Training Requirements for Dual Training Programs *Dual Training Section*	A
23	Information Sharing, Regular ACEP/Chapter Contact, and Regional State/Chapter Relationships *Pennsylvania College of Emergency Physicians*	A
24	Maintenance of Certification for Practicing Emergency Physicians *Texas College of Emergency Physicians*	A
25	Resolution Co-sponsorship Memo *Pennsylvania College of Emergency Physicians*	A
26	Study the Impact & Potential Membership Benefits of a New Chapter Representing Locums Physicians *Angela Mattke, MD, FACEP* *Eric Maur, MD, FACEP* *Howard Mell, MD, FACEP*	A
27	9-1-1 Number Access and Prearrival Instructions *Alaska Chapter* *EMS-Prehospital Care Section* *Illinois College of Emergency Physicians* *Missouri College of Emergency Physicians* *Oklahoma College of Emergency Physicians* *West Virginia Chapter*	B

Resolution #	Subject/Submitted by	Reference Committee
28	Coverage for Patient Home Medication While Under Observation Status *New York Chapter* *Observation Medicine Section*	B
29	CPR Training *Pennsylvania College of Emergency Physicians*	B
30	Demonstrating the Value of Emergency Medicine to Policy Makers & the Public *James Antinori, MD, FACEP* *John Bibb, MD, FACEP* *Fred Dennis, MD, FACEP* *Ramon Johnson, MD, FACEP* *Lawrence Stock, MD, FACEP* *California Chapter*	B
31	Endorsement of Supervised Injection Facilities *Donald Stader, MD, FACEP* *Erik Verzemnieks, MD*	B
32	Essential Medicines *New York Chapter*	B
33	Immigrant & Non-Citizen Access to Care *Pennsylvania College of Emergency Physicians*	B
34	Generic Injectable Drug Shortages *Rick Blum, MD, FACEP* *Mark DeBard, MD, FACEP* *Nicholas Jouriles, MD, FACEP* *Brian Keaton, MD, FACEP* *Robert Solomon, MD, FACEP* *West Virginia Chapter*	B
35	Legislation Requiring Hyperbaric Medicine Facility Accreditation for Federal Payment *Undersea & Hyperbaric Medicine Section*	B
36	Maternity & Paternity Leave *AAWEP Section* *Emergency Medicine Residents' Association* *Diana Fite, MD, FACEP* *Sarah Hoper, MD, FACEP* *Iowa Chapter* *Fotini Manizate, MD* *Missouri College of Emergency Physicians* *Washington Chapter* *Young Physicians Section*	B
37	Medically Supervised Injection Facilities *Larry Bedard, MD, FACEP* *Susan Haney, MD, FACEP* *Dan Morhaim, MD, FACEP*	B
38	Prescription Drug Pricing *Connecticut College of Emergency Physicians* *Emergency Medicine Residents' Association* *Geriatric Emergency Medicine Section*	B

Resolution #	Subject/Submitted by	Reference Committee
39	Prohibition on ACEP Interference in State Legislative Activities *Texas College of Emergency Physicians*	B
40	Reimbursement for Emergency Services *Indiana Chapter*	B
41	Reimbursement for Hepatitis C Virus Testing Performed in the ED *Illinois College of Emergency Physicians*	B
42	ACEP Policy Related to Cannabis *Arizona College of Emergency Physicians*	C
43	Expanding ACEP Policy on Workforce Diversity in Health Care Settings *AAWEP Section* *Larry Bedard, MD, FACEP* *Nicole Berwald, MD, FACEP* *Leila Getto, MD, FACEP* *Susan Haney, MD, FACEP* *Bernard Lopez, MD, FACEP* *Tracy Sanson, MD, FACEP* *Vicken Totten, MD, FACEP* *Evangeline Sokol, MD, FACEP* *Mary Westergaard, MD, FACEP*	C
44	Guidelines for Opioid Prescribing in the Emergency Department *Illinois College of Emergency Physicians*	C
45	Group Contract Negotiation to End-of-Term Timeframes *New York Chapter*	C
46	Impact of Climate Change on Patient Health and Implications for Emergency Medicine *California Chapter* *Washington Chapter* *Wilderness Medicine Section*	C
47	Improving Patient Safety Through Transparency in Medical Malpractice Settlements *Jack Handley, MD, FACEP* *Charles Pilcher MD FACEP*	C
48	Non-Fatal Strangulation *Forensic Medicine Section* *William Green, MD, FACEP* *Michael L. Weaver, MD, FACEP* *Ralph Riviello, MD, FACEP* *Heather Rozzi, MD, FACEP* *William Smock, MD*	C
49	Participation in ED Information Exchange and Prescription Drug *Monitoring Systems* *Alaska Chapter* *Government Services Chapter* *New Mexico Chapter* *Ohio Chapter* *Oregon Chapter* *South Carolina College of Emergency Physicians* *Washington Chapter*	C

Resolution #	Subject/Submitted by	Reference Committee
50	Promoting Clinical Effectiveness in Emergency Medicine *Hawaii Chapter*	C
51	Retirement or Interruption of Clinical Emergency Medicine Practice *Texas College of Emergency Physicians*	C
52	Support for Harm Reduction and Syringe Services Programs *Donald Stader, MD, FACEP* *Erik Verzemnieks, MD*	C
53	Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders *Georgia College of Emergency Physicians*	C
54	Use of Cannabis as an Exit Drug for Opioid Dependency *Larry Bedard, MD, FACEP* *Dan Morhaim, MD, FACEP*	C
55	Workplace Violence *Howard Mell, MD, FACEP* *Missouri College of Emergency Physicians*	C

Late Resolutions

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: 1(17)

SUBMITTED BY: Colorado Chapter

SUBJECT: Commendation for James M. Cusick, MD, FACEP

WHEREAS, James M. Cusick, MD, FACEP, has served the American College of Emergency Physicians with distinction and dedication as Council Vice Speaker 2013-15 and Council Speaker 2015-17; and

WHEREAS, Dr. Cusick has represented the Council at Board of Directors meetings during his terms as Vice Speaker and Speaker, representing the Council with dedication, tireless efforts, and a voice of common sense; and

WHEREAS, Dr. Cusick has diligently devoted time, creativity, and enthusiasm to his duties as a Council officer, leading in the management and conduction of business of the Council and has been instrumental in streamlining and coordinating efforts to enhance productivity within the Council; and

WHEREAS, Dr. Cusick has demonstrated a long history of service to the College and the Council, serving many years as councillor, serving on the Steering Committee as a member and Chair, being instrumental in the further diversification of the Steering Committee, and utilizing his expertise on many other committees and task forces of the College; and

WHEREAS, Dr. Cusick has been recognized as a pioneer in the field of EMS, was a charter member and past Chair of the EMS-Prehospital Care Section, past Medical Director of a national ambulance company, and serves as the College's liaison to the Commission on Accreditation of Ambulance Services (CAAS) Board of Directors; and

WHEREAS, Dr. Cusick is a leader in the field of international emergency medicine, is an active member of the International Emergency Medicine Section, and serves as the College's International Ambassador to the emergency medicine community in Argentina where he continues to teach and train EMS personnel and physicians; and

WHEREAS, Dr. Cusick has served both the College and the specialty of emergency medicine in an exemplary fashion in his roles as member, donor, and board member of both the Emergency Medicine Foundation (EMF) and the National Emergency Medicine Political Action Committee (NEMPAC); and

WHEREAS, Dr. Cusick has maintained an active presence in the Colorado Chapter and has demonstrated leadership by his previous service on the Board of Directors and as President of the Colorado Chapter; and

WHEREAS, Dr. Cusick has continued to practice full-time clinical emergency medicine while serving his constituents in the College as Vice Speaker and Speaker; and

WHEREAS, Dr. Cusick maintains commitment to the cause and mission of emergency medicine and is a recognized leader and advocate for the specialty of emergency medicine; therefore be it

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.

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: 2(17)

SUBMITTED BY: Delaware Chapter
Virginia College of Emergency Physicians

SUBJECT: Commendation for Robert E. O'Connor, MD, MPH, FACEP

WHEREAS, Robert E. O'Connor, MD, MPH, FACEP, has capably served the American College of Emergency Physicians in a variety of leadership positions since becoming a member in 1982; and

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

WHEREAS, Dr. O'Connor has devoted his career to education and research in a quest to train future physicians and to find better ways to care for our patients; and

WHEREAS, Dr. O'Connor has participated in 310 scientific presentations, with 250 published abstracts and 162 peer-reviewed publications; and

WHEREAS, Dr. O'Connor has delivered more than 150 national and international invited lectures to a wide range of audiences; and

WHEREAS, Dr. O'Connor has extensive service in leadership roles with the Delaware and Virginia Chapters; and

WHEREAS, Dr. O'Connor has served the College with his service on the national Board of Directors from 2010 through 2016, including serving as Chair of the Board 2015-16, Vice-President 2013-14, and Secretary-Treasurer 2012-13; and

WHEREAS, Dr. O'Connor has shown exemplary leadership and outstanding service with his dedication, tireless efforts, and expertise on a variety of ACEP committees, task forces, sections, the Council, and Board of Directors; and

WHEREAS, Dr. O'Connor has served academic emergency medicine programs in the roles of EMS Director, Research Director, Residency Director, and Department Chair; and

WHEREAS, Dr. O'Connor has had a profound, positive, and enduring impact on emergency medicine at the Christiana Care Health System in Newark, Delaware and the University of Virginia School of Medicine in Charlottesville, Virginia; and

WHEREAS, Dr. O'Connor will no doubt 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 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.

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: 3(17)

SUBMITTED BY: Washington Chapter

SUBJECT: Commendation for Gordon B. Wheeler

WHEREAS, Gordon B. Wheeler served the American College of Emergency Physicians (ACEP) with distinction and dedication as Associate Executive Director of Public Affairs for 17 years; and

WHEREAS, Mr. Wheeler played a critical role in the evolution and current success of ACEP, influencing and guiding the College at every level; and

WHEREAS, Mr. Wheeler has been a mentor for hundreds, if not thousands, of emergency physicians, encouraging their interests, helping them find their voice, and guiding their careers within the College; and

WHEREAS, Mr. Wheeler provided unwavering support and sage counsel to chapter and national leaders, including dozens of College presidents; and

WHERAS Mr. Wheeler managed the highly effective Washington, DC office, strengthened collaboration with government agencies and professional organizations, and cultivated relationships with numerous Members of Congress; and

WHEREAS, Mr. Wheeler was instrumental to the College's leadership and advocacy efforts at state and national levels; therefore be it

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

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: 4(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: In Memory of Charles R. Bauer, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a compassionate physician, dedicated educator, mentor, pioneer, military officer, and colleague in Charles R. Bauer, MD, FACEP, who passed away on June 4, 2017, at the age of 83; and

WHEREAS, Dr. Bauer joined the University of Texas Health Science Center as a general and trauma surgeon, served as the assistant dean for ambulatory and emergency services, was board certified in both surgery and emergency medicine, and laid the foundation for the Department of Emergency Medicine and the emergency medicine residency at UT Health San Antonio; and

WHEREAS, Dr. Bauer served as the first chief of emergency medicine at UT Health and medical director of the emergency department at University Health System; and

WHEREAS, Dr. Bauer developed the South Texas Poison Center located at the Health Science Center, was instrumental in the establishment of the Texas Poison Center Network, and served as the founding chair of the Southwest Texas Regional Advisory Council (STRAC); and

WHEREAS, Dr. Bauer served in the US Air Force and retired as a colonel in the Texas State Guard, served as the chief medical officer of the Texas State Guard Medical Brigade and was awarded the Superior Service Award, the highest non-combat award given to a Texas military forces member; and

WHEREAS, Dr. Bauer was recognized by the Bexar County Medical Society and honored with its highest accolade, the Golden Aesculapius Award, for a lifetime of distinguished service to his patients and the medical profession; and

WHEREAS, Dr. Bauer mentored hundreds of medical students, taught for 35 years, and was actively involved in the medical student clerkship in emergency medicine at age 83 until just weeks before his passing; and

WHEREAS, Dr. Bauer touched the lives of countless individuals as an educator, physician, role model, mentor, colleague, pioneer, friend, and devoted husband and father; and

WHEREAS, Dr. Bauer shaped the future of emergency medicine in San Antonio 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 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.

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).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 5(17)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: In Memory of Diane Kay Bollman

WHEREAS, Emergency medicine lost a staunch advocate for the specialty in Diane Kay Bollman, an organizational leader, dedicated mentor, and dear friend, who passed away on July 2, 2017, at the age of 67; and

WHEREAS, Diane served as Executive Director of the Michigan College of Emergency Physicians for 24 years; and

WHEREAS, Diane was recognized for her exemplary service to emergency medicine by election to honorary membership in the American College of Emergency Physicians (ACEP); and

WHEREAS, Diane served on ACEP's National/Chapter Relations Committee, as well as its Membership Committee; and

WHEREAS, Diane's outstanding organizational leadership was further recognized by her induction into the Michigan Society of Association Executives Hall of Fame; and

WHEREAS, Diane was known for her broad smile and warm hug, as well as her educated and informed opinion, was a respected professional in the field of association management, and was a dear friend to the ACEP chapters' executive directors; and

WHEREAS, Diane understood the value of camaraderie by hosting the seemingly never ending, late night social events, making certain there were sufficient poker chips, popcorn, and a welcoming room always available; and

WHEREAS, Diane demonstrated a resilient and unwavering commitment to professionalism in executive director leadership, and throughout her career continued to be recognized by her peers, serving as Chair of the ACEP Chapter Executive's Forum in 1999 and from 2011 – 2013; and

WHEREAS, Diane was an organizational "den mother" to a generation of emergency medicine leaders, "big docs and baby docs" alike, and this mentorship advanced the social mission of the College and indirectly benefitted the lives of millions of patients cared for by members of the Michigan College of Emergency Physicians; and

WHEREAS, Diane touched the lives of countless individuals as a role model, colleague, consultant, friend, and devoted wife, mother, and grandmother; therefore be it

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.

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).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 6(17)

SUBMITTED BY: New York Chapter

SUBJECT: In Memory of Aaron T. Daggy, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a staunch advocate, compassionate physician, dedicated educator, mentor, and dear friend and colleague in Aaron T. Daggy, MD, FACEP, who passed away suddenly December 7, 2015, at the age of 39, leaving behind his beloved wife Bridgett, young son Eli, and newborn twins, Owen and Willow; and

WHEREAS, Dr. Daggy graduated from Case Western University and Indiana University School of Medicine, completing his emergency medicine residency at the University of Pittsburgh and served in emergency departments in the states of Pennsylvania and New York; and

WHEREAS, Dr. Daggy demonstrated a life-long passion for EMS and fire, serving as medical director, and indeed, an active firefighter in multiple agencies in Pennsylvania and New York in the spirit of his late maternal grandfather; and

WHEREAS, Dr. Daggy was an exemplary clinician who was looked up to by fellow physicians, nurses, physician assistants, EMS personnel, and hospital staff; and

WHEREAS, Dr. Daggy touched the lives of countless individuals as an educator, physician, role model, mentor, colleague, consultant, friend, and devoted husband and father; and

WHEREAS, Dr. Daggy shaped the future of pre-hospital care and fire response in the areas he served with his leadership, vision, enthusiasm, and boundless energy; therefore be it

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.

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(17)

SUBMITTED BY: South Carolina College of Emergency Physicians

SUBJECT: In Memory of Geoffrey Edmund Renk, MD, PhD, FACEP

WHEREAS, The specialty of emergency medicine and the South Carolina College of Emergency Physicians (SCCEP) lost a staunch advocate, compassionate physician, dedicated educator, and dear friend and colleague in Geoffrey E. Renk, MD, PhD, FACEP, who passed away April 30, 2017, at the age of 62; and

WHEREAS, Dr. Renk was educated at the Medical University of South Carolina in Charleston (MS 1979; MD, PhD 1986) and completed his residency in emergency medicine at Martin Luther King Hospital in Los Angeles, and practiced emergency medicine in the Los Angeles area before moving to Charleston where he practiced at St. Francis Hospital for almost 20 years; and

WHEREAS, Dr. Renk served as Medical Director of the emergency department at St. Francis Hospital in Charleston, SC, was on the Board of Directors for Bon Secours-St. Francis Hospital, was head of his emergency physician group, and helped design the new emergency department at St. Francis hospital; and

WHEREAS, Dr. Renk was an active and contributing member of the South Carolina College of Emergency Physicians, the American College of Emergency Physicians, and the American Medical Association since relocating to South Carolina; and

WHEREAS, Dr. Renk served as the President of the SCCEP, as well as representing SCCEP in the ACEP Council, and mentored many physicians and nurses into leadership positions from all areas of South Carolina; and

WHEREAS, Dr. Renk actively promoted life-long education and learning for himself and others, becoming certified in ultrasound during his practice, and developing and sharing his talents as a musician, sailor, surfer, kite-boarder, and hotelier; and

WHEREAS, Dr. Renk touched the lives of countless individuals as an educator, physician, role model, mentor, colleague, consultant, friend, and devoted husband; therefore be it

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.

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(17)

SUBMITTED BY: Florida College of Emergency Physicians

SUBJECT: In Memory of Salvatore Silvestri, MD

WHEREAS, Salvatore "Sal" Silvestri, MD, a leader in EMS for Florida and the United States, passed away February 26, 2017, at an early age and left behind family, friends, residents, medical students, and colleagues; and

WHEREAS, Dr. Silvestri served on the Florida College of Emergency Physicians (FCEP) Board of Directors, the Florida Emergency Medicine Foundation, FCEP EMS/Trauma Committee, Florida Association of EMS Medical Directors, national ACEP EMS Section, and the Orange County EMS Advisory Council; and

WHEREAS, Dr. Silvestri was the EMS Medical Director for Orange County EMS; and

WHEREAS, Dr. Silvestri was the Emergency Medicine Residency Program Director for Orlando Health; and

WHEREAS, Dr. Silvestri was an original investigator and author of numerous publications on prehospital care that advanced the science and practice of emergency medical services; and

WHEREAS, Dr. Silvestri mentored medical students to recognize emergency medicine as their life-long field for career development; and

WHEREAS, Dr. Silvestri was the mentor for many emergency medicine residents who looked up to him for knowledge, faith, and family support; and

WHEREAS, Dr. Silvestri also had hundreds of EMTs and paramedics who he educated, supported, and mentored; and

WHEREAS, Dr. Silvestri, to his family and his FCEP family, will always be remembered for his kind heart; therefore be it

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.

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: 9(17)

SUBMITTED BY: Florida College of Emergency Physicians

SUBJECT: In Memory of Robert Wears, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a premier researcher, staunch advocate, compassionate physician, dedicated educator, and dear friend and colleague in Robert Wears MD, FACEP, who passed away July16, 2017, at the age of 70; and

WHEREAS, Dr. Wears was an active and contributing member of both national ACEP and the Florida College of Emergency Physicians since their beginnings and was recognized with life fellow status since 1980; and

WHEREAS, Dr. Wears was an associate editor for *Annals of Emergency Medicine,* as well as serving on the editorial boards of *Human Factors and Ergonomics*, the *Journal of Patient Safety*, and the *International Journal of Risk and Safety in Medicine*; and

WHEREAS, Dr. Wears graduated from the Johns Hopkins School of Medicine and was in the very first class of emergency medicine residents at the University of Florida College of Medicine Jacksonville; and

WHEREAS, Dr. Wears earned a master's degree in computer sciences from the University of North Florida and a doctorate degree in industrial safety from the Crisis & Risk Research Centre at the Ecole des Mines de Paris - Paris Institute of Technology in France; and

WHEREAS, Dr. Wears served as a Professor at the University of Florida College of Medicine Jacksonville for over 40 years, as well as a visiting Professor in the Clinical Safety Research Unit at Imperial College London; and

WHEREAS, Dr. Wears was an international leader and expert in patient safety, and his internationally recognized research led to improvements in patient care by focusing on human factors engineering, including the study of team dynamics during emergency department shift changes and patient-care handoffs; and

WHEREAS, Dr. Wears published more than 150 articles in medical journals around the world, more than 20 book chapters, and co-edited five books; and

WHEREAS, Dr. Wears was a mentor to so many students, residents, and young faculty throughout his career being generous with his time, vast knowledge, and his wisdom; and

WHEREAS, Dr. Wears touched the lives of countless individuals as an educator, physician, role model, mentor, colleague, friend, and devoted husband and father; and

WHEREAS, Dr. Wears was a pioneering force in academic emergency medicine and a masterful, yet humble, academic scholar who was always in "learner mode" and the pursuit of new knowledge; and

WHEREAS, Dr. Wears shaped the future of emergency medicine, not only in Florida, but throughout the nation, whose leadership and continuous innovations resulted in improved system efficiency, and ultimately, more effective patient care; therefore be it

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.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2017 Council Meeting
Reference Committee Members

Reference Committee A
Governance & Membership
Resolutions 10-26, Compensation Committee Report

Brahim Ardolic, MD, FACEP (TX), Chair
Patricia A. Bayless, MD, FACEP (AZ)
Justin Fuehrer, DO, (EMRA)
Mark Notash, MD, FACEP (CO)
Susanne J. Spano, MD, FACEP (Wilderness Section)
Arvind Venkat, MD, FACEP (PA)

Leslie Moore, JD
Cynthia Singh, MS

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).

Bylaws Amendment

RESOLUTION: 10(17)

SUBMITTED BY: Bylaws Committee
Board of Directors

SUBJECT: Chapter Bylaws Conformance Standards – Housekeeping Change

PURPOSE: Amends the Bylaws by removing the titles to specific chapter bylaws guidance documents, which may change in the future and necessitate additional amendments to the national ACEP Bylaws, and simply refers to "current approved chapter bylaws guidance documents."

FISCAL IMPACT: Budgeted resources to update and distribute the Bylaws.

WHEREAS, Chapter bylaws are addressed in the ACEP Bylaws Article VI – Chapters, Section 2 – Chapter Bylaws; and

WHEREAS, The ACEP Board and Bylaws Committee have made concerted effort to provide chapters with clear and useful guidance in chapters' review and revision of their bylaws; and

WHEREAS, Conformity to the ACEP Bylaws and guidance documents is an ongoing requirement of chapters; and

WHEREAS, Chapter bylaws guidance documents are referenced in the ACEP Bylaws by specific titles which may change; and

WHEREAS, Amendment of the ACEP Bylaws may be necessary to update references that are no longer technically accurate; therefore be it

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.

Background

This resolution amends the Bylaws by removing the titles to specific chapter bylaws guidance documents, which may change in the future and necessitate additional amendments to the national ACEP Bylaws, and simply refers to current approved chapter bylaws guidance documents."

The Bylaws Committee has the ongoing responsibility to provide guidance to chapters in the review and revision of chapter bylaws and to ensure compliance with the national ACEP Bylaws. The Whereas statements in the resolution explain that this housekeeping change deletes references to specific titles of chapter bylaws guidance documents that may change in the future. The current chapter bylaws guidance documents include the Bylaws Guide to Chapters, the Bylaws Committee Chapter Review Process, the Guidelines for Bylaws, and the Model Chapter Bylaws. The Board of Directors must approve any changes to these chapter bylaws guidance documents.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted resources to update and distribute the Bylaws.

Prior Council Action

Resolution 5(10) Chapter Bylaws Amendments adopted. Clarified the procedures for chapter bylaws proposed amendments and the response to such proposals.

Amended Resolution 6(97) Chapter Bylaws Compliance adopted. Defined the period of time within which chapters must amend their bylaws to resolve conflicts that may be caused by Council action to amend national ACEP's Bylaws.

Amended Resolution 11(96) Chapter Charter adopted. Instituted the requirement that chapter bylaws must conform to the "Model Chapter Bylaws."

Prior Board Action

June 2017, approved cosponsoring the Chapter Bylaws Conformance Standards resolution with the Bylaws Committee for submission to the 2017 Council.

Resolution 5(10) Chapter Bylaws Amendments adopted.

Amended Resolution 6(97) Chapter Bylaws Compliance adopted

Amended Resolution 11(96) Chapter Charter adopted.

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

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

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).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Bylaws Amendment

RESOLUTION: 11(17)

SUBMITTED BY: Emergency Medicine Residents' Association
Young Physicians Section

SUBJECT: Diversity of ACEP Councillors

PURPOSE: Seeks to amend the Bylaws to encourage chapters to appoint and mentor councillors and alternate councillors that represent diversity of membership, including candidate physician and young physician members.

FISCAL IMPACT: Budgeted resources to update and distribute the Bylaws.

WHEREAS, As of May 2017, ACEP had 7,525 candidate physician members who comprised 20% of ACEP's total membership; and

WHEREAS, At the 2016 ACEP Council meeting, only 4% of credentialed councillors were candidate physicians; 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 adequately 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 ACEP throughout their careers; and

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

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.**"

Background

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

physician members. It is important for residents, young physicians, and others who represent a minority of members of the College, to become active in their state 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.

A Diversity Summit was convened by ACEP in April 2016 to discuss diversity and inclusion and a task force was appointed in June 2016 with the following objectives:

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

The Diversity & Inclusion Task Force has 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. They are also performing a survey to look at the diversity within current leadership positions in the field. These will become baseline data and will be compared to data in the future as ACEP continues diversity and inclusion initiatives.

Additionally, in response to Amended Resolution 7(16) Diversity in Emergency Medicine Leadership, a Leadership Diversity Task Force was appointed with 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 the Council's 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.

The task force plans to present their recommendations to the Board of Directors in April 2018.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Objective A – Increase total membership and transitioning resident retention.

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 Impact

Budgeted resources to update and distribute the Bylaws.

Prior Council Action

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to develop strategies to increase diversity within the ACEP Council and its leadership and provide a report to the Council on effective means of implementation.

Substitute Resolution 33(04) Future Leaders of ACEP adopted. Directed ACEP to work with chapters, committees,

and sections to establish leadership development priorities and strategies and compile a list of innovative leadership development strategies and disseminate them through its publications and meetings.

Resolution 27(00) Future Policy Leaders in Emergency Medicine adopted. The resolution called for ACEP to develop a financial mechanism to support residents to attend the legislative and leadership meeting, and that ACEP explore partnerships in developing a specific leadership program for future leaders.

Resolution 26(00) Leadership Challenge adopted. The resolution called for ACEP to formally study and evaluate its leadership development process and leadership requirements in consideration of changing emergency physician practices and demographics, and that the Board report back to the Council in one year regarding recommendations for consideration based on that assessment.

Resolution 2(92) EMRA Councillor Allotment adopted. The resolution provided EMRA with two additional councillors.

Amended Resolution 40(88) Training Leaders in Academic Emergency Medicine adopted. The resolution directed ACEP to continue to work with UA/EM to develop policies to ensure that leaders in academic emergency medicine have access to leadership development materials including information on development of academic departments, staffing and residency funding, faculty development, and academic advancement.

Resolution 1(88) EMRA Councillor Allotment adopted. This resolution entitled EMRA to two councilors and two alternate councilors.

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

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

Resolution 33(04) Future Leaders of ACEP adopted.

Resolution 27(00) Future Policy Leaders in Emergency Medicine adopted.

Resolution 26(00) Leadership Challenge adopted.

Resolution 2(92) EMRA Councillor Allotment adopted.

Amended Resolution 40(88) Training Leaders in Academic Emergency Medicine 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: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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).

Bylaws Amendment

RESOLUTION: 12(17)

SUBMITTED BY: Florida College of Emergency Physicians
Louisiana Chapter
Virginia College of Emergency Physicians
Washington Chapter
Wisconsin Chapter

SUBJECT: Seating of Past Chairs of the Board in the ACEP Council

PURPOSE: Seeks to amend the Bylaws to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

FISCAL IMPACT: Budgeted staff resources to update and distribute the Bylaws. Minimal additional costs for increasing the number of seats on the Council floor.

WHEREAS, The management and control of the College is vested in the Board of Directors; and

WHEREAS, The meetings of the Board of Directors are chaired by an elected officer of the Board; and

WHEREAS, The Board of Directors are required to meet at least three times annually; and

WHEREAS, The Chair of the Board is responsible for all matters of business that come before the Board of Directors during regularly scheduled and special meetings; and

WHEREAS, The Bylaws permit ACEP Past Presidents and ACEP Past Speakers, if not certified as councillors or alternate councillors by a sponsoring body, to be seated with their delegations and participate in the Council in a non-voting capacity; and

WHEREAS, The ACEP Council encourages and values the participation of past leaders during discussion of business on the Council floor; therefore be it

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."

Background

This is a companion resolution to Resolution 13(17) Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment.

This resolution seeks to amend the Bylaws to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and

past speakers of the Council.

Since 1989, past presidents and past speakers have been allowed to sit with their Council delegations and participate in a non-voting capacity.

Beginning in 2002, the Board implemented a trial process of the immediate past president serving as chair of the Board. In 2005, the Council and the Board adopted Resolution 13(05) Election of Board Chair by the Board of Directors. This resolution amended the Bylaws to codify the position of chair of the Board, elected by the Board from among the current Board members.

Since 2005, the Board has elected eight individuals as chair of the Board who had not previously served as ACEP president; however, one was elected president-elect after serving as chair and this year's chair is a candidate for president-elect. Adoption of this resolution will result in an additional seat on the Council floor (if these individuals are not serving as councillors) beginning in 2018 for: California (2 seats), Indiana, New Mexico, Florida, and Virginia.

Past chairs of the Board (as well as past presidents and past speakers) have an opportunity to serve as councillors or alternate councillors within their component bodies. However, some may not pursue this opportunity so that others can serve. Two past chairs of the Board, who did not serve as president, served as councillors in 2016.

As mentioned in the resolution, the Council encourages and values the participation of past leaders during Council discussions. The Council Standing Rules allow for seating of the current members of the Board on the Council floor and they are granted full floor privileges except the right to vote. Additionally, the Council Standing Rules "Debate" section, paragraph 4, state: "…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." Testimony in a Reference Committee is allowed by any person recognized at the microphone by the Reference Committee chair.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted staff resources to update and distribute the Bylaws. Minimal additional costs for increasing the number of seats on the Council floor

Prior Council Action

Resolution 13(05) Election of Board Chair by the Board of Directors adopted. This Bylaws amendment formally created the position of chair of the Board, elected by the Board from among the current Board members.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted. This resolution allowed for seating of Past Presidents and Past Speakers of ACEP with their delegations as non-voting participants in the Council.

Prior Board Action

Resolution 13(05) Election of Board Chair by the Board of Directors adopted.

June 2005, approved submitting the "Election of Board Chair by the Board of Directors" Bylaws resolution to the 2005 Council.

April 2005, directed the President-Elect Ramifications Task Force to prepare a Bylaws resolution to formalize the chair of the Board position.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted.

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

Leslie Patterson Moore, JD
General Counsel

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

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).

American College of Emergency Physicians®
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Council Standing Rules Amendment

RESOLUTION: 13(17)

SUBMITTED BY: Florida College of Emergency Physicians
Louisiana Chapter
Virginia College of Emergency Physicians
Washington Chapter
Wisconsin Chapter

SUBJECT: Seating of Past Chairs of the Board in the ACEP Council

PURPOSE: Seeks to amend the Council Standing Rules to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council

FISCAL IMPACT: Budgeted staff resources to update and distribute the Council Standing Rules. Minimal additional costs for increasing the number of seats on the Council floor

WHEREAS, The management and control of the College is vested in the Board of Directors; and

WHEREAS, The meetings of the Board of Directors are chaired by an elected officer of the Board; and

WHEREAS, The Board of Directors are required to meet at least three times annually; and

WHEREAS, The Chair of the Board is responsible for all matters of business that come before the Board of Directors during regularly scheduled and special meetings; and

WHEREAS, The Council Standing Rules permit ACEP Past Presidents and ACEP Past Speakers, if not certified as councillors or alternate councillors by a sponsoring body, to be seated with their delegations and participate in the Council in a non-voting capacity; and

WHEREAS, The ACEP Council encourages and values the participation of past leaders during discussion of business on the council floor; therefore be it

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."

Background

This is a companion resolution to Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment.

This resolution seeks to amend the Council Standing Rules to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

Since 1989, past presidents and past speakers have been allowed to sit with their Council delegations and participate in a non-voting capacity.

Beginning in 2002, the Board implemented a trial process of the immediate past president serving as chair of the Board. In 2005, the Council and the Board adopted Resolution 13(05) Election of Board Chair by the Board of Directors. This resolution amended the Bylaws to codify the position of chair of the Board, elected by the Board from among the current Board members.

Since 2005, the Board has elected eight individuals as chair of the Board who had not previously served as ACEP president; however, one was elected president-elect after serving as chair and this year's chair is a candidate for president-elect. Adoption of this resolution will result in an additional seat on the Council floor (if these individuals are not serving as councillors) beginning in 2018 for: California (2 seats), Indiana, New Mexico, Florida, and Virginia.

Past chairs of the Board (as well as past presidents and past speakers) have an opportunity to serve as councillors or alternate councillors within their component bodies. However, some may not pursue this opportunity so that others can serve. Two past chairs of the Board, who did not serve as president, served as councillors in 2016.

As mentioned in the resolution, the Council encourages and values the participation of past leaders during Council discussions. The Council Standing Rules allow for seating of the current members of the Board on the Council floor and they are granted full floor privileges except the right to vote. Additionally, the Council Standing Rules "Debate" section, paragraph 4, state: "…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." Testimony in a Reference Committee is allowed by any person recognized at the microphone by the Reference Committee chair.

There is a potential problem with adoption of this resolution by the Council prior to the adoption by the Board of Directors of companion Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment. The Council Standing Rules, "Amendments to Council Standing Rules" section, state: "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." (The Board does not act on amendments to the Council Standing Rules.) Bylaws amendments (Article XIII – Amendments, Section 3 – Amendment Under Initial Consideration), after adoption by a two-thirds vote of the Council, require an "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." There is not a contingency provision that Resolution 13(17), if adopted, would not take effect unless or until Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment is adopted by the Board of Directors.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted staff resources to update and distribute the Council Standing Rules. Minimal additional costs for increasing the number of seats on the Council floor

Prior Council Action

Resolution 13(05) Election of Board Chair by the Board of Directors adopted. This Bylaws amendment formally created the position of chair of the Board, elected by the Board from among the current Board members.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted. This resolution allowed for seating of Past Presidents and Past Speakers of ACEP with their delegations as non-voting participants in the Council.

Prior Board Action

Resolution 13(05) Election of Board Chair by the Board of Directors adopted.

June 2005, approved submitting the "Election of Board Chair by the Board of Directors" Bylaws resolution to the 2005 Council.

April 2005, directed the President-Elect Ramifications Task Force to prepare a Bylaws resolution to formalize the chair of the Board position.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted.

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

Leslie Patterson Moore, JD
General Counsel

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

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).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Council Standing Rules Amendment

RESOLUTION: 14(17)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Unanimous Consent

PURPOSE: Amends the Council Standing Rules "Unanimous Consent Agenda" section by placing all resolutions, except Bylaws amendments, on the Unanimous Consent Agenda and requiring a second for extraction.

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

WHEREAS, The ACEP Council is a deliberative body dedicated to shaping the policy and direction of the College; and

WHEREAS, Many resolutions are brought before the Council each year for consideration; and

WHEREAS, It is the responsibility of the Council to make informed decisions regarding the issues before them; and

WHEREAS, The Council has limited time in each session to conclude its business; and

WHEREAS, Council Reference Committees provide a forum for in-depth discussion regarding the issues before the Council and the merits of proposed resolutions; and

WHEREAS, Council Reference Committees, having heard all relevant testimony provided by interested parties then prepares a detailed report summarizing the testimony provided and makes recommendations for disposition of each resolution based upon the testimony; and

WHEREAS, Council Reference Committees may make amendments to resolutions as required to reflect the testimony provided; and

WHEREAS, It is the duty of the Council to protect the right of each councillor's viewpoint to be heard and to present new information not considered by a Reference Committee or reflective of its recommendation; therefore be it

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.

Background

This resolution Amends the Council Standing Rules "Unanimous Consent Agenda" section by placing all resolutions, except Bylaws amendments, on the Unanimous Consent Agenda with the Reference Committee's recommendation for adoption, not adoption, or referral for each resolution and requiring a second for extraction.

The Unanimous Consent Agenda is used for resolutions that are non-controversial, or generated little/no debate, or had a clear consensus of opinion in favor, opposed, or for referral. If one person objects, then it is not unanimous and the item is removed from consent. This procedure is also discussed in ACEP's parliamentary authority, *The Standard Code of Parliamentary Procedure (aka "Sturgis")* and in the Council Standing Rules (CSR). The CSR supersede *Sturgis* in the conduct of Council business.

Using the Unanimous Consent Agenda can greatly reduce the amount of time needed by the Council to act on resolutions. However, there are numerous extractions from the consent agenda each year. The Council Steering Committee has discussed revising the rule regarding the Unanimous Consent Agenda and submitted a resolution to the 2016 Council. That resolution sought to require the requestor for extraction to provide up to a one-minute summary of the reason for extraction and a one-third affirmative vote of the councillors present and voting to remove the item from consent. A majority of the testimony in the Reference Committee was against adoption, although there was acknowledgment that the resolution was intended to create a more efficient process and respect the time of the Council and the efforts of the reference committees. Those expressing support testified that because this resolution requires the Council to provide its support, it exemplifies the democratic process and many times items are removed from the consent agenda even when the outcome is clear. Those opposed argued that limiting the ability to remove items from the Consent Agenda is undemocratic and stifles debate. Historically, select resolutions have been removed from the Consent Agenda by a single individual, whose testimony to the Council body has reversed the recommendation of the Reference Committee.

At their January 2017 meeting, the Steering Committee discussed the Council's action on the 2016 resolution and decided not to resubmit a resolution to the 2017 Council. The Steering Committee discussed this resolution submitted by the Pennsylvania College of Emergency Physicians at their meeting in June 2017 and decided against cosponsorhip. The committee expressed concerns expressed about placing all resolutions on the consent agenda.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted resources to update and distribute the Council Standing Rules.

Prior Council Action

Resolution 3(16) Unanimous Consent not adopted. The resolution sought to require the requestor for extraction to provide up to a one-minute summary of the reason for extraction report and a one-third affirmative vote of the councillors present and voting to remove the item from consent.

Amended Resolution 30(05) Standing Rules Housekeeping Changes adopted. Revised several sections of the Standing Rules, including Unanimous Consent. The changes to this section were primarily editorial to provide clarity and also revised the section title from "Consent Calendar" to "Unanimous Consent Agenda."

Resolution 19(02) Consent Calendar adopted. Removed the statement "At the speaker's discretion, without objection, such an item is extracted from the consent calendar." If any credentialed councillor can request an item to be removed from consent, it is not at the speaker's discretion.

Prior Board Action

Not applicable.

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

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

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RESOLUTION: 15(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: ABEM Financial Transparency

PURPOSE: 1) Request detailed financial audit of ABEM; 2) provide all ABEM financial information to the ACEP Board at least every two years; 3) encourage ABEM to allow financial statements to be available to diplomates; 4) convene a meeting with ABEM to discuss financial transparency and responsiveness to diplomates; and 5) develop procedures to ensure anyone nominated by ACEP to serve on the ABEM Board will advocate for financial transparency and disclosure to diplomates.

FISCAL IMPACT: Budgeted Board of Directors and staff resources.

WHEREAS, Certification by the American Board of Emergency Medicine (ABEM) is a de facto requirement for practicing Emergency Medicine in most large communities; and

WHEREAS, Investigations of other American Board of Medical Specialties (ABMS) boards have revealed multi-million-dollar condos and exorbitant staff salaries, neither of which are appropriate; and

WHEREAS, ABEM is spending significant amount of the diplomates' funds annually, with no accountability; and

WHEREAS, ABEM has a net worth of over $37 million without a reasonable need for such massive assets; and

WHEREAS, ACEP should use its small amount of influence to encourage ABEM to be more financially transparent; therefore be it

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.

Background

This resolution directs ACEP to request a detailed financial audit of the American Board of Emergency Medicine (ABEM), provide all ABEM financial information to the ACEP Board at least every two years, encourage ABEM to

allow financial statements to be available to diplomates, convene a meeting with ABEM to discuss financial transparency and responsiveness to diplomates, and develop procedures to ensure anyone nominated by ACEP to serve on the ABEM Board will advocate for financial transparency and disclosure to diplomate

The Internal Revenue Service requires all non-profit organizations to file a 990 tax return each year. Additionally, tax-exempt organizations are subject to a variety of disclosure and compliance requirements through various schedules that are attached to the Form 990. Filing of schedules by organizations supplements, enhances, and further clarifies disclosures and compliance reporting made in Form 990. Public Inspection IRC 6104(d) regulations state that an organization must provide copies of its three most recent Forms 990 to anyone who requests them, whether in person, by mail, fax, or e-mail. Non-profit organizations are not required by federal or state law to provide copies of their audited financial statements to the public, although it is good business practice to conduct an annual audit and provide copies to the organization's Board of Directors. Per the 2016-2017 ABEM Annual Report (page 19), the ABEM Board of Directors reviewed the final audit report for the fiscal year ending June 30, 2016, at their February 2017 meeting.

When contacted about the subject of this resolution, ABEM provided the following response:

> ABEM fully complies with federal financial reporting requirements. Detailed financial information is available publicly and provided in the Form 990. As reported in the 2016-2017 ABEM Annual Report, the fiscal year ending June 30, 2016, showed gross revenue totaling $14,324,783, and a revenue margin showing a loss from operations of ($170,548) for an operating margin of negative 1.3 percent. Equity holdings totaled approximately $32.8 million, most of which resulted from the stock market recovery that began in 2008. ABEM uses these funds strategically, much like an endowment, to hold initial certification and Maintenance of Certification (MOC) fees fixed. Though the cost of administering the Oral Certification Examination has more than doubled with the introduction of the eOral format, ABEM has not passed on any of the increased costs to physicians seeking initial certification.
>
> By strategically using these equity holdings, ABEM has been able to offer the lowest application and written exam fees for initial certification. ABEM also has the lowest initial certification fees for those specialties that have an oral examination (14 of the 24 boards). ABEM's MOC costs are at the mean for all specialties.
>
> Though costs to ABEM-certified physicians are often emphasized, there is a financial benefit to being ABEM-certified for many physicians. The last ACEP/Stern survey (2015) showed that board-certified emergency physicians receive around $7,000 more in total annual compensation. This would result in over $240 million in annual compensation to the 35,000 physicians who are certified by ABEM.

Past editions of the ABEM annual report are available on the ABEM Website. The ABEM annual report is also provided to the Council in the distribution of the Council meeting materials, available at www.acep.myeventpartner.com.

ACEP, as one of the founding organizations of ABEM, has maintained a close and collegial relationship with ABEM. ACEP and ABEM officers meet at least twice each year, usually during the annual Society of Academic Emergency Medicine meeting and ACEP's annual *Scientific Assembly,* to discuss issues and concerns of mutual interest and importance. While ACEP can request copies of audited financial information, and encourage that the audited financials also be released to diplomates, ACEP cannot compel ABEM to do so.

The ABEM Bylaws provide that three directors will be elected from nominees provided by ACEP. The nomination and election processes are governed by ABEM. The fiduciary duty of directors is to the organization for which they are serving as directors and not to the sponsoring or nominating organization. ACEP is supportive of financial transparency, but it would be inappropriate for ACEP to develop procedures (i.e., requirements to advocate for certain positions as a member of the ABEM Board) for nomination outside of the criteria established by ABEM.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted Board of Directors and staff resources.

Prior Council Action

None

Prior Board Action

None

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

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

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: 16(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: ABEM Governance

PURPOSE: 1) Encourage 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; 2) ACEP initiate a nomination process, including developing criteria to be acknowledged and agreed upon by a member before being nominated, ensuring those nominated by ACEP are in agreement with the need for a more democratic and responsive ABEM; 3) charge ABEM directors nominated by ACEP to create a sponsoring organization-driven director recall procedure within the ABEM Bylaws.

FISCAL IMPACT: Budgeted Board of Directors and staff resources.

WHEREAS, Certification by the American Board of Emergency Medicine (ABEM) is a de facto requirement for practicing Emergency Medicine in most large communities; and

WHEREAS, ACEP, the American Medical Association (AMA), and the Society for Academic Emergency Medicine (SAEM) were sponsoring societies for ABEM; and

WHEREAS, ACEP nominates directors for ABEM to represent the College; and

WHEREAS, It is vital for ACEP to ensure the voice of the College is clearly heard; and

WHEREAS, ACEP should use its small amount of influence to encourage ABEM to be more democratic; therefore be it

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.

Background

This resolution directs ACEP to 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; initiate a nomination process, including developing criteria to be acknowledged and agreed upon by a member before being nominated, ensuring those nominated by ACEP are in agreement with the need for a more democratic and

responsive ABEM; and charge ABEM directors nominated by ACEP to create a sponsoring organization-driven director recall procedure within the ABEM Bylaws.

ACEP is one of the original sponsors that created ABEM. The ABEM Bylaws provide that three directors will be elected from nominees provided by ACEP. The nomination and election processes are governed by ABEM. The fiduciary duty of directors is to the organization for which they are serving as directors and not to the sponsoring or nominating organization. ACEP is supportive of a democratic and responsive organization, but it would be inappropriate for ACEP to develop procedures (i.e., requirements to advocate for certain positions as a member of the ABEM Board) for nomination outside of the criteria established by ABEM.

As a sponsoring organization, and per the ABEM Bylaws, ACEP is notified at least 60 days in advance of any contemplated Bylaws changes. ABEM Bylaws do not require that the sponsoring organizations approve the Bylaws revisions, but they must give the sponsors notice and an opportunity to comment. Most proposed amendments in the past have been minor edits to language and ACEP has not opposed these changes. On a few occasions, ACEP has expressed concerns about proposed Bylaws changes. ABEM has either revised such proposals or implemented the changes after acknowledging ACEP's concerns.

The nomination and election process for the ABEM Board of Directors and election of its president is also defined in the ABEM Bylaws. ABEM is a certifying organization and not a member organization. Although ACEP could encourage ABEM to change its Bylaws to allow for election of the president by the diplomates from among the ABEM Board, ACEP could not compel them to do so.

ACEP has maintained a close and collegial relationship with ABEM. ACEP and ABEM officers meet at least twice each year, usually during the annual Society of Academic Emergency Medicine meeting and ACEP's annual *Scientific Assembly,* to discuss issues and concerns of mutual interest and importance. While ACEP can request ABEM to make changes in their Bylaws for election of the president, ACEP cannot compel ABEM to do so.

When contacted about the subject of this resolution, ABEM provided the following response:

> "A substantial majority of the ABEM Board of Directors is selected from nominations coming from key EM organizations, such as ACEP. Twelve of ACEP's 45 Past-Presidents have served on the ABEM Board of Directors.
>
> Six of the current 19 ABEM directors were nominated by ACEP. ABEM has at least 16 seats at any given time, and can have up to 19 directors (when terms are extended due to leadership responsibilities). Of the current 19 directors, 15 were nominated from EM membership organizations and the AMA (four were nominated by multiple organizations). Only four of the 19 were self-nominated or nominated by other ABEM diplomates.
>
> Currently serving on the board are two past ACEP directors, one of whom is an ACEP Past-President. Six of the directors are Past-Presidents of ACEP state chapters, and seven have served on state chapter boards. Seven ABEM directors have served on key ACEP committees, of whom five have served as committee chairs. Eight ABEM Board members have served as an officer in other major EM organizations such as the Society of Academic Emergency Medicine, the Council of Emergency Medicine Residency Directors, and the ACGME, often serving as chair.
>
> In addition to ABEM directors, ABEM has a significant body of volunteers who serve in the interest of the specialty. These 500 ABEM volunteers serve in many capacities, such as oral examiners, item (question) writers for examinations, task force members, advisory panel members, standard-setting study participants, oral case reviewers, and focus group participants. These 500 volunteers have an active and influential voice in ABEM's policies and practices.
>
> Democratic governance is optimized when the organization is attentive to the voice of its stakeholders. ABEM solicited and received over 20,000 survey responses from our 35,000 diplomates this year. ABEM also monitors EM and other medical specialties' social media sites to hear physicians' thoughts and ideas about ABEM activities and requirements. In response to listening to our stakeholders, ABEM made 27 changes in the last three years that specifically benefit ABEM-certified physicians. Such improvements

include holding ABEM fees fixed, eliminating several penalty-based fees, modifying LLSA activities to broaden choices and strengthen learning, eliminating the patient safety LLSA and integrating patient safety into every LLSA (focusing on high-risk diagnoses), offering an easy way to receive credit for Improvement in Medical Practice (Part IV) requirements for physicians using CEDR for CMS quality reporting, and working supportively with physicians in recovery for substance use disorders."

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted Board of Directors and staff resources.

Prior Council Action

None

Prior Board Action

Reviews and comments on any proposed changes to the ABEM Bylaws.

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

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

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: 17(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: ACEP Membership and Status is Independent of Other Organizations

PURPOSE: Directs ACEP to remove references to other organizations and certification boards as criteria for membership and fellow status and review and revise all categories of membership and fellowship criteria to prohibit the actions of any other organization from impacting ACEP's membership eligibility.

FISCAL IMPACT: Budgeted committee and staff resources to update governance documents and policy statements. Unknown costs for potential loss of membership for those that disagree with any adopted changes in membership requirements. Unknown costs for changing computer programming, internal processes, online and printed membership materials, etc.

WHEREAS, ACEP is the professional organization for career emergency physicians; and

WHEREAS, Membership and status within the College should be determined directly and solely by the College; and

WHEREAS, Residency training and initial board certification is acknowledged as essential and valued by members beginning the practice of Emergency Medicine in the 21st century; and

WHEREAS, ACEP's voice is not always heard clearly or timely by other organizations; and

WHEREAS, Other organizations may have different priorities than ACEP; therefore be it

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.

Background

Directs ACEP to remove references to other organizations and certification boards as criteria for membership and fellow status and review and revise all categories of membership and fellowship criteria to prohibit the actions of any other organization from impacting ACEP's membership eligibility.

Prior to January 1, 2000, active membership in ACEP was open to physicians "who devote a significant portion of their medical endeavors to emergency medicine." Other medical specialty societies had long-standing membership criteria that were more restrictive and typically were linked to board certification in the specialty or residency training. After extensive, multi-year study, and discussions, the Board of Directors and the Council Steering Committee submitted a resolution to limit the College's membership. The Council and the Board adopted Amended Resolution 2(97) College Membership that amended the Bylaws to include the following criteria for membership in ACEP:

> "1) Satisfactory completion of an emergency medicine residency program accredited by the Accreditation Council on Graduate Medical Education (ACGME). 2) Satisfactory completion of an emergency medicine subspecialty training program accredited by ACGME. 3) Satisfactory completion of an emergency medicine residency training program accredited by the American Osteopathic Association (AOA). 4) Satisfactory completion of an emergency medicine residency program approved by an ACEP-recognized accrediting body in a foreign country. 5) Certification by an emergency medicine certifying body recognized by ACEP. or 6) Active membership in the College at any time prior to close of business December 31, 1999."

Adoption of Amended Resolution 2(97) completed the evolution of the College to secure its place among other medical specialty societies. Additionally, it reinforced to residents the value of residency training and membership in the College. Residency training and board certification is the "gold standard" in emergency medicine.

The language was revised again based on adoption of Amended Resolution 9(14) Membership Classification Restructure, which changed the classifications of membership (from active to regular) and increased the flexibility and readability of the Bylaws without changes to the criteria for current members. It also closed a potential loophole for non-emergency medicine subspecialists to join the College.

ACEP's policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine," reinforces that ACEP recognizes and supports the American Board of Emergency Medicine (ABEM) as the sole American Board of Medical Specialties (ABMS) certifying body for emergency medicine; the American Osteopathic Board of Emergency Medicine (AOBEM) as a certifying body in emergency medicine, under the jurisdiction of the American Osteopathic Association (AOA), limited to osteopathic physicians; and the American Board of Pediatrics (ABP) as an ABMS certifying body in pediatrics that provides subspecialty certification for pediatricians in the subspecialty of pediatric emergency medicine.

ACEP's policy statement "Definition of an Emergency Physician," developed as a direct result of Referred Amended Resolution 25(10) Definition of an Emergency Physician, states:

> An emergency physician is defined as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians.

ACEP has adopted many policy statements that reference certification by ABEM, AOBEM, and ABP. (See prior "Board Action – Policy Statements.") These policies (and potentially others) would need to be revised if ACEP's membership and fellowship criteria are changed,

The Council has discussed fellow status ad nauseam (see prior "Council Action – Fellowship"). The criteria have evolved over time and it took many years for the Council to reach consensus.

A potential unintended consequence of adopting this resolution is a significant loss of membership. Changes to the ACEP Bylaws Article IV – Membership, Section 2.1 – Regular Members, paragraph one, and Article V – ACEP Fellows, Section 1 – Eligibility, will be required if this resolution is adopted.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective A – Increase total membership and transitioning resident retention.

Fiscal Impact

Budgeted committee and staff resources to update governance documents and policy statements. It is impossible to predict the fiscal impact of the potential loss of membership for those that disagree with any adopted changes in membership requirements. Unknown costs for changing computer programming, internal processes, online and printed membership materials, etc.

Prior Council Action – Membership Criteria

Amended Resolution 9(14) Membership Classification Restructure adopted. Restructured the Bylaws Article IV – Membership, Article V – Fellowship, and Article VIII – Council for increased flexibility and readability without changes to the criteria for current members and closed a potential loophole for non-emergency medicine subspecialists to join.

Resolution 11(13) Membership Restructuring referred to the Board of Directors.

Resolution 28(05) Active Membership Eligibility adopted. This Bylaws amendment altered the requirements for active membership to include physicians who were eligible for active or international membership prior to the close of business December 31, 1999.

Substitute Resolution 25(00) Membership not adopted. Called for an impact study and a suggested mechanism for an alternative membership status for physicians who practice emergency medicine by are not currently eligible for full membership in the College.

Amended Resolution 2(97) College Membership adopted. Changed the membership criteria, as of January 1, 2000.

Resolution 6(95) not adopted. It called for restricting new active membership to individuals certified in emergency medicine or an emergency medicine subspecialty by the American Board of Emergency Medicine or the Royal College of Physicians and Surgeons of Canada. Current members would have been allowed to continue membership. Certification by the American Board of Osteopathic Emergency Medicine was excluded. Candidate membership was expanded to allow for members to continue in that category for four years after completion of their program. Implementation would have occurred January 1997.

Resolution 5(95) Criteria for Active Members adopted. Removed the words “and must be eligible for a license to prescribe narcotics and dangerous drugs” from the membership criteria.

Resolution 15(94) not adopted. It called for limiting membership to emergency medicine board certified physicians as of January 1, 1995. There was no provision for allowing current non-certified members to retain their membership after that date.

Resolution 35(93) Criteria for Membership not adopted. Called for the analysis of current classes of membership and their requirements.

The criteria for active membership was proposed and approved in November 1972 (the inaugural year of the ACEP Council).

Prior Council Action – Fellowship

Resolution 4(16) Legacy Fellows – Housekeeping Change adopted. Amended the Bylaws to clarify that members who met the criteria for fellowship in ACEP under prior criteria retain their fellowship status.

Resolution 6(15) Fellowship Criteria adopted. Removed the requirement for a letter of recommendation from the chapter or two letters of recommendation from current Fellows to be submitted on behalf of the member seeking Fellow status, in addition to meeting the other criteria.

Resolution 11(14) Eligibility Criteria for Fellow Emeritus – Housekeeping Changes College Manual Amendment adopted. Removed companion language in the College Manual related to eligibility criteria for Fellow Emeritus rendered moot by subsequent changes to the Fellow Status criteria.

Resolution 8(14) Fellow Status: Continued vs. Continuous Membership Requirement referred to the Board. The resolution stipulated retention of ACEP Fellow status is contingent on maintaining continuous membership (i.e., no lapse in membership after becoming a Fellow).

Resolution 7(14) Fellow Status – Housekeeping Changes Bylaws Amendment adopted. Removed language no longer applicable and clarified the terms "Fellow" and "Fellow Status" by removing the word "Fellowship."

Resolution 10(08) Fellowship Criteria not adopted. Requested ACEP to appoint a task force to study modification and implementation of revised Fellow status criteria and provide recommendations to the 2009 Council.

Resolution 9(08) Fellowship adopted. Created a sunset date for Amended Resolution 11(07) closing the date for "legacy" fellowship applications and confirmation.

Amended Resolution 11(07) Fellowship adopted. Added a second set of criteria allowing non-board certified members to attain Fellow status, removed the requirement to maintain board certification to maintain Fellow status, deleted "Life Fellow" status as it was no longer necessary, and modified the membership requirement for Fellow status by adding, "Maintenance of Fellow status requires continued membership in the College.

Resolution 5(06) Eligibility Criteria for Fellow Emeritus adopted. Amended the College Manual to add eligibility criteria for Fellow Emeritus.

Amended Resolution 4(06) Fellow Emeritus adopted. Created the Fellow Emeritus designation to allow esteemed ACEP members who might otherwise lose their Fellow status due to the loss of board certification, (e.g., after retirement from clinical practice).

Resolution 24(05) Fellowship and its Implications adopted. Called for the president to establish a task force to study the political, economic, and personal implications of opening ACEP fellowship eligibility to all active members of the College and to report to the College by April 1, 2006.

Resolution 15(04) Simplification of Requirements to Retain Fellow Status not adopted. Called for a Bylaws amendment simplifying the requirements for fellow status by allowing those members who are elected to fellow status to maintain their status whether or not they remain diplomates of their respective Boards as long as they maintain membership in ACEP.

Resolution 1(03) Fellow Reapplication adopted. Called for a Bylaws amendment omitting the requirement that fellows must reapply for fellow status when they recertify with their respective Boards.

Resolution 4(03) ACEP Members with Disabilities adopted. Called for a Bylaws amendment establishing a mechanism for a member who has attained fellow status to maintain it indefinitely in the event of permanent disability.

Resolution 1(00) Membership Requirement for Fellowship not adopted. called for a Bylaws amendment eliminating restrictions in the fellow criteria that keep new active members from applying for fellow status until after their third year in the active category of membership.

Resolution 1(99) Fellowship – AOBEM and ABP adopted. Called for a Bylaws amendment allowing board certification by the American Board of Osteopathic Emergency Medicine to be acceptable criteria for fellow status in ACEP.

Amended Resolution 2(98) American Osteopathic Board of Emergency Medicine Certification for Fellow Status adopted. Called for the recognition of the American Board of Osteopathic Emergency Medicine as an emergency medicine certifying body.

Resolution 8(96) Fellowship Criteria not adopted. Sought to expand the fellowship criteria to recognize members who were certified in emergency medicine by AOBEM.

Amended Resolution 35(95) Fellow Status Extensions adopted. Allowed the Board to grant an extension of fellow status for a period of up to one year past their certification expiration date for fellows who for reasons of illness or other significant personal obstacles are unable to take the board examination.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted. Called for a Bylaws amendment expanding fellowship criteria to include the subspecialty certification in pediatric emergency medicine by either the American Board of Pediatrics or the American Board of Emergency Medicine.

Resolution 13(95) Fellowship Criteria not adopted. Sought to add a five-year practice track plus certification in certain specialties as a pathway to fellowship.

Substitute Resolution 31(94) Fellow Status adopted. Called for the college to establish fellow status eligibility for ACEP members certified in the joint ABEM/AAP subspecialty certification of pediatric emergency medicine.

Resolution 28(94) Fellow Status not adopted. Called for a Bylaws amendment expanding fellowship criteria to include BCEM certification.

Resolu7tion 26(94) Change in Fellowship Criteria not adopted. Sought alternative pathways to fellowship, including a 10-year practice track,

Resolution 5(92) Fellowship Status adopted. Called for a Bylaws amendment omitting the requirement that candidates for fellow status submit letters from two fellows of the College and allowed the Board of Directors to define the documentation required from a candidate.

Amended Resolution 6(90) Fellow Status adopted. Called for refinement of the requirements for fellow status including the addition of the requirement for active involvement in emergency medicine as the physician's chief professional activity exclusive of training.

Amended Resolution 7(90) Life Fellow adopted. Called for a Bylaws amendment creating the Life Fellow status.

Resolution 8(89) Fellowship Requirements adopted. Called for the implementation of a notice period of three years before the requirements for fellow status adopted in 1988 took effect.

Resolution 4(89) Fellow Requirements adopted. Instructed the College to review fellow criteria and revise old criteria or add new criteria as deemed appropriate and to report to the 1990 Council.

Amended Resolution 11(88) Fellowship Requirements adopted in lieu of resolutions 10(88) and 12(88). Called for a Bylaws amendment modifying fellow requirements to make them more stringent.

Resolution 6(87) Fellowship Requirements postponed to the 1988 Council meeting. Called for a Bylaws amendment tightening the requirements for fellow status.

Resolution 54(86) Fellow Status adopted. It directed the Board of Directors to augment the qualifications for fellow status and report to the 1987 Council.

Resolution 6(84) Fellow Status postponed to the 1985 Council meeting. It called for additional professional criteria for fellow status eligibility.

Amended Resolution 4(81) Fellow Status adopted. Called for a Bylaws amendment establishing fellow criteria.

Substitute Resolution 17(80) Fellow Status postponed to the 1981 Council meeting. Called for the establishment of criteria for fellow status.

Substitute Resolution 7(74) adopted. It directed the Board of Directors to establish a category of membership to be called fellow and establish its qualifications and requirements.

Prior Board Action – Council Resolutions and other Actions regarding Membership Criteria

Amended Resolution 9(14) Membership Classification Restructure adopted.

June 2014, reviewed the final report from the Membership Restructuring Task Force and approved cosponsoring the Membership Classification Restructure Bylaws Amendment for submission to the 2014 Council.

April 2014, reviewed an interim report from the Membership Restructuring Task Force and provided guidance on development of a Bylaws Amendment for the 2014 Council to consider.

November 2013, appointed the Membership Restructuring Task Force to address Referred Resolution 11(13) Membership Restructuring.

Referred Resolution 11(13) Membership Restructuring assigned to the Membership Restructuring Task Force.

Resolution 28(05) Active Membership Eligibility adopted.

Amended Resolution 2(97) Membership Criteria adopted.

Note: The Board did not act on Bylaws amendments prior to 1993.

Prior Board Action – Council Resolutions and other Actions regarding Fellowship

Resolution 4(16) Legacy Fellows – Housekeeping Change adopted.

Resolution 6(15) Fellowship Criteria adopted.

Resolution 11(14) Eligibility Criteria for Fellow Emeritus – Housekeeping Changes College Manual Amendment adopted.

Referred Resolution 8(14) Fellow Status: Continued vs. Continuous Membership Requirement was assigned to the Membership Committee for review and to provide a recommendation to the Board of Directors regarding further action. The resolution stipulated retention of ACEP Fellow status is contingent on maintaining continuous membership (i.e., no lapse in membership after becoming a Fellow). The Membership Committee recommended to the Board in June 2015 to submit a resolution to the 2015 Council amending the Bylaws to stipulate retention of ACEP fellow status is contingent on maintaining “continuous” membership (no lapse in dues) instead of “continued” membership. The Board did not adopt the recommendation and the proposed resolution was not submitted to the 2015 Council.

Resolution 7(14) Fellow Status – Housekeeping Changes Bylaws Amendment adopted. Removed language no longer applicable and clarified the terms “Fellow” and “Fellow Status” by removing the word “Fellowship.”

Resolution 9(08) Fellowship adopted.

Amended Resolution 11(07) Fellowship adopted

Resolution 5(06) Eligibility Criteria for Fellow Emeritus adopted.

Amended Resolution 4(06) Fellow Emeritus adopted.

February 2006, the president appointed a task force to consider the political, economic, and personal implications of opening ACEP fellowship eligibility to all active members of the College. A preliminary report was submitted to the Board in June and will be provided to the 2006 Council for its information. The final report is expected in

Resolution 1(03) Fellow Reapplication adopted.

Resolution 4(03) ACEP Members with Disabilities adopted.

March 2000 adopted the procedure that former fellows who desire to regain membership have their ACEP fellow status immediately reinstated upon initiation of their new membership in ACEP, if their board certification and previous fellow status is current.

Resolution 1(99) Fellowship – AOBEM and ABP adopted.

Amended Resolution 2(98) American Osteopathic Board of Emergency Medicine Certification for Fellow Status adopted the first resolved and contested the second resolved.

Amended Resolution 35(95) Fellow Status Extensions adopted.

Resolution 14(95) Fellowship Criteria – Pediatric Subspecialty adopted.

Substitute Resolution 31(94) Fellow Status adopted and asked the Bylaws Committee to provide language for the 1995 Council.

March 1993 adopted a change to the deadline for reapplication for fellow status to May one of each year and allowed for members to reapply for fellow status as they recertify with ABEM.

January 1993 adopted a change to the deadline for new fellow applications to December 15.

Resolution 5(92) Fellowship Status adopted.

January 1992 adopted key elements of the process for handling recertification of fellows.
Endorsed Amended Resolution 7(90) Life Fellow. The Board did not adopt Bylaws amendments prior to 1993.

Endorsed Amended Resolution 6(90) Fellow Status. The Board did not adopt Bylaws amendments prior to 1993.

Resolution 8(89) Fellowship Requirements adopted.

Resolution 4(89) Fellow Requirements adopted.

Resolution 54(86) Fellow Status adopted.

Amended Resolution 4(81) Fellow Status adopted and referred to the Membership Committee for the development of procedures.

Substitute Resolution 7(74) amended and adopted.

Prior Board Action – Policy Statements

ABEM and other organizations are referenced in numerous policy statements. The following is a partial listing:

April 2017, reaffirmed the policy statement "Definition of an Emergency Physician;" originally approved June 2011.

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

January 2017, approved the revised policy statement "Code of Ethics for Emergency Physicians;" revised and approved June 2016, June 2008; reaffirmed October 2001; approved June 1997 with the current title; originally approved January 1991 with the title "Ethics Manual."

October 2016, approved the revised policy statement "Role of the State EMS Director;" revised and approved April 2009; originally approved October 2004.

April 2016, approved the policy statement "CME Burden."

January 2016, approved the revised policy statement "Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment;" revised and approved April 2012; reaffirmed September 2005; revised and approved with the current title June 1999, June 1997, and August 1992; originally approved January 1984 with the title Certification in Emergency Medicine."

June 2014, approved the revised policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine;" reaffirmed April 2014, October 2008 and October 2002; originally approved March 1988.

June 2013, approved the revised policy statement, "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013, reaffirmed October 2007; originally approved June 2001.

January 2012, approved the revised policy statement "Recognition of Subspecialty Boards in Emergency Medicine;" originally approved August 2007.

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

April 2012, reaffirmed the policy statement "The Role of the Legacy Emergency Physician in the 21st Century;" originally approved June 2006.

January 2012, approved the revised policy statement "Subspecialty Certification in Critical Care Medicine;" reaffirmed April 2004, October 1998, April 1994; originally approved April 1984 with the title "Certificate of Competency in Critical Care Medicine."

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

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

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: 18(17)

SUBMITTED BY: Arizona College of Emergency Physicians

SUBJECT: ACEP Wellness Center Services

PURPOSE: 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 Wellness Center and explore ways to better promote the resources provided.

FISCAL IMPACT: Budgeted committee, section, and staff resources. Approximately $50,000 to restore lab services.

WHEREAS, A decision (based largely on financial considerations) was made to eliminate certain wellness services (i.e. Screening Labs, Immunizations, Burnout Survey, BMI, etc.) traditionally available at the Wellness Center as part of the Annual ACEP Scientific Assembly; and

WHEREAS, The Wellness Center itself is being modified with limited information included in the Annual Conference materials and promotions; and

WHEREAS, Alternative funding options (e.g., use of personal insurance reimbursement, now mandated at no cost to the consumer via the ACA and/or sponsorship of the Wellness Center by third parties) may be possible; and

WHEREAS, Outsourcing of the Wellness Center "billable" services to a third party (who could assume responsibility for provision of services and billing) would result in a significant profit margin such that it could potentially offset the cost of booth space and personnel for a net INCREASE in revenue for ACEP; and

WHEREAS, Physician wellness has been the subject of passionate, hard fought, past Council debates in efforts to bring awareness to the many issues surrounding wellness; and

WHEREAS, There is no evidence ACEP members are not in need of such wellness efforts (i.e., we are all now perfectly healthy), and, perhaps to the contrary[1, 2, 3], a lack of awareness (despite traditional promotion) has apparently led to a dramatic decrease in utilization of the Wellness Center services and other ACEP wellness resources; and

WHEREAS, There is limited mention (as of June 2017) of wellness services in the current ACEP17 conference materials on the website or in print; and

WHEREAS, There have been several examples of ACEP members that have experienced life-saving[4] and life-altering information via the Wellness Center over many years; therefore be it

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.

References

1. Information Paper by the ACEP Well-being Committee, May 2016 https://www.acep.org/Physician-Resources/Work-Life-Balance/Wellness/Wellness-in-the-Workplace/
2. Policy on Physician Impairment (Revised 2013): {EXCERPT} *ACEP endorses the following principles: Emergency*

physician groups, employers, and residency programs should promote wellness, burnout prevention, early recognition of and non-punitive mechanisms for reporting potential impairment, and early intervention and treatment or other forms of assistance to help prevent or resolve impairment. https://www.acep.org/clinical---practice-management/2017-policy-compendium

3. ACEP Vision Statement (Approved February 18, 2003): {EXCERPT} *Emergency physicians practice in an environment in which their rights, safety, and wellness are assured.* https://www.acep.org/clinical---practice-management/2017-policy-compendium
4. ACEP Wellness Booth Brings One Member a Health Warning. ACEP News. October 9, 2014 http://www.acepnow.com/article/acep-wellness-booth-brings-one-member-health-warning/

Background

This resolution directs ACEP to 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 Wellness Center and explore ways to better promote the resources provided.

In 1988, ACEP formed a Wellness Working Group that identified wellness topics upon which the College could focus. One year later, in 1989, ACEP formed a Wellness Task Force with wellness-related objectives. The task force paved the way for the formation of the committee. In 1990, ACEP officially formed the Personal & Professional Well-being Committee. The following year it was re-named the Well-Being Committee.

The ACEP Member Wellness Booth was established in 1992 by Richard Goldberg, MD, FACEP, and other members of the Well-Being Committee. Originally, the committee collaborated with the Department of Emergency Medicine at the Los Angeles County and University of Southern California Medical Center as well as ACEP's California Chapter in establishing a wellness booth at the annual *Scientific Assembly* in Seattle, WA. Funding was provided by the Department of Emergency Medicine, LA County+USC and grants from outside entities. Originally, the services were offered free-of-charge to all physician registrants and included distribution of literature on wellness-related topics, measurement of blood pressure and body fat, measurement of serum cholesterol with a drop of blood, and a burnout survey. In 1995, ACEP took over the funding of the Wellness Booth as a member service and through the years, different offerings have been added based on member suggestions at the booth. Its historic purpose has been to provide health-screening services and promote awareness of the many factors impacting the physical and emotional health of emergency physicians.

The Well-Being Committee was charged to "monitor and make recommendations for offerings and services at the ACEP Wellness Booth and the promulgation of information to members for their individual wellness and health screening." To provide the most informed set of recommendations possible, the committee collected data from the following sources: historic usage metrics and expenses; survey data compiled from ACEP members attending *ACEP16*; suggestions from members who utilized the Wellness Booth services at *ACEP16*; and suggestions made by committee members.

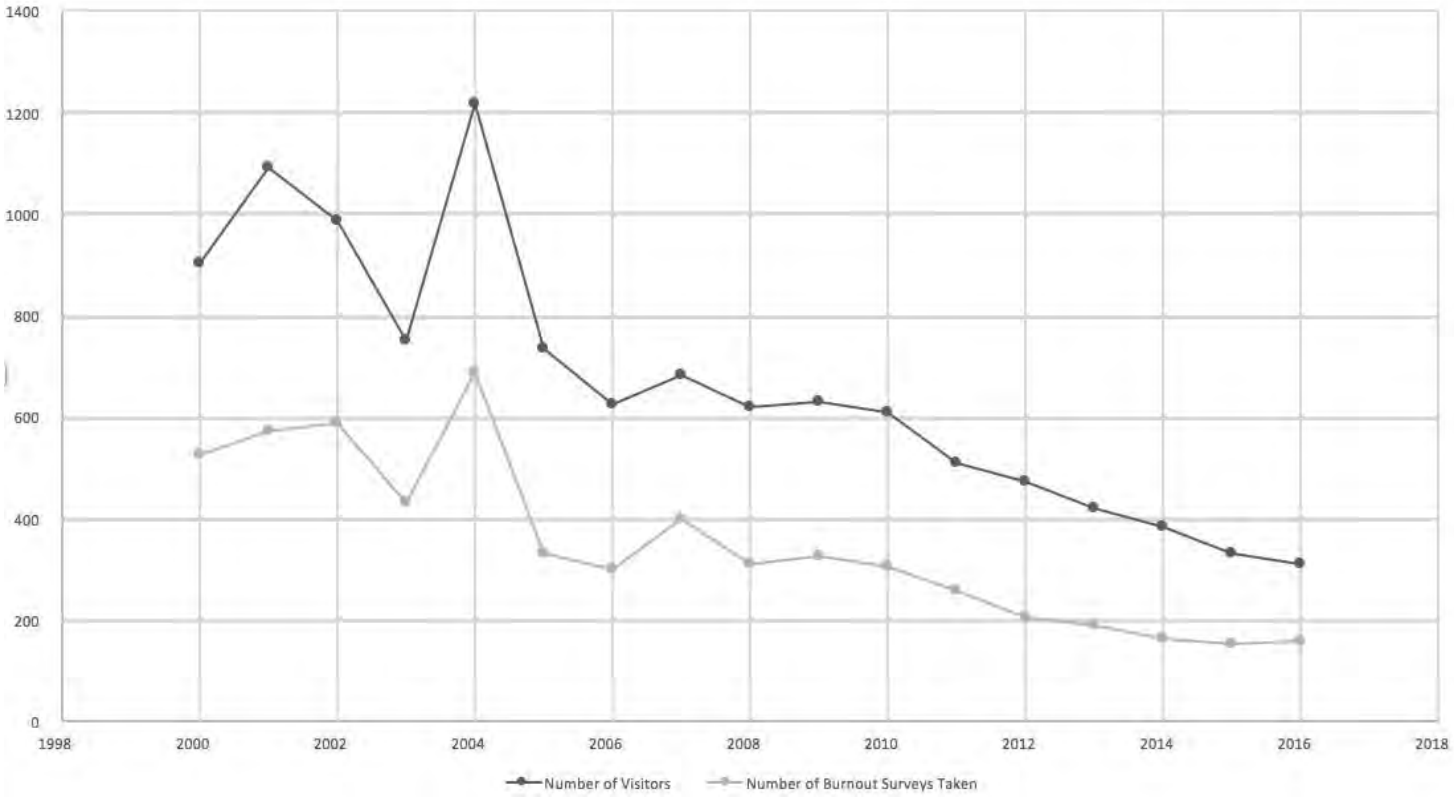
Historic Wellness Booth Usage Data and Financial Data

The first five years saw large numbers of members attending the Wellness Booth and utilizing its services. Peak attendance came in 2004, the year when there was a general shortage of flu vaccine, but availability of the vaccine at the Wellness Booth. Attendance and usage of specific services, including the burnout survey, has declined each year. Since 2010, total visits to the Wellness Booth declined ~ 49%. Labs and services have seen similar decreases.

Year	Wellness Booth Sales	4-day Paid Attendees
2007	752	4213
2008	579	4561
2009	763	4680
2010	567	5952
2011	488	5718

2012	460	5413
2013	408	6224
2014	332	6535
2015	313	6508
2016	299	7461

Visitors and Burnout Surveys Taken Over Time — ACEP Wellness Resource Center



Member ticket prices have increased over time:

2003, 2004:	$10
2005, 2006:	$15
2007 – 2010:	$20
2011, 2012:	$30
2013 – 2015:	$50

Historic costs vary due to the volume of participation, as do increases in the costs of labs. Direct annual expenses:

2012-13	$67,708
2013-14	$48,409
2014-15	$46,206
2015-16	$43,787
2016-17	$47,235

ACEP's corporate development team has tried to secure sponsorship for the Wellness Booth for many years with limited success (only twice in seven years). In 2016, a total of $10,000 in external funding was received.

The Wellness Booth, now called the "Wellness Resource Center" (WRC) has provided benefits to ACEP members for the last 17 years. However, the overall number of members taking advantage of the benefit is steadily diminishing, and the WRC has operated at a financial deficit since FY 12-13.

Approximate Financial Loss Summary (Direct expenses less ticket sales and any sponsorship)

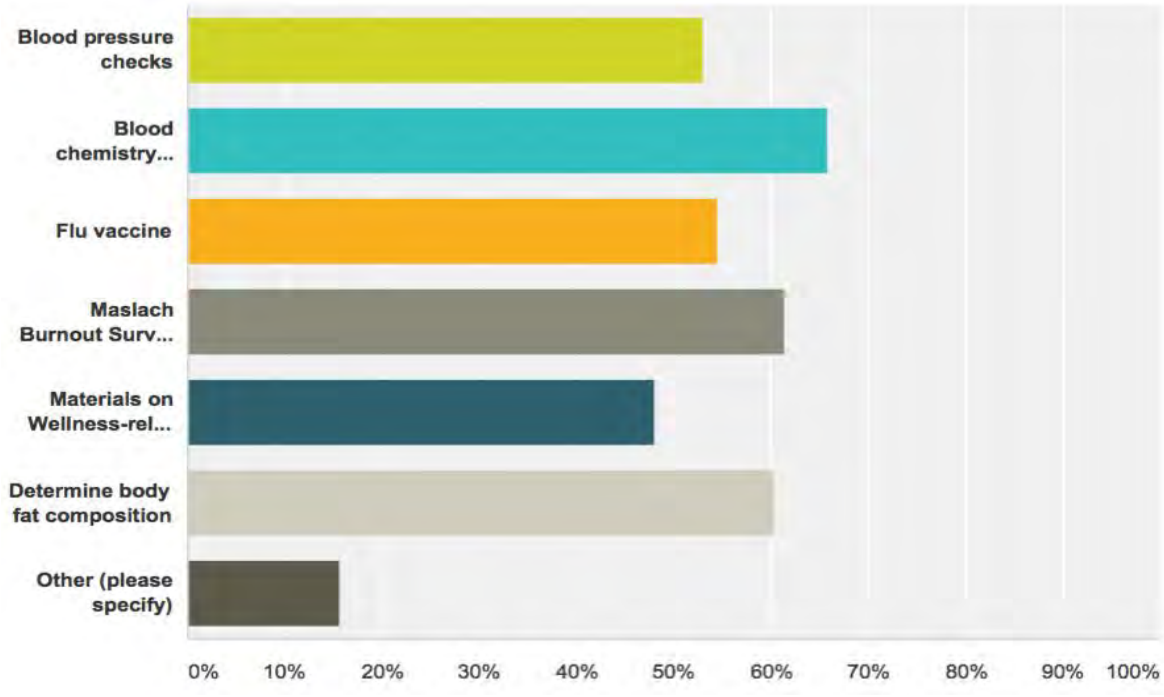
Fiscal Year	Loss
2012-13	($51,598)
2013-14	($22,909)
2014-15	($28,566)
2015-16	($27,987)
2016-17	($28,585)

Survey Data

In an attempt to obtain the most updated opinions from the ACEP membership, a survey about the WRC was sent to all ACEP members who attended *ACEP16*. The survey population included all 4-day registrants who are ACEP members, life members, honored guests, and faculty. Medical student and resident attendees were not included in the survey. The survey consisted of 12 questions, many with the option of providing open-ended answers. The survey was sent to a total of 4,043 attendees on December 7; the survey closed December 22, for a survey period of 2 weeks. Non-respondents received a reminder notification mid-way through the survey period. There were a total of 336 responses, for a response rate of 8.3%.

Highlighted items from the survey:

- Reasons why people have not used the WRC:
  - Didn't know it existed/unaware of it
  - Receive care from own primary care physician (63% see PCP--see Q 10)
- $50 cost is perceived as good value by 67% of respondents
- 59% of respondents would be more likely to use the WRC if hours were earlier and if it were located more conveniently
- Only 40% of respondents would be interested if WRC services were available to spouses/children/guests
- Additional offerings of most interest (question 12) were: personal resiliency (41%), sleep survey (39.6%), mindfulness workshop (39%), one-on-one session with professional life coach (34.6%), and exercise-related activities (34%)
- Question 5 asked about services respondents would like to continue (see graph).



Suggestions for the Wellness Resource Center

Suggestions on how to update the WRC were solicited from ACEP members who used the WRC at *ACEP16* and from members of the Well-Being Committee and the Wellness Section. Not surprisingly, this group is overwhelmingly in

support of sustaining the WRC and having it remain at the annual meetings. Suggestions grouped into a few major categories:

- *Accessibility*: Many requested that the WRC be more accessible by placing it outside the Exhibit Hall and provide earlier hours for those fasting for blood work. Other comments suggested providing services to spouses/partners/guests for a fee (to be determined).
- *More targeted labs/vaccines*: Many suggested deleting the flu vaccine, but replacing it with a pneumonia vaccine. Others indicated certain labs were not useful (as supported by specific lab usage data from 2012-16.) and some labs could be dropped to reduce expenses.
- *Advertising and Sponsorship*: Many suggested that more aggressive and broader advertising/marketing of the WRC to ACEP members would help increase attendance and usage of the benefit. Marketing, in conjunction with improved WRC location at the meeting, was also suggested. Furthermore, some suggested that broader industry support of the WRC would be appropriate.
- *Expanded Range of Services*: The meaning of "wellness" and "well-being" has changed in the last 17 years. Wellness previously referred primarily to physical health and the WRC services reflected that general meaning. Wellness now refers to much more than just physical health; it refers to many inter-related life components including social, mental, emotional, vocational, financial, and spiritual well-being. The current format of the WRC does not address many elements of the expanded concept of wellness. Many suggested changes to the WRC called for an expansion of services that address all areas of wellness. Suggestions included offering the following:

    - Painting classes
    - Mini-Yoga sessions
    - Qi Gong demonstrations
    - Exercise-related activities: yoga, morning jog coordination, guided meditation, fitness sessions
    - Poetry writing classes
    - One-on-one sessions with a professional coach
    - Cooking classes (healthy recipes with an in-booth chef)
    - Personal Resiliency Survey with recommendations
    - Hands-on seminars for de-escalation of workplace violence techniques
    - Group counseling on how to de-stress (without alcohol)
    - Jazz music sessions
    - Personal Sleep Survey with recommendations
    - Invited speakers to present wellness topics
    - Mindfulness workshop

Based upon the wide-ranging collection of information on the WRC, the Well-Being Committee recommended, and the Board approved in January 2017:

1. Changing the name of the Wellness Booth to the Wellness & Resiliency Center (WRC).
2. The WRC mission statement: "To promote wellness and resiliency in Emergency Physicians by providing resources and access to quality resources and services."
3. Renew and uplift the WRC so that members truly have a "wellness experience."
    a. Move the wellness center out of the exhibit hall and to a high-profile area.
    b. Market and promote the WRC aggressively.
    c. Retain the labs at the WRC for one more year (except for flu shots) and open lab services to non-ACEP members.
    d. Open the WRC prior to *ACEP17* and be available for Council meeting attendees and Board members during the Council meeting, providing a laboratory premium package, with the ability to open earlier (and therefore close earlier) for those needing to fast for blood work.
    e. Discontinue administration of flu shots.
    f. Provide most/all of the other services mentioned on the survey to include fitness opportunities, education, assessment tools, and other assorted wellness services.

The committee also recommended conducting another in-depth assessment of the WRC after *ACEP17.* If it is determined that usage of the WRC continues to drop, additional considerations and actions would be warranted.

Upon further review and discussion with key stakeholders, there was critical information discovered that was not available to the Board in January 2017 to make a thoroughly informed decision. The space at the Walter E. Washington Convention Center in Washington, DC, and current space assignments, make it impossible to expand or move the Wellness Booth outside of the exhibit hall. Additionally, after consultation and discussion with Well-Being Committee leaders and staff, there was consensus to recommend discontinuing the laboratory services as part of the WRC since the use of lab services has been declining in the last several years. It has become easier for members to obtain lab services, especially flu shots, and when obtained at the booth there is additional paperwork involved to document the services. Providing lab services results in a $50,000 loss to ACEP as the fee charged does not cover the actual cost. Exhibit booths surrounding the Wellness Resource Center have already been sold at a premium price because of its proximity and those premiums would need to be refunded if the Wellness Resource Center is moved.

In April 2017, the Board rescinded their decision to relocate the WRC outside the exhibit hall, retain the laboratory services for one more year, and provide access to the WRC during the Council meeting.

Staff are working with the Well-Being Committee to rework the Wellness & Resiliency Center inside the Member Resource Center and will offer many new and innovative elements to promote wellness among members and other *ACEP17* attendees:

1. #meetupatWellness Twitter account
2. Wellness Center TV – contains a loop of wellness videos
3. "Your Space in the ED" – Static set-up of ergonomic ED with standing desks, lighting, ergonomic chairs, sound cancelling headphones, computer screens, age-related adaptations, pregnancy, breast feeding, etc.
4. Wellness Center Story Booth "Come Tell your Story" will feature the ability to record 90-second stories with one of 4 prompts
5. Wellness Center Mural – "Come Share your Imagination" "Wellness is_____" Show your happy place. Markers on 20 x 10 board (or larger), guided by an artist.
6. Wellness Center Montage – "Come Take Your Picture with your Residency Class" – grouped by regions of the country (states) with designated times to meet.
   – post videos of wellness activities
   – large screen printed with "BEING WELL IN EMERGENCY MEDICINE ACEP 2017"
7. "Legends of the College" – Wellness Champions will feature 5-minute talks by several prominent ACEP members. Wellness TED Talks at the Wellness Center, provided by Well-Being Committee members, Wellness Section members, and EMRA members. These will be recorded and used for the 2018 Wellness Week.
8. Morning Workouts:
   No Joe, Wake Up and Go
   Skip the coffee and enjoy a 30-minute stretch session that begins with breathing awareness, meditation, and simple stretches to energize your body. No special workout clothes or shoes needed.
   Ways to Tell If You Might Have a Food Allergy?
   Simple 5-minute assessment tool to see if you have a food allergy.
   Personal Assessment investment
   Looking for some personal attention to improve your health and well-being. Drop in for a 5-minute VEST test and learn where to begin with living optimally. Includes:
   - Visual postural alignment (exercise)
   - Eating IQ (nutrition)
   - Sound sleep assessment (recovery)
   - Total plan for optimal health (receive ¼ plans to start living better)
9. Interactive Wellness Sessions:
   Performing at Your Best
   Simple ways to improve your health, diet, sleep and sex life. Break down the barriers to feel your best in every area of your life.
   Traveling Tips for Healthy Eating with and without Food Sensitivities
   Is prepping meals and making good choices taking a toll on your waistline? Learn simple ways to make a fast breakfast, lunch and dinner plus why eating out may keep your belly and wallet trimmer.
   5 Ways to Improve Your Energy Balancing work, family and free time can zap your energy pool. Let's peel away what's dragging you down and learn 5 strategies for putting some pep in your step.

10. Interactive Food Demos:
    All Juiced Up
    No time for eating your fruits and veggies? Simple ways to juice up your diet and discover nuts in a new way.
    Yogurt for Dinner
    Greek yogurt is a good source of calcium, probiotics, and protein… but why save it only for breakfast? Learn the sweet and savory side of eating Greek.
    Get Jerky
    The latest trend on fast food snacks is protein. Taste the latest flavors that are beefing up this portable snack.

Staff did explore the possibility of having the lab testing company file insurance claims for members. The company declined citing that it would be necessary to set up a contract with every major insurance carrier, some insurers do not like for wellness vendors to compete with their internal offerings, and there are varying reimbursement rates and some carriers will not pay for any testing except a lipid panel."

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective C – Promote member well-being and improve resiliency.

Fiscal Impact

Budgeted committee, section, and staff resources. Approximately $50,000 to restore lab services. The actual cost in FY 2016-17 for lab services was $46,297.

Prior Council Action

Substitute Resolution 13(99) Wellness Booth not adopted. Called for ACEP to promote the Wellness Booth in the exhibit hall at each *Scientific Assembly* and make every effort to ensure that adequate funding for the booth continues annually, regardless of financial support from corporate sponsors.

Prior Board Action

April 2017, rescinded the decision to relocate the Wellness Booth outside the exhibit hall, retain the laboratory services for one more year, and provide access to the booth during the Council meeting.

January 2017, approved several recommendations from the Well-Being Committee regarding the Wellness Booth, including relocating it from the exhibit hall to another location.

June 1992-present approved budget for the Wellness Booth.

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

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

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: 19(17)

SUBMITTED BY: Emergency Medicine Research Section

SUBJECT: Advocacy and Support for "Scholarly Activity" Requirements for Emergency Medicine Residents

PURPOSE: Work with several stakeholders to develop a uniform, consistent approach towards the scholarly activity for residents using a consensus approach.

FISCAL IMPACT: Budgeted staff resources. Additional travel costs of approximately $15,000 to convene one in-person meeting.

WHEREAS, Scholarly activity is a requirement for Emergency Medicine residents in allopathic programs and osteopathic programs; and

WHEREAS, Scholarly activity has been left to the interpretation of residency programs, and there exists vast variability in its interpretation; and

WHEREAS, A research curriculum should be in place as a part of the scholarly activity requirement; and

WHEREAS, The research curriculum is ill defined in most residencies, with very little dedicated time during residency training for research; and

WHEREAS, Institutions should provide support to residents completing scholarly activity; therefore be it

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.

References

1. ACGME Common Program Requirements (ACGME approved focused revision: September 29, 2013; effective: July 1, 2016)
2. AOA Basic Documents for Postdoctoral Training, Effective 7/1/2016
3. Accreditation Council for Graduate Medical Education (ACGME) Resident/Fellow Scholarly Activity, Updated 10/2016
4. Amrhein, et al.: Radiology residency scholarly activity policy. Education for Health, Volume 28, Issue 1 (April 2015) Page 68-73
5. Geyer et al.: A National Evaluation of the Scholarly Activity Requirement in Residency Programs: A Survey of Emergency Medicine Program Directors. ACADEMIC EMERGENCY MEDICINE • November 2015, Vol. 22, No. 11 ISSN 1069-6563
6. Abramson et al.: Research Training Among Pediatric Residency Programs – A National Assessment. Acad Med. 2014 December; 89(12): 1674–1680. doi:10.1097/ACM.0000000000000404.

Background

This resolution asks ACEP to work with several stakeholders to develop a uniform, consistent approach towards the scholarly activity for residents using a consensus approach.

Scholarly activity has been required of residents for many decades. Program requirements for both the Accreditation

Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA)/American College of Osteopathic Emergency Physicians (ACOEP) include a scholarly activity as one of the requirements for the resident.

An early argument against board recognition for emergency medicine was that there was not a unique body of knowledge. Initially, the requirement for a scholarly activity, and for scholarship by faculty, was to produce that body of knowledge and foster improvement in patient care.

The program requirements of the AOA/ACOEP state:

> *"The resident shall complete a research project during the course of the emergency medicine training program that will be sent to the ACOEP in the following manner. The resident shall submit an outline for the project by the end of the osteopathic graduate medical education (OGME)-2 training year, implementation and data collection methods and provide an interim report by the end of the OGME-3 year, and a final product suitable for publication six months prior to the completion of the OGME-4 year of residency. A permanent copy shall be retained in the resident's file at the institution. All research projects shall be approved by the program director."*

The program requirements of the ACGME state:

> *"IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.*
> *IV.B.2. Residents should participate in scholarly activity.*
> *IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. "*

Interpretation of what constitutes a scholarly activity has largely been left up to the individual program. In 1999, the Society for Academic Emergency Medicine (SAEM) attempted to define the requirement by defining the goals of the scholarly activity. The consensus of that group was that the primary role of the scholarly project is to "instruct residents in the process of scientific inquiry, to teach problem-solving skills, and to expose the resident to the mechanics of research."[1] In this same document they suggested that the project "should include the general elements of hypothesis formulation, data collection, analytic thinking, and interpretation of results" and that it should be written up with a literature review.

In 2014, the ACGME, the AOA, and the American Association of Colleges of Osteopathic Medicine (AACOM) announced that there would be a single accreditation system for graduate education. The consolidated program would be phased in over several years, becoming fully adopted July 1, 2020. This change allows for a reexamination and possible reinterpretation of the scholarly activity.

In 2013, ACEP's Research Committee, with assistance from the Council of Emergency Medicine Residency Directors (CORD), conducted a survey of program or research directors of allopathic and osteopathic emergency medicine residency programs. The survey demonstrated high variability in the interpretation of the requirements for scholarly activity. Only 39% of the responding programs required a formal research project. There was no difference in the number of residents who went on to academic careers between programs that required a research project and those that did not. At that time, 76% of the respondents said they would support a national initiative to define the scholarly activity. The committee recommended that ACEP collaborate with CORD to develop a standardized definition of the scholarly activity requirement. An article was published in the July 2015 issue of *Academic Emergency Medicine* titled "Improving the Emergency Care Research Investigator Pipeline" as a collaborative effort with SAEM's Research Committee.

In 2017, SAEM revisited the consensus document from 1999. That group has just finished its work and has a publication pending. Its focus is on the primary role/outcome of the scholarly project and the general elements as outlined above.

Currently, the interpretation of "scholarly activity" is determined by the individual residency director. Because of the ambiguity of the requirement, some residents may fulfill the requirement by giving a lecture or doing a literature review. Other programs require that the residents complete a research project with IRB approval that is potentially publishable. Providing direction to residency directors and residents would allow a more consistent education.

References

1. Summer RL, Fish S, Blanda M, Terndrup T. Assessment of the "scholarly project" requirement for emergency medicine residents: report of the SAEM Research Directors' workshop. SAEM Research Directors' Interest Group. *Acad Emerg Med*. 1999;6:1160-5.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources. Additional travel costs of approximately $15,000 to convene one in-person meeting.

Prior Council Action

None

Prior Board Action

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.

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

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

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: 20(17)

SUBMITTED BY: Douglas Char, MD, FACEP
Marco Coppola, DO, FACEP
Henderson McGinnis, MD, FACEP
Jamie Shoemaker, MD, FACEP
Annalise Sorrentino, MD, FACEP
Jennifer L'Hommedieu Stankus, MD, JD, FACEP
Arlo Weltge, MD, FACEP
Anne Zink, MD, FACEP

SUBJECT: Campaign Financial Reform

PURPOSE: Directs the Council Steering Committee to: 1) create expenditure limits in the Candidate Campaign Rules; 2) amend the Rules regarding chapter visits by candidates; 3) consider other changes in the election process such as financial disclosures, other campaign expenditure limitations, prohibiting chapter and residency visits during the period of declared candidacy, restricting publication of non-scholarly work in non-peer reviewed journals, and restricting the use of social media.

FISCAL IMPACT: Budgeted Council and staff resources for the Council Steering Committee, updating the Candidate Campaign Rules, and distributing the updated Rules to candidates.

WHEREAS, The American College of Emergency Physicians (ACEP) is the world's premier and leading organization representing emergency medicine and its members; and

WHEREAS, It is an honor and a privilege for an ACEP member to serve in leadership roles; and

WHEREAS, The founders of ACEP made every attempt to "level the playing field" so that pursuing leadership opportunities would not be hindered because of exorbitant financial obligations and hardship; and

WHEREAS, In recent years, many candidates for Council Officer, the Board of Directors, and the President-Elect have increased expenditures to appear at chapter annual meetings to "campaign" for their candidacy; and

WHEREAS, Appearances at chapter annual meetings would hinder the candidacies of qualified individuals from geographically remote areas; and

WHEREAS, Also in recent years, many candidates for Council Officer, the Board of Directors, and the President-Elect have increased expenditures for professional "coaches," fashion consultants, and high quality video presentations; and

WHEREAS, Such need for increased expenditures would limit the variety of candidates for leadership positions to those who are older in age and have more financial resources; and

WHEREAS, Such need for increased expenditure would also exclude members from a younger demographic and those from academic circles who may lack financial means; and

WHEREAS, The Leadership Development Advisory Group, the National/Chapter Relations Committee, and the Compensation Committee have long recognized the financial concerns and hardships of members considering candidacy; and

WHEREAS, The campaign rules of the American Medical Association state, "Candidates for AMA office should not attend meetings of the state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.;" therefore be it

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."

Background

This resolution directs the Council Steering Committee to: 1) create expenditure limits in the Candidate Campaign Rules; 2) amend the Rules regarding chapter visits by candidates; 3) consider other changes in the election process such as financial disclosures, other campaign expenditure limitations, prohibiting chapter and residency visits during the period of declared candidacy, restricting publication of non-scholarly work in non-peer reviewed journals, and restricting the use of social media.

The Candidate Forum Subcommittee, a subcommittee of the Council Steering Committee, is tasked with the responsibility of reviewing the Candidate Campaign Rules each year and recommending any changes to the Steering Committee. The subcommittee is also responsible for developing the requirements for candidate campaign material and implementing the annual Candidate Forum. The intent of creating and implementing the Campaign Rules is to ensure fairness in the campaign process for all candidates. This process has been in place for decades, although the Campaign Rules have evolved over the years to address campaign issues that have arisen and also based on feedback from councillors and the candidates. The intent is not to be proscriptive or prevent members from learning as much as they can about each candidate.

The Council Steering Committee has discussed campaign expenditure limitations many times over the years and has attempted to make changes that are reasonable and fair to all candidates. Many individuals who have considered seeking nomination have reported that the expense for being a candidate is a barrier.

The Steering Committee has struggled with prohibiting, or limiting, the amount of travel for candidates. Visits to various chapters by candidates is typically self-funded, although some candidates may receive a portion of their travel costs paid by the chapter if serving as faculty for the meeting. Some smaller chapters have expressed concerns because the candidates do not necessarily give equal consideration for attending the smaller chapter meetings. Attending chapter meetings is a great opportunity to learn about the chapter and not just an opportunity for campaign purposes. There may be unintended consequences if chapter visits by candidates are banned and it may be difficult to enforce such a rule, particularly if a candidate (or candidates) is invited to participate in their program. However, it may be an unfair advantage to the candidate(s) invited to attend a chapter meeting and other candidates are excluded.

The last Resolved asks the Steering Committee to consider additional campaign limitations. Some of these suggestions are addressed in the Campaign Rules, but not to the extent that is requested. This year, the candidates were required to disclose the financial expenditure for developing a video (if one was submitted). Limiting residency visits by candidates could have unintended consequences. Residency programs can select whomever they want for the visit, and their selection is probably not because the individual is a candidate for ACEP president-elect or the ACEP Board of Directors. The current Campaign Rules prohibit communications and/or interviews regarding candidacy in emergency medicine newsletters or publications other than those published by ACEP, but allows publication on issues other than candidacy. Restrictions regarding the use of social media are also included.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted Council and staff resources for the Council Steering Committee, updating the Candidate Campaign Rules, and distributing the updated Rules to candidates

Prior Council Action

Each year the Council Steering Committee reviews and approves the Candidate Campaign Rules. All action taken by the Steering Committee is subject to final approval by the Council at the next regularly scheduled meeting. This action occurs by the Council ratifying the minutes of the Steering Committee meetings.

Resolution 16(14) Freedom of Speech not adopted. Requested the Council to revoke the Candidate Campaign Rule prohibiting communications or interviews in non-ACEP publications by candidates and encourage candidates to conduct such interviews.

1992, the Council Speaker appointed a Council Steering Committee Subcommittee on Election Norms to develop a paper on Norms of Behavior for Elections.

Resolution 19(76) Expenditure of Funds for Campaigning adopted. Limitation of campaign expenditures provided by the College in its official publications.

Prior Board Action

None. The Board does not take action on the Candidate Campaign Rules.

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

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

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: 21(17)

SUBMITTED BY: Emergency Medicine Informatics Section

SUBJECT: Creation of an Electronic Council Forum

PURPOSE: Seeks to create a year-round forum to introduce, debate, and vote on resolutions, use the results of the votes in the electronic Council forum as nonbinding resolutions to offer ACEP leadership expeditious guidance on emergent issues, and that the electronic Council forum feature include a user experience that can be used during the Council meeting to receive and display proposed amendments in real time during discussion and voting.

FISCAL IMPACT: Unknown actual costs to create a new electronic forum. Also unknow at this time whether ACEP's Technology Services staff would be used to create the forum or if an outside firm would be required. Costs of the project depend on the scope of work. Additional staff resources would be needed to monitor the forum.

WHEREAS, ACEP is the largest organization in the world for addressing the concerns of Emergency Physicians; and

WHEREAS, ACEP addresses a broad range of physician practice, regulatory, and practice environment issues and challenges on a dynamic basis; and

WHEREAS. The Council meets only one time a year, creation of an electronic Council forum would afford a forum for issues that occur at times not conveniently addressed by the current annual meeting; and

WHERAS, The ACEP annual meeting allows the Council body to offer guidance to the Board of Directors; and

WHEREAS, The leadership does an able job, but by using electronic methods, the Council's membership could be afforded the opportunity to provide interim guidance, input and feedback on emergent issues, as well as offering a venue for broader pre-meeting debate of annual meeting resolutions; and

WHEREAS, We are maturing as a specialty and have grown significantly as a Council, we should move to the 21st century communication methods in an effort to be more inclusive and democratic to encourage thoughtful input from the entire Council body; and

WHEREAS, There can be confusion during the Council meeting as to what is being discussed and being called to question leading to unnecessary delays and even errors; therefore be it

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.

Background

This resolution seeks to create a year-round forum to introduce, debate, and vote on resolutions, use the results of the votes in the electronic Council forum as nonbinding resolutions to offer ACEP leadership expeditious guidance on emergent issues, and that the electronic Council forum feature include a user experience that can be used during the Council meeting to receive and display proposed amendments in real time during discussion and voting. The authors of the resolution have provided a description of how they envision the forum would work and additional commentary for the Council to review and understand their proposal (Attachment A).

In 2013, the Council Steering Committee considered a similar proposal as described in this resolution. A subcommittee was assigned to review the proposal and provide a recommendation to the Steering Committee. The subcommittee received information regarding Texas law, which governs ACEP's operations. Texas law specifies that there is no better process than face-to-face deliberation where everyone has the opportunity to participate and receive the same information. After much discussion regarding the pros and cons, the Steering Committee determined that a change in the current resolution process was not needed at that time.

There are several process issues for the Council in considering this resolution. The traditional format of the annual Council meeting is a time-honored tradition. While some may favor a new electronic means of conducting Council business, the traditional method continues to provide the Council an effective means of operation.

A comprehensive analysis needs to be conducted to determine the financial and human resource costs. A new electronic forum may create a substantial increase in the amount of work for the Council officers, councillors, and staff. Additional staffing may be needed to implement the electronic forum. Potential unintended consequences in implementing a new system could be "Council work fatigue" and discouraging members' willingness to participate in the Council if additional work is required beyond the current timeframe.

ACEP's Bylaws and Council Standing Rules may need to be amended to facilitate a new process for the Council Forum. The Bylaws require component bodies to certify (provide the names) their councillors and alternates (those who are eligible to vote) 60 days prior to the annual Council meeting. Having the Council Forum active year-round could be problematic since the designated councillors would be changing as component bodies determine their councillors and alternates. The timing of submitting a resolution and who is eligible to vote would be inconsistent. The integrity of the voting process could be compromised. Although the results of the electronic forum are nonbinding, it is unknown whether it would enhance or detract from the current process of in-person debate in the Reference Committees and on the Council floor at the annual meeting. The processes for Reference Committees and Council floor debate would need to be revised to accommodate the electronic Council Forum discussions and votes.

Additional processes and criteria for submitting resolutions would need to be developed. The current resolution process requires that background information be prepared by staff on all resolutions submitted by the deadline. The background information is vitally important to inform the Council and it is unclear whether the new electronic forum would include time for staff to prepare background information. It is also unclear whether this new system would be required to submit resolutions to the Council, or whether the traditional process of submitting resolutions would also continue. If both processes are in place, it could be duplicative work.

The Council currently has the ability to discuss issues, and resolutions once they are released to the Council, via the Council e-list (c-mail). Although this is a simple email system, its creation was intended to serve as a forum for councillors to communicate throughout the year on any relevant topic. Its 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.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Unknown actual costs to create a new electronic forum. It is also unknown at this time whether ACEP's Technology Services staff would be used to create the forum or if an outside firm would be required. The costs are dependent on the scope of work. Additional staff resources would be needed to monitor the forum.

Prior Council Action

None

Prior Board Action

None

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

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

Comments from the authors of Resolution 21(17)

ACEP is an organization of over 35,000 physicians, residents and medical students operating in an intensely dynamic environment. As councillors, we meet once a year to consider and debate several dozen resolutions to offer guidance to the organization and express the concerns of the rank and file.

Regardless of the presence of 20 or 50 resolutions, the time frame for the management of the resolutions is relatively static: a single weekend. It is an impressive feat, but this structure cannot effectively addresses issues that are emerging in our practice environment.

The concept for this forum started in 2012, about 3 months before our annual meeting in Denver, there was a mass shooting less than 20 miles from where we were meeting. Resolutions were introduced on an emergency basis, but one line of argument against considering the resolutions were the haste with which they were brought and being considered. By the next year, nothing more was introduced on the subject.

Now, this is not about gun control or any single issue. So as a second example consider what we are currently dealing with, the health care act replacement. The evolving stance of ACEP regarding the emerging provisos in the bill is difficult at best given how little information is being provided. Leadership, for example, ultimately came out strongly against any bill that would not support coverage of emergency care, but it took time for the issue to become apparent.

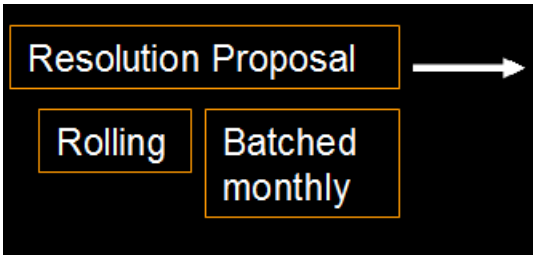
In something so dynamic and immense, the collective Council would have greater resources than the leadership alone in evaluating information and offering feedback to create the strongest possible response and advocacy for our constituents.

<u>Consider that our ability to discuss the current health care act in October will not impact the current conversation and votes this Summer.</u>

LEGAL ISSUE- It has been suggested that under Texas state law that an electronic forum may not be employed to conduct the affairs of an entity incorporated under Texas state law. For this reason the deliberations would be considered NONBINDING.

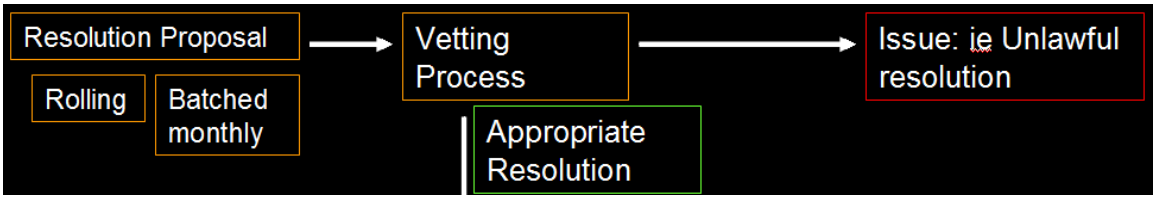
How the forum works.

For the more visually inclined I have attached PPT slides, but as briefly as I can:

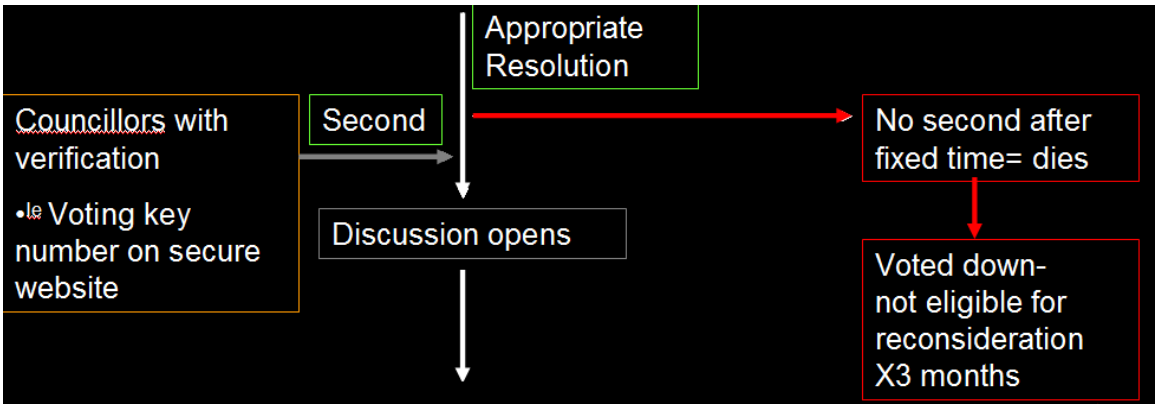


1) Resolutions are introduced either on a rolling basis or in batches, weekly or the 1st and 15th of every month. The latter allows for a clean slate on a regular basis. Emergency resolutions can be introduced at any time.

2) The resolutions go through a vetting process to determine if they are lawful and appropriate. If we go with the batched introduction approach, emergency resolution will be assessed to see if they meet criteria.



3) Councillors with a voting key can then consider the resolution. If any member considers the subject worthy of discussion they second the resolution and debate begins. If no one seconds the resolution in a fixed amount of time (TBD) the resolution “Dies” and cannot be reintroduced for a fixed period of time (TBD- three months in the example).

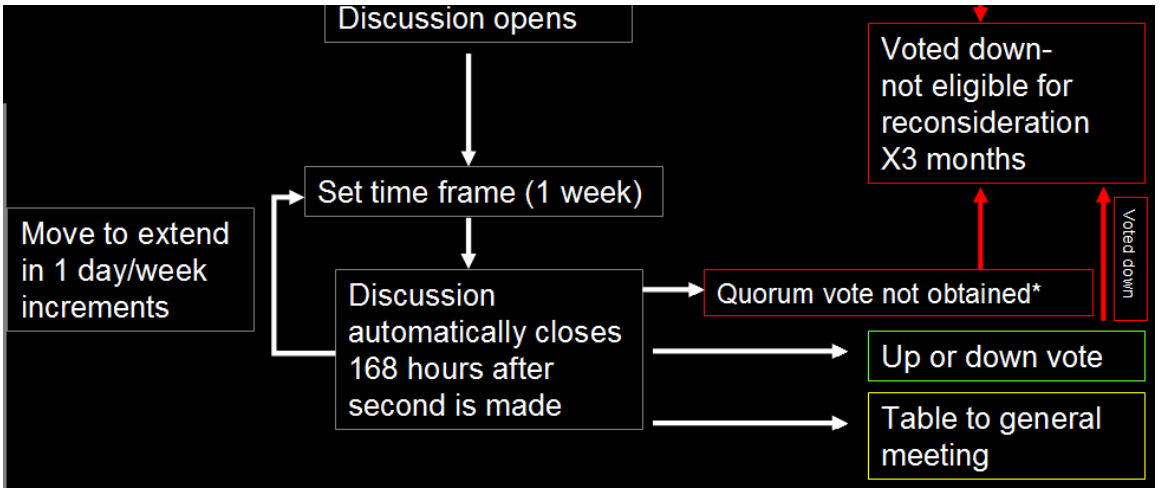


4) Discussion/debate is open for a period of 1 week in a discussion forum format. Debate can be extended if needed. That mechanism can be a vote to extend or simply empower the moderator to extend it. The latter is simpler in the context of not getting bogged down in sub discussions. There will be one of three outcomes:

1) Quorum not obtained. To have a quorum at the annual meeting, a certain number of councillors must be in attendance. If this number of votes is not obtained, the quorum not met and the resolution dies.

2) The resolution is tabled to the general meeting.

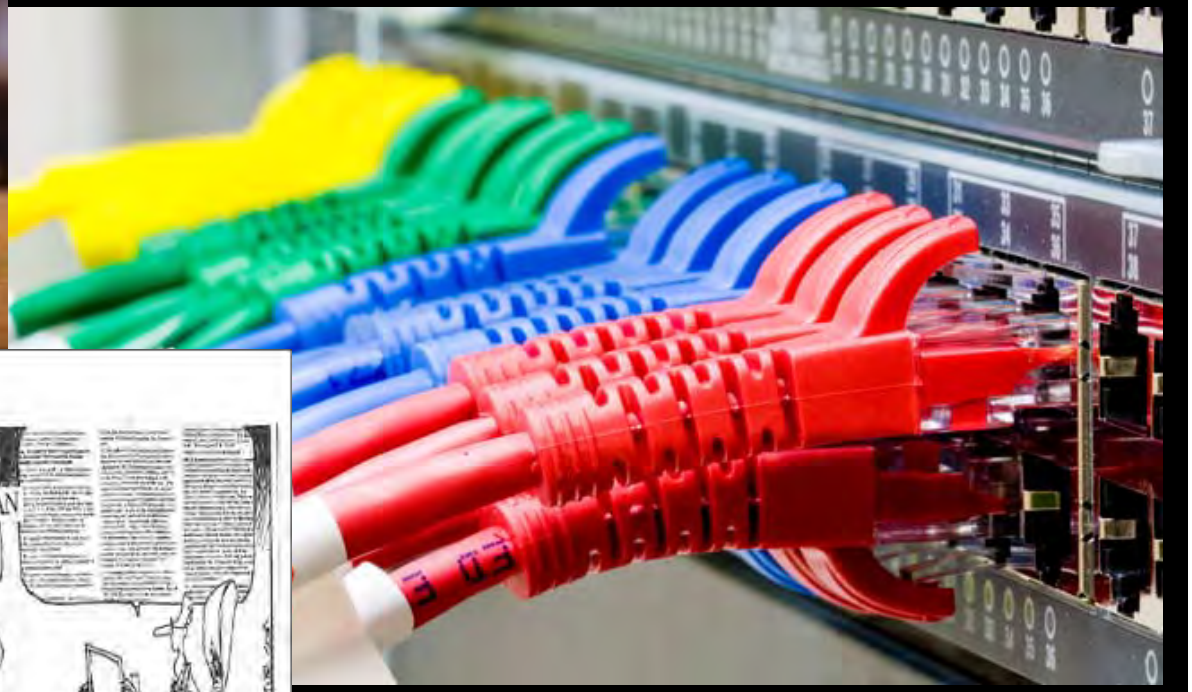
3) An up or down vote.



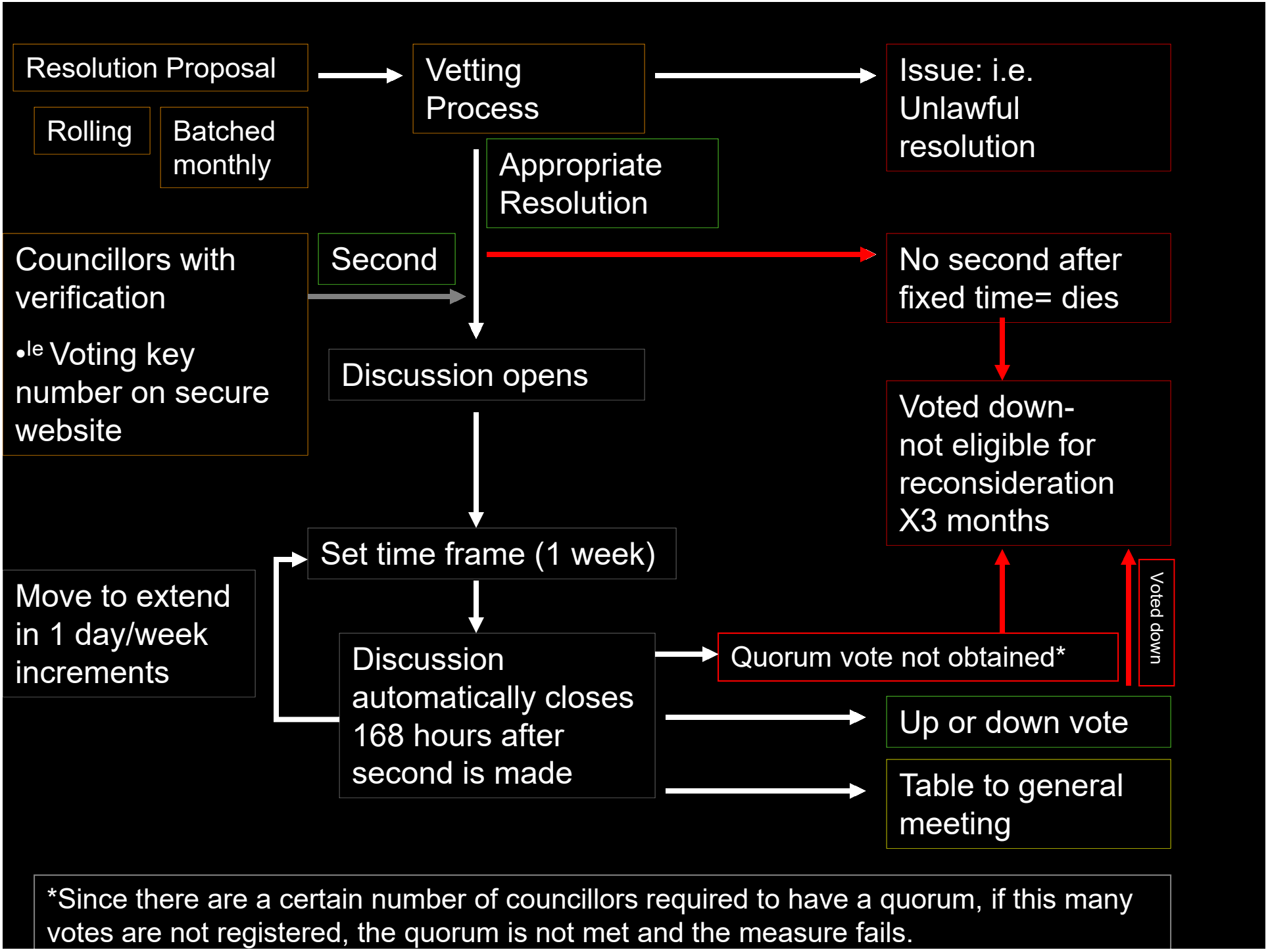
Certainly, a possible 4th outcome is to defer to the Board. While this would run counter to the point of the forum, circumstances that I cannot see could make that a potential outcome.

In sum, this is a starting point. I don't imagine that this is what the forum will actually look like, but for conceptualization purposes, it should suffice.

Proposal for Electronic Voting Forum for Addressing Emergent Issues while Council is not in Session



Process


Resolution Proposal
Rolling
Batched monthly
Vetting Process
Issue: i.e. Unlawful resolution
Appropriate Resolution
Councillors with verification
•Ie Voting key number on secure website
Second
No second after fixed time= dies
Discussion opens
Voted down- not eligible for reconsideration X3 months
Set time frame (1 week)
Move to extend in 1 day/week increments
Discussion automatically closes 168 hours after second is made
Quorum vote not obtained*
Voted down
Up or down vote
Table to general meeting
*Since there are a certain number of councillors required to have a quorum, if this many votes are not registered, the quorum is not met and the measure fails.

Forum interface example 1

RESOLUTION: 2(12)

Debate closes in: 120 Hrs 15 M 30 Sec

SUBJECT: Commendation for Gregory House, MD, FACEP

1 WHEREAS, Gregory House, MD, FACEP, has served the American College of Emergency
2 Physicians in many leadership roles since his election to the Board of Directors
3 including Secretary-Treasurer, Vice President, President-Elect, and Immediate Past President; and
4
5 WHEREAS, Dr. House has shown exemplary leadership and outstanding service to the College for
6 his dedication, tireless efforts, and skills on various committees, the ACEP Council, and the ACEP Board
7
8 RESOLVED, That the American College of Emergency Physicians commends Dr. Gregory House,
8 MD, FACEP, for his outstanding service, leadership, and commitment to the specialty of emergency medicine
9 and to the College.

SUBMITTED BY:
California Chapter

SECOND BY:
Kel Brackett MD, CA

Seen by

Josiah Barlett
Lyman Hall
Matthew Thornton
Ben Rush

Yeas:
NY1
NY2
NY3
MD5
C09

Nays:
MA 7
NY 9

Table
MI 4

Abstain
HI 1

Number left to quorum
vote achieved #150

Debate:

For

Against

Forum interface example 2

Debate closes in: 120 Hrs 15 M 30 Sec

Amendments for RESOLUTION: 2(18)

SUBJECT: Commendation for Kelly Brackett, MD, FACEP

Original	As recommended By Dr. Gage	Accepted as friendly amendment by DR EARLY
11 Department of Emergency Medicine at the University of Rochester, serving 14 years as its founding Chair; and	11 Department of Emergency Medicine at Harvard serving 14 years as its founding Chair; and	No

Pro	Con	Informational/Other
It was Harvard	No it wasn't	www.Harvardyearbook.com

Line as it will read if passed:

Department of Emergency Medicine at HARVARD, serving 14 years as its founding Chair; and

Line as it will read if it doesn't pass:

Department of Emergency Medicine at University of Rochester, serving 14 years as its founding Chair; and

SUBMITTED BY:
California Chapter

SECOND BY:
Kel Brackett MD, CA

Seen by

Josiah Barlett

Lyman Hall

Matthew Thornton

Yeas:	Nays:
NY1 NY2 NY3 MD5 C09	MA 7 NY 9

Table	Abstain
MI 4	HI 1

Number left to quorum vote achieved #150

"Look, the herd instinct has gotten us this far— why do we need parliamentary procedure now?"

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: 22(17)

SUBMITTED BY: Dual Training Section

SUBJECT: Emergency Medicine Residency Training Requirements for Dual Training Programs

PURPOSE: Work with ABEM and possibly ABMS to create a new definition of Initial Residency Period that would permit Graduate Medical Education funding for the duration of dual training periods.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The Initial Residency Period (IRP) determines the reimbursement received by the hospital where the training takes place; and

WHEREAS, For emergency medicine the IRP is established by the American Board of Emergency Medicine and currently the IRP is listed as either 3 or 4 years; and

WHEREAS, These IRPs were established before dual training programs such as Emergency Medicine-Pediatrics, Emergency Medicine-Internal Medicine, or Emergency Medicine-Critical Care were common; and

WHEREAS, An IRP that does not reflect more extended periods of training may be a financial disincentive to the creation of additional dual training programs; therefore be it

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.

Background

This resolution calls for ACEP to work with ABEM and possibly ABMS to create a new definition of Initial Residency Period that would permit Graduate Medical Education funding for the duration of dual training periods.

Historically, Medicare has been the primary funding source for graduate medical education (GME). 47 states also provide support as a secondary GME funding source. Since its inception in 1965, Medicare has reimbursed teaching hospitals for their portion of the direct GME costs (DGME or DME). DME costs include resident stipends and fringe benefits, faculty salaries and fringe benefits, and administrative overhead.

With the advent of diagnosis-related groups (DRGs) in 1983, Medicare began to include reimbursement for indirect GME costs (IGME or IME). IME payments compensate teaching hospitals for greater inpatient costs from treating higher acuity patients, and indirect costs of GME programs such as decreased faculty productivity and increased lab and diagnostic tests ordered by residents in training.

Over the years, Congress has changed the law upon which formulas for determining DME and IME payments were based. In 1985, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services or CMS) began to limit DME payments to a resident's period of board eligibility plus one year, with a maximum of five years. After that, Medicare pays 50% of the per resident amount (PRA). For emergency medicine, the initial residency period (IRP) limitation was three years. Considering the recent movement of osteopathic residencies into ACGME, ABEM now affirms an IRP of 3 or 4 years.

For physicians who want to train in more than one specialty (EM/IM, EM/Peds, etc.), CMS notes that "counting for GME purposes, a physician would be limited by his/her 'initial residency period' which generally limits full funding to a first residency only. Generally, for a second residency, for direct GME purposes, he/she would be weighted at 0.5 FTE." The initial residency period rules do not apply for IME and thus, he/she would be counted at 1.0 FTE for IME regardless of how long he/she trains.

Dual training has significant advantages; creating a workforce that can bridge two specialties and provide a perspective otherwise lost. Individuals who practice these dual specialties often receive less reimbursement, yet remain enthusiastic about their practice environment. However, because of the reduced payment, some institutions that provide the training have begun to question this investment. A recent closure of a long-standing EM/IM program for financial reasons raises questions of the financial viability of dual programs.

ABEM sets the IRP, but CMS determines the rules by which the IRP is paid. In addition to ABEM and ABMS, it will be important to advocate with CMS to enact changes to the IRP to reflect dual training.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Emergency Care
Objective D – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted. Called for the College to address workforce shortage by lobbying for increased EM residency slots and meeting with appropriate organizations to address development of an EM fellowship.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted. Directed ACEP to lobby Congress and pertinent government agencies to reduce the shortage of board certified emergency physicians and lobby Congress and the federal government to eliminate barriers to creating adequate emergency medicine residency positions and achieving optimal funding for those positions.

Prior Board Action

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

April 2012 reaffirmed the policy statement "Emergency Medicine Workforce;" reaffirmed June 2006; revised and approved September 1999; originally approved November 1987 with the title "Manpower."

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted.

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

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

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: 23(17)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Information Sharing, Regular ACEP/Chapter Contact, and Regional State/Chapter Relationships

PURPOSE: Implement processes enhancing chapter relationships and information sharing; assign Board members and an appropriate staff member to participate in regular contact with chapters; explore concept of developing regional state chapter relationships; provide a report to the 2018 Council.

FISCAL IMPACT: Budgeted staff resources. Additional travel expenses for Board members and staff to attend chapter and regional meetings.

WHEREAS, ACEP and its constituent state chapters have converging interests as expressed in their mutual mission and vision; and

WHEREAS, ACEP and state chapters function philosophically as an integrated goal oriented group of allied intertwined organizations seeking to support Emergency Physicians, assure access for their patients and inform and protect the general citizenry; and

WHEREAS, The directors and leadership of ACEP and state chapters are necessarily changing annually, creating an additional challenge to communication between the national and state organizations; and

WHEREAS, A framework for building and maintaining relationships between and among national and state chapters will allow for collaboration on future projects; and

WHEREAS, In our current 24/7 news cycle, with social media at the forefront of interactions, having a framework to communicate relevant information rapidly and receive feedback from stakeholders quickly is essential; therefore be it

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.

Background

The resolution requests that ACEP implement processes that enhance chapter relationships and information sharing, assign national ACEP Board members and an appropriate staff member to participate in regular contact with chapters, explore the concept of developing regional state chapter relationships, and provide a report to the 2018 Council.

ACEP has 53 chartered chapters, each governed independently by its own elected Board of Directors. Chapters

advocate for the rights of physicians and their patients, provide CME and other educational resources, news, and leadership opportunities. As would be expected, due to geography and demographics, chapters vary widely in size and available resources. ACEP provides a broad array of resources to chapters consistent with our joint mission on behalf of our specialty and our patients.

ACEP's Chapter Services Department has responsibility for coordination with and among chapter staff and member leadership. The department conveys ACEP information and resources to the chapters through a variety of programs, including functioning as a liaison between chapter and national ACEP staff, planning for chapter executive forums and audio conferences, and otherwise sharing information to meet chapter needs.

ACEP also promotes leader visit and residency visit programs through which ACEP officers and Board members attend chapter meetings and residencies on a rotating basis. The leader visit program was created in 1989. During his presidency, Jay Kaplan, MD, FACEP, asked staff to prioritize planning of leader visits to all chapters that had not received a visit within the last five years. The objective was achieved.

The concept of assigning Board Liaisons to chapters has been implemented and revisited several times, beginning in June 1997 when the Board decided to submit a resolution to the Council to close the membership of the College as of December 31, 1999. A campaign was undertaken to contact councillors and other chapter leaders to discuss the resolution and encourage its adoption. Each Board member was assigned specific chapters to contact. The campaign, along with many communication strategies, was successful and the 1997 Council ultimately adopted the resolution. The Board decided to continue with the concept of Chapter Board Liaisons for the next few months and provide reports at each Board meeting regarding any concerns or issues facing chapters. Board members often reported on the difficulty in contacting chapter leaders and the program was discontinued in June 1998.

In January 2010, the Board again considered establishing Board Liaisons to chapters. There was consensus to delay implementing such a program at that time. The potential program was discussed again in January 2012. There were mixed reactions to establishing a formal program and questions were raised about the potential responsibilities for the Board and chapter leaders. A workgroup was assigned to further investigate establishing a program.

In May 2012, the National/Chapter Relations Committee discussed the concept of Board liaisons to chapters. There was unanimous and strong support from the committee and their recommendations were presented to the Board in June 2012 to develop a pilot program with the goal of improving communications between national and chapters. The Board approved establishing a one-year pilot program with the chapters most likely to benefit from such a program (identified as small chapters and unstaffed or utilizing part-time staffing).

Chapter Liaison Pilot Program Description

1. Pilot program for two years.
2. Send program information to all chapters; participation is optional.
3. Communication with chapters will be by email or phone call.
4. Chapters will absorb the cost for the Board liaison to visit the chapter.
5. Pilot program would not replace the Leader Visit Program. A chapter in the rotation schedule for the year may request whomever they wish for the leader visit.
6. Board liaison assignments made by the president.
7. Board liaisons contact designated chapters quarterly and provide feedback to the Chapter & State Relations Department.
8. At the end of each year of the pilot program a survey will be sent to chapters for feedback. The Board of Directors will evaluate the results of the program survey.

Eleven chapters were approved by the president to participate in the pilot program: AR, DE, ID, KS, MS, ND, NH, NM, PR, SD, and WY. The expectations for the program included: provide information, serve as a resource, and bring issues from these chapters to the Board as needed. On their April 17, 2013, conference call, the Board reviewed the Criteria for Board Liaisons to Chapters, recommendations for Board Liaison assignments, and information about each of the 11 chapters identified for the program. In June 2013, the Board approved the criteria and duties of the Chapter Board Liaison Pilot Program with implementation to begin after the 2013 *Scientific Assembly*.

Staff attempted to contact each of the chapters to confirm their willingness to participate in the pilot program. After many months of effort trying to contact the chapter leaders and formalize the program, it was abandoned for lack of response.

Some pros and cons to consider in creating a formalized chapter contact program are:

Pros
1. Reinforces that relations with chapters are a priority.
2. Provides a specific Board member for chapters to contact.
3. Enhances ongoing communications with chapters.

Cons
1. Time constraints of Board members and chapter leaders.
2. Difficulty in making contact, either by phone or e-mail.
3. Additional workload for national and chapter leaders.
4. Unintended negative consequences.
5. Potentially creates an expectation that a particular chapter's issues have higher priority than other chapters (such as those who were not able to be contacted) or issues facing national ACEP.
6. Potentially circumvents the role of the Chapter & State Relations staff, the National/Chapter Relations Committee, the Membership Committee, the Executive Director, and ACEP President if chapters perceive there is a prescribed or expected method to voice questions and concerns.
7. May create expense concerns for ACEP's budget or awkwardness if chapters want to invite the ACEP President, President-Elect, or another director for whatever reason, but the designated director liaison to the chapter expects to be invited and wants to attend.

Some chapters work together on joint regional meetings. For example, an annual Southeastern Chapters (SEC) conference is a collaboration of the Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee chapters. Similarly, the states of Georgia, North Carolina, and South Carolina have collaborated for the last five years on their Coastal Emergency Medicine Conference. The Alaska and Washington chapters have also begun working on joint meetings.

For the 2017-18 year, the National/Chapter Relations Committee, with assistance from the State Legislative/ Regulatory Committee has been assigned an objective to "identify opportunities for regional collaboration and conferences.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective A – Increase total membership and member retention.

Fiscal Impact

Travel expenses for Board members and staff to travel for purposes of participating in regular contact with state chapters; budgeted staff resources for supporting and promoting these efforts.

Prior Council Action

Substitute Resolution 45(95) Leader Visits to Chapters adopted. The resolution directed ACEP leadership to prioritize communication with state chapters and investigate technologies for improved communications.

Substitute Resolution 28(90) Leadership Visits to Chapters adopted. Directed ACEP to continue to investigate options for providing national physician/staff leader visits to chapters, including the option of conducting annual visits to chapters..

Prior Board Action

June 3013, approved the criteria and duties of the Chapter Board Liaison Pilot Program with implementation to begin after the 2013 *Scientific Assembly.*

April 2013, reviewed the Criteria for Board Liaisons to Chapters, recommendations for Board Liaison assignments, and information about each of the 11 chapters identified for the program.

June 2012, approved establishing a one-year Chapter Board Liaison pilot program to the chapters most likely to benefit from such a program.

January 2012, discussed the potential of establishing a Chapter Board Liaison. A workgroup was assigned to further investigate establishing a program.

January 2010, discussed establishing Board Liaisons to chapters. There was consensus to delay implementing a program at that time.

Substitute Resolution 45(95) Leader Visits to Chapters adopted.

Substitute Resolution 28(90) Leadership Visits to Chapters adopted and with a revised budget to change from a three year to a two year rotation schedule.

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

Sonja Montgomery, CAE
Governance Operations Director

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

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: 24(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: Maintenance of Certification for Practicing Emergency Physicians

PURPOSE: 1) Study the needs and cost-effective evidence-based requirements to support practicing board-certified emergency physicians to demonstrate ongoing competence and skills necessary for their own practice setting. 2) Develop appropriate guidelines for "maintenance of competence" with minimum and legitimate barriers to continued practice. 3) Develop a report for the 2018 Council.

FISCAL IMPACT: Creation of a task force with four in person meetings and 10-12 conference calls, plus staff resources to support the task force, approximately $80,000 – $100,000.

WHEREAS, Residency training and American Board of Emergency Medicine (ABEM) certification is the gold standard for entry into the practice of Emergency Medicine in the 21st century; and

WHEREAS, The American Board of Medical Specialties (ABMS) is the oversight organization that sets the standards and requirements for primary board certification and for the continued certification of physicians by its member specialty boards including ABEM; and

WHEREAS, ABMS has demonstrated its disdain of professionals actively engaged in the practice and profession of medicine who have completed residency training and requirements for board certification as not competent to recognize their own needs for their practice or their own ability to maintain their professional skills and competence thereby necessitating proscribed requirements of learning, practice assessment, "high stakes" recertification tests that are "secured," leading to the implication that all these physicians are dishonest, lazy, and disinterested; and

WHEREAS, The practice of Emergency Medicine is already highly regulated, requires state medical board license and oversight, medical staff and hospital review of practice and privileges, active ongoing practice quality review, insurance and third-party payor monitoring, and a host of other regulatory oversights in addition to the ongoing threat of medical malpractice liability lawsuits; and

WHEREAS, There are clear examples where unregulated, non-competitive monopolies on professional standards and practice can lead to egregious and unrealistic standards, substantial increased costs, self-dealing and lack of connection to realistic professional practice expectations, creating significant disruption and unnecessary barriers to the practice of medicine and the care of the patients we serve; and

WHEREAS, There are a host of other options for these unregulated professional standard monopolies short of turning the responsibility over to government control and oversight, including appropriate oversight and review of the organizational activities, creation of alternative or parallel organizations, and formal direct input and demands for proof of effectiveness and justification for regulatory requirements; therefore be it

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.

Background

This resolution calls for ACEP to study the needs and cost-effective evidence-based requirements to support practicing board-certified emergency physicians to demonstrate their ongoing competence and skills necessary for their own practice setting. It also calls for ACEP to develop appropriate minimum guidelines for appropriate "maintenance of competence" with minimum and legitimate barriers to continued practice and present a report at the 2018 Council meeting.

When ACEP was formed in 1968, it was decided to pursue the formation of a specialty, with residency training programs and board certification. In fact, the original logo of ACEP shows emergency medicine as the "missing" piece in the box portraying the recognized specialties. After nearly a decade of work, emergency medicine was recognized by the American Medical Association (AMA) and the American Board of Medical Specialties (ABMS), and a conjoint board was formed. ACEP heavily supported the formation of the American Board of Emergency Medicine (ABEM) and even provided funding through donations by ACEP members. Members eagerly sat for the board exam to not only prove their individual competence, but also to validate the decision to create the specialty.

Emergency medicine was among the first specialties to develop a time-limited certification process (Family Medicine offered the first time-limited certification in 1971). By the late 70's, progress in medical science had accelerated, and there was a recognition of the need for a process to ensure that physicians would continue to remain current with medical knowledge. In time, other specialties created time-limited certifications, although some older physicians in some specialties still retain their life-long certification.

The American Board of Internal Medicine was one of the first to suggest that the 10-year gap between certifications was too long, and developed an elaborate, comprehensive, and expensive yearly assessment process involving the Medical Knowledge Self-Assessment Program (MKSAP). ABMS adopted this philosophy suggesting yearly maintenance of certification (MOC) was beneficial and in the public interest. ABEM created its life-long self-assessment program (LLSA), which provides for open book exams on a limited number of articles. Some other specialties have a process that is more burdensome and costly. No certifying board has firm evidence that their approach is superior.

ABEM now requires completion of four components for MOC: 1) license in good standing; 2) LLSA; 3) a ConCert recertification exam every 10 years; and 4) attestation of participation in a quality performance improvement activity. ABEM's approach to MOC is considered more reasonable and less burdensome than many other specialties, yet for some diplomates, ABEM's MOC is viewed as onerous and expensive.

ABEM believes that MOC participation reassures the public that the physician is engaged in rigorous and continuous professional development. ABEM believes that multiple-choice exams are the best tools, as well as the most efficient and cost-effective methods, to evaluate cognitive knowledge and assess complex domains (clinical synthesis and diagnostic processes). A study in 2016 showed that of the physicians who did not study for the ConCert exam, 86% passed. The study also reported that more than 90% of physicians who had just completed the ConCert exam felt that the preparation had added to or reinforced their medical knowledge.[1] A Harris poll showed that 83% of the public believed that emergency physicians should be required to pass a recertification exam. ABEM also raises the concern that absence of physician professional self-regulation would result in governmental intervention. They note that there is support in the literature that ABEM certification is associated with improved patient care.[2] The average cost per year for ABEM MOC is $265, and that cost has been fixed for the past five years. On average, diplomates devote 15 hours per year to complete all MOC activities, according to ABEM.

The vast majority of ACEP members participate in MOC. Legacy members are not board certified and cannot participate. Those certified by the American Osteopathic Board of Emergency Medicine have a similar process called Osteopathic Continuous Certification (OCC). That Board has similar requirements – initial certification, followed by Continuous Osteopathic Learning Assessment, Practice Assessment (including chart reviews from at least 10 patients), and a Cognitive Assessment every 10 years.

At the same time MOC was evolving, board certification took on new importance. In the 70's, many medical students opted for one year of training (or in fewer cases, no further training). Some surgical programs were pyramidal,

assuring that 50% or more of the trainees would not complete the program and therefore not be eligible for board certification. The doctor draft during the Vietnam war often interrupted residency education. Now, board certification is required for academic faculty and increasingly for hospital privileges. MOC and the ConCert exam now are viewed by some emergency physicians as “high stakes” programs.

Critics of MOC find that parts of the test are not relevant to their individual practice. It can be expensive for some; the cost is not only that of the exam, but time away from work for preparation and taking the exam, as well as materials and courses to prepare for the exam.

ABMS was not the only group to become interested in maintenance of knowledge. Continuing medical education (CME) became more formalized around this same period of time, with the development of the AMA categories of CME and a more stringent process for programs offering education. Now, any organization providing CME must undergo a complicated process to be certified itself. State licensing boards and individual hospitals developed minimum CME requirements. Along with the movement to verify CME content, self-declaration of CME was replaced with the requirement to produce a certificate for each hour of CME. This additional complexity in the CME process added to the CME providers’ costs to produce the educational material, and to the costs for the physicians receiving it.

In addition to requirements for CME, most states and hospitals have additional educational requirements for physicians. Some states now require verifiable education in topics such as child abuse, infection control, palliative care, opioid prescribing, and a host of other topics. Emergency physicians, because of the breadth of their knowledge base, may have requirements from many different specialties.

Basic and Advanced Cardiac Life Support courses were developed in the mid-1970s, after development of CPR in the late-1960s and the beginnings of resuscitation research. Other merit badge courses were added. Many hospitals require these merit badge courses to work in certain areas of the hospital such as the ICU or ED, and to perform certain procedures such as intubation and sedation. In the early years, the requirement for merit badges was beneficial as it accelerated the dissemination of resuscitation and critical interventions. However, the value of repetitive courses over decades has not been established. ABEM has been working with ACEP and other ED organizations against the requirement for such merit badges, arguing that residency training and board certification are superior to any merit badge course.

MOC should not be confused with the requirements for CME, merit badge courses, and other certification requirements. However, the combined education, time, and financial burden from these processes is significant to the practicing physician.

Discontent with MOC first surfaced in relation to the requirements of the American Board of Internal Medicine. The discontent spread and has led to resolutions at the AMA and action by state legislatures. Concern has been raised regarding the value of the requirement for MOC, its cost, and whether the public really understands the process or value of MOC.

There has been pressure to create alternatives to the once-a-decade, one-size-fits-all, high-stakes exam. The majority of ABMS certifying boards have either eliminated the high stakes recertification exam, are offering options as an alternative to the exam, or they are piloting options. Some of these alternatives are similar to MOCA 2.0 created by the American Board of Anesthesiology. MOCA 2.0 delivers questions on a weekly basis, about 30 questions every 3 months. This has been well received by anesthesiologists; however, the participation rates are lower than expected, and failure rates are higher than the ConCert exam. If the physician does not meet the MOCA 2.0 standard, they must still pass the 10-year high-stakes exam. ABMS has developed a platform similar to MOCA 2.0, but it is anticipated that this platform will increase the cost of MOC, as it would add item-writers. The American Board of Obstetrics and Gynecology requires the completion of LLSAs (45-50 articles per year) in lieu of the high-stakes exam.

ABEM allows a diplomate to take the ConCert exam several years earlier than the year in which their certification expires, and to re-take it. Starting in 2013, ABEM has allowed each diplomate to get the full 10 years of certification regardless of whether the exam is passed early. This provides an incentive to take the ConCert early and to lessen the high-stakes nature of the exam.

While we would like to believe that all emergency physicians remain up-to-date and provide quality care, there is evidence suggesting there are some emergency physicians, even within ACEP, who exhibit practice patterns that are at odds with current evidence.

ACEP has been discussing MOC with ABEM over the past year in response to last year's Referred Resolution 8(16). Opposition to Required High Stakes Secured Examination for Maintenance of Certification. During this time, ACEP has relayed the growing discontent among some ACEP members with the MOC process and particularly the high-stakes ConCert exam.

ABEM has been 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 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. ABEM will hold a national ConCert Summit October 2-3, 2017, that will include representatives from every emergency medicine organization to explore modifications and options to the ConCert examination. ABEM is also 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 will meet with ABMS and its certifying boards in early December 2017 to discuss concerns regarding both MOC and the high-stakes exams.

ACEP believes in lifelong learning, physician competency, and periodic assessment. It is important that the specialty of emergency medicine not lose the right of professional self-regulation to state governments or the federal government.

References

1. Marco CA, Counselman FL, Korte RC, et al. Emergency physicians maintain performance on the American Board of Emergency Medicine Continuous Certification (ConCert) Examination. Acad Emerg Med 2014; 21:532-7.
2. Wilson M, Welch J, Schuur J, et al. Hospital and emergency department factors associated with variation in missed diagnosis and costs for patients age 65 years and older with acute myocardial infarction who present to emergency departments. Acad Emerg Med 2014; 21: 1101-8.
3. Davis DA, Mazmanian PE, Fordis M, et al. Accuracy of physician self-assessment compared with the observed measures of competence: a systematic review. JAMA 2006; 2296: 1094-102.

ACEP Strategic Plan Reference

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

Goal 2 – Enhance Membership Value and Member Engagement
Objective B – Provide robust communications and educational offerings including novel delivery methods.

Fiscal Impact

Creation of a task force with four in person meetings and 10-12 conference calls, plus staff resources to support the task force, approximately $80,000 – $100,000

Prior Council Action

Resolution 8(16) Opposition to Required High Stakes Secured Examination for Maintenance of Certification referred

to the Board. Directed ACEP to oppose mandatory, required, high stakes, secured examination for Maintenance of Certification in emergency medicine and work with members, other interested organizations, and 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.

Amended Resolution 31(15) American Board of Medical Specialties Maintenance of Certification and Maintenance of Licensure adopted. Directed ACEP to communicate appreciation to ABEM for sensitivity in interpreting ABMS mandates; develop policy supporting the ABMS MOC as appropriate state medical license MOL, but actively oppose mandates that linking MOC as requirements for ongoing MOL; and develop policy opposing efforts of ABMS and its specialty boards to become independent sole source and for-profit autonomous entities mandating continuing education credit and uncontrolled fiduciary and financial autonomy

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted. Directed ACEP to adopt a position that board certification in emergency medicine through the ABEM, AOBEM, and/or sub-board on Pediatric Emergency Medicine of the ABP, along with participation in Maintenance of Certification programs currently required by these Boards is sufficient for practicing emergency physicians to maintain hospital privileges, health plan participation and medical group inclusion, and Maintenance of Licensure, and requiring additional certifications beyond board certification for emergency physicians, such as Basic Life Support, Advanced Cardiac Life Support, Advanced Trauma Life Support, and Pediatric Advanced Life Support, and other maintenance programs is redundant and unnecessary.

Prior Board Action

In response to Referred Resolution 8(16) Opposition to Required High Stakes Secured Examination for Maintenance of Certification, ACEP has had multiple meetings and conversations with ABEM regarding MOC concerns from ACEP members.

Amended Resolution 31(15) American Board of Medical Specialties Maintenance of Certification and Maintenance of Licensure adopted.

October 2015, approved the revised policy statement, "Emergency Physician Rights and Responsibilities;" revised and approved April 2008, July 2001, and September 2000.

June 2014, revised and approved the policy statement, "ACEP Recognized Certifying Bodies in Emergency Medicine;" reaffirmed and approved April 2014, October 2008, October 2002; originally approved March 1998.

Amended Resolution 35(13) "Credentials for Hospital Privilege and Maintenance of Licensure" – adopted October 13, 2013.

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

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

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

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: 25(17)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Resolution Co-sponsorship Memo

PURPOSE: Directs the Council Steering Committee to develop and promote a standardized format for a "co-sponsorship memo" that can be distributed through the Council elist or other platform so that councillors may collaborate and further refine resolutions prior to submission.

FISCAL IMPACT: Budgeted Steering Committee and staff resources.

WHEREAS, The time that our councilors; members; Steering Committee; Tellers, Credentials, & Elections Committee; Board members; and staff donate to drafting and reviewing resolutions is both valuable and limited; and

WHEREAS, Often multiple resolutions on a single issue, with overlapping concerns, are brought before the Council; and

WHEREAS, Time on the Council floor is limited and best used by discussing issues, rather than wordsmithing; and

WHEREAS, Collaboration in drafting a resolution leads to more refined and better resolutions; therefore be it

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.

Background

This resolution directs the Council Steering Committee to develop and promote a standardized format for a "co-sponsorship memo" that can be distributed through the Council elist or other platform so that councillors may collaborate and further refine resolutions prior to submission.

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 resolutions. Using c-mail is a simple way to discuss resolutions, whether 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.

In any given year, there may be multiple resolutions submitted on the same topic. Once the resolutions are received, 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.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted Steering Committee and staff resources.

Prior Council Action

None

Prior Board Action

None

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

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

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: 26(17)

SUBMITTED BY: Angela Mattke, MD, FACEP
Eric Maur, MD, FACEP
Howard Mell, MD, MPH, FACEP

SUBJECT: Study the Impact & Potential Membership Benefits of a New Chapter Representing Locums Physicians

PURPOSE: Study the impact and potential membership benefit of a new chapter representing locums physicians and provide a report to the 2018 Council.

FISCAL IMPACT: Budgeted committee and staff resources. Potential additional costs if an outside consultant is engaged to conduct the study, approximately $5,000-$10,000.

WHEREAS, Emergency physicians are unique in their practice mobility; and

WHEREAS, Anecdotal evidence suggests that an increasing number of newly graduated resident physicians are choosing to enter the workforce as locums physicians; and

WHEREAS, Anecdotal evidence suggests that a large number of emergency physicians either currently work as locum physicians, have worked as locums physicians in the past, or will work as locum physicians in the future, including as internal locums for larger companies; and

WHEREAS, It has been suggested that locums physicians are disproportionately under represented within the College membership; and

WHEREAS, Locums physicians have a unique position in the College and are often not served by the current chapter structure as they often work in states other than their states of residence, have administrative and practice issues that are unlikely to be prioritized by state chapters, and often have difficulty accessing chapter leadership positions; and

WHEREAS, Social media commentary and discussions with staff indicate that some locums physicians do not join ACEP due to the increased costs of joining multiple state chapters and a belief that their needs are not met under the current chapter structure; and

WHEREAS, The founders of the College acknowledged that physicians who frequently change work location may have unique needs by including a provision for a Government Services Chapter that represents physicians in a non-geographic distribution; and

WHEREAS, A membership section is unlikely to encourage locums physicians to join ACEP as it does not address the barriers of cost and access to leadership opportunities; therefore be it

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.

Background

This resolution requests ACEP to study the impact and potential membership benefit of a new chapter representing locums physicians and provide a report to the 2018 Council.

ACEP has not chartered a new chapter in many years. Conducting a study of the impact and potential benefits of creating a locums physicians chapter could be completed internally, or by engaging an outside consult.

Leadership opportunities are cited as an advantage of a new chapter instead of a section because sections have a much smaller leadership structure than a chapter with a Board of Directors and officer structure. Many locums physicians find it difficult to achieve leadership in the state chapter because they do not typically work in that state. Another advantage could be an increase in ACEP membership if some emergency physicians have declined to join or dropped membership because of the requirement to join a state chapter.

One potential disadvantage of creating a new chapter would be the effect on state chapter memberships. It is unknown whether locums physicians would designate the state chapter as a secondary chapter.

Some of the questions to address in a study include:

1. How many ACEP members identify themselves as locums physicians?
2. How many ACEP members would potentially join a locums physicians chapter?
3. Does ACEP have any data on the number of emergency physicians who have declined to join ACEP or dropped membership in ACEP because they work as locums physicians?
4. Would a locums physicians chapter have a negative effect on the membership of state chapters?
5. Would locums physician members designate the state chapter in which they reside as a secondary chapter?
6. What are the potential benefits that a locums physicians chapter could provide?
7. Could a chapter better meet the needs of locums physicians instead of a section?
8. What are the unique administrative and practice issues that could be addressed by a locums physicians chapter?

Chartering new chapters is addressed in the ACEP Bylaws, Article VI – Chapters, Sections 1-3:

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 to the "Guidelines for Bylaws and Model Chapter Bylaws for Chapters of the American College of Emergency Physicians." 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.

Additional guidance about chartering chapters is provided in the College Manual:

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.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective A – Increase total membership and transitioning resident retention.

Fiscal Impact

Budgeted committee and staff resources. Potential additional costs if an outside consultant is engaged to conduct the study, approximately $5,000-$10,000.

Prior Council Action

None

Prior Board Action

None

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2017 Council Meeting
Reference Committee Members

Reference Committee B
Advocacy & Public Policy
Resolutions 27-41

Michael Lozano, MD, FACEP (FL), Chair
Daniel Freess, MD, FACEP (CT)
Nathaniel T. Hibbs, DO, FACEP (CO)
Jeffrey F. Linzer, MD, FACEP (GA)
Heather A. Marshall, MD, FACEP (NM)
John Matheson, MD, FACEP (WA)

Harry Monroe
Ryan McBride, MPP

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).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 27(17)

SUBMITTED BY: Alaska Chapter
EMS-Prehospital Care Section
Illinois College of Emergency Physicians
Missouri College of Emergency Physicians
Oklahoma College of Emergency Physicians
West Virginia Chapter

SUBJECT: 9-1-1 Number Access and Prearrival Instructions

PURPOSE: Develop a policy statement to support and advocate to achieve 100% coverage of the U.S. population with 9-1-1 next generation level service and every Public Safety Answering Point or EMS dispatch center provides appropriate medical pre-arrival instructions with EMS physician oversight. Work with appropriate stakeholders to collect information on 9-1-1 and PSAP funding models and engage in development of model legislation incorporating enduring funding for 9-1-1 and PSAPs that includes EMS physician involvement.

FISCAL IMPACT: Budgeted committee and staff resources. Additional staff resources to inventory PSAP funding models and working with stakeholders to develop model 9-1-1 funding legislation.

WHEREAS, 9-1-1 number access to Public Safety Answering Points (PSAP) is not uniformly available nationwide; and

WHEREAS, 240 million calls are made to 9-1-1 annually in the US, of which >70% of calls were through wireless carriers (2011 data); and

WHEREAS, 29.7% of U.S. households relied on wireless communication as their primary service (2011) and it is expected that number is considerably higher now, therefore, maximizing benefit of wireless communication by capitalizing on the ability to determine exact call location, and using this location determination to route calls to the responsible call center, are critical capabilities for PSAPs; and

WHEREAS, A call to 9-1-1 is not necessarily routed to a local PSAP, as some areas do not provide access to their PSAP through the 9-1-1 number and this results in delays (which may be considerable) to appropriate resource deployment as calls are routed to the PSAP that serves that emergency call location; and

WHEREAS, PSAPs, regardless of 9-1-1 or 10 digit dial access number, have different capabilities with regard to being able to verify emergency call location using wireless technology and those with basic or enhanced 9-1-1 service do not have the ability to use GPS location to pinpoint call location and must rely on the caller's knowledge and ability to describe the location accurately, which can be significantly problematic if the caller is in distress, or in an unfamiliar location (i.e. Interstate, rural road); and

WHEREAS, PSAP and EMS dispatch point ability to provide any (or appropriate) medical prearrival instruction is inconsistent; and

WHEREAS, Medical prearrival instructions for bystander aid in life threatening medical emergencies are a critical element for survival in some time critical diagnoses (TCD) and in cardiac arrest; therefore be it

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.

Background

This resolution directs ACEP to advocate and promote efforts that support achieving 100% coverage of the U.S. population with 9-1-1 next generation level service and every Public Safety Answering Point (PSAP) or EMS dispatch center provides appropriate medical pre-arrival instructions with EMS physician oversight. It also directs the College to work with appropriate stakeholders to collect information on 9-1-1 and PSAP funding models and engage in development of model legislation incorporating enduring funding for 9-1-1 and PSAPs that incorporates EMS physician involvement.

Currently, more than 99% of the U.S. is covered by 9-1-1 service and many communities are working to implement the Next Generation 9-1-1 (NG911) level. The current 9-1-1 system includes a single number to access emergency services for a given area that provides caller location, name, and telephone number. Some of the limitations of the current system include the inability to transfer calls and data between PSAPs and the lack of routing to the appropriate PSAP based on actual caller location versus the cell phone tower location that was accessed.

The NG911 system will greatly enhance and upgrade the 9-1-1 infrastructure and includes enhanced coverage for wireless calls, more accurate caller location detection for wireless callers, receiving text messages, and data images and videos. It will be able to receive electronic data directly from programs such as Advanced Automatic Collision Notification (AACN) systems, medical alert systems, and safety sensors of various types. NG911 will also allow the PSAP to issue emergency alerts to wireless devices in a specific area via voice or text messages and to highway alert systems.

The type and detail of medical pre-arrival instructions provided to callers varies greatly across the country. While there are only a few standardized medical pre-arrival systems in use today, there is a lack of uniformity on how they are used and the kind of information provided to the caller by individual PSAPs or EMS services. There is also a lack of uniformity in the involvement of an EMS physician in the medical directions provided and in quality oversight.

ACEP's policy statement "Physician Medical Direction of EMS Dispatch Programs" partially addresses both the NG911 and medical pre-arrival instructions.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective A – 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. Additional staff resources to inventory PSAP funding models and working with stakeholders to develop model 9-1-1 funding legislation

Prior Council Action

None

Prior Board Action

June 2017, revised and approved the policy statement "Physician Medical Direction of EMS Dispatch Programs;" reaffirmed June 2010; revised and approved September 2003; and originally approved October 1998.

Background Information Prepared by: Rick Murray, EMT-P
EMS & Disaster Preparedness Director

Deanna Harper, EMT-I
Coordinator, EMS & Disaster Preparedness

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

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: 28(17)

SUBMITTED BY: New York Chapter
Observation Medicine Section

SUBJECT: Coverage for Patient Home Medication While Under Observation Status

PURPOSE: Support the coverage of self-administered medications in observation patients and support a goal that patient out-of-pocket expenses for observation be no greater than the cost to the patient for inpatient services.

FISCAL IMPACT: Budgeted committee and staff resources to support regulatory efforts.

WHEREAS, The number of emergency department patients being placed under observation status is continually increasing; and

WHEREAS, There is an increasing focus on cost shifting to patients especially the uninsured/under insured and traditional Medicare patients; and

WHEREAS, The average cost of "self-administered" home medications is greater than $100 USD per observation visit for Medicare patients as Medicare Part B does not cover them; and

WHEREAS, There is not a standard way of dealing with billing for patient "self-administered" home medications across hospitals; and

WHEREAS, The Joint Commission regulation of hospitals identifying, verifying, and securing patient medication is time consuming and resource intensive; and

WHEREAS, Patients with Medicare Part D coverage can submit claims for their medications given in observation but must pay out of pocket initially; and

WHEREAS, The Office of the Inspector General's report recommends that Centers for Medicare and Medicaid Services (CMS) explore methods to protect patients from variable outpatient costs; therefore be it

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.

Background

This resolution calls for ACEP to support the coverage of self-administered medications in observation patients and to support a goal that patient out-of-pocket expenses for observation be no greater than the cost to the patient for inpatient services.

The Centers for Medicare & Medicaid Services (CMS) 2016 final rule for the Outpatient Prospective Payment System (OPPS) included important changes to observation billing on the facility side. Specifically, it retired facility payment observation code APC 8009 and introduced C-APC 8011, a more comprehensive payment that increased

reimbursement by almost $1,000 and bundled in previously separately reported services such as diagnostic imaging, stress testing, and medication infusions. However, the new rule does not address long-standing observation-related issues, including lack of coverage for self-administered medications (SAM). For example, if an insulin dependent diabetic patient is admitted to observation for a heart condition, the cost of the facility providing the insulin would not be covered. This lack of coverage exposes patients to the cost of medications as listed in the hospital charge master, which can be many times higher than the cost for those same drugs outside the hospital. The mark up can be as high as several hundred percent, a significant hardship on patients, and particularly individuals with a fixed income. The Medicare Payment Advisory Commission (MedPAC) estimated that in 2012 hospitals billed patients, on average, approximately $209 for self-administered drugs, compared to an average actual cost to the hospitals of $43. At their April 2015, public meeting, MedPAC Commissioners voted to recommend that outpatient observation beneficiaries no longer be subject to out-of-pocket costs related to self-administered drugs. CMS did not implement that recommendation.

Despite the lack of guidance by CMS, a patient's self-administered drugs may be covered by a Part D prescription drug plan if the following criteria are met: 1) The drug must be a prescription and not an over-the-counter drug; 2) the prescription cannot be received "in an outpatient [setting] or emergency department on a regular basis;" and 3) the drug must be either included in the Part D prescription drug plan's formulary or covered as an exception in the plan. However, since most hospital pharmacies do not participate in Part D, the patient would likely have to pay the hospital bill and file a Part D claim to be reimbursed.

In October 2015, the HHS office of the Inspector General (OIG) released a statement that it would not administratively sanction hospitals if they discount or waive charges for an outpatient's self-administered drugs, but it does not compel them to do so.

In the hospital's defense, drug spending per capita in the hospital inpatient setting is increasing at a pace far exceeding reimbursement increases. Growth in annual inpatient drug spending between FY2013 and FY2015 increased on average 23.4%, and 38.6% on a per admission basis. Growth in spending in the inpatient setting exceeded the growth in retail spending, which increased 9.9% during this period. However, CMS's update to hospital rates through the IPPS increased by only 2.7%. Large and unpredictable increases in the price of drugs used in the inpatient setting significantly impacted hospitals' ability to manage costs within a fixed price based payment system.

The other important cost to Medicare patients placed in observation rather than inpatient admission is that patient costs, other than self-administered drugs, are covered after the inpatient 2017 Part A $1,316 deductible, whereas the observation patient is responsible for 20% of Medicare approved charges and could theoretically face substantial extra costs if they are admitted to a skilled nursing facility (SNF) without a three-day hospital stay prior to that SNF admission. Such additional costs, though uncommon for patients in the ED or in Observation units, would potentially have to be addressed to achieve the goal of true patient out-of-pocket costs being equal between observation and inpatient stays.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted committee and staff resources to support regulatory efforts.

Prior Council Action

Resolution 25(13) Public Perception of Observation Status and its Financial Responsibility referred to the Board of Directors.

Amended Resolution 36(05) Medicare Requirement of Three-Night Hospital Stay referred to the Board of Directors.

Prior Board Action

January 2015, approved supporting legislation to rescind the 3-day inpatient stay and supporting regulatory efforts for an exemption for integrated payment models.

January2014, approved supporting legislation to rescind the 3-day inpatient stay and supporting regulatory efforts for an exemption for integrated payment models.

January 2013, assigned Referred Resolution 25(13) to the Public Relations Committee

January 2005, assigned Amended Referred Resolution 36(05) to the Federal Government Affairs Committee.

Background Information Prepared by: David A. McKenzie, CAE
Reimbursement Director

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

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: 29(17)

SUBMITTED BY: Pennsylvania Chapter

SUBJECT: CPR Training

PURPOSE: Draft model state legislation to assist chapters in advocating for mandatory CPR training in schools and work with other stakeholder organizations to draft and advocate for federal legislation and support to mandate CPR training in schools and increased CPR training for laypersons.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Over 300,000 Americans die from sudden cardiac arrest each year [1]; and

WHEREAS, Bystander CPR (layperson CPR) is an important intervention that can double the chance for patients to be discharged to home neurologically intact[2]; and

WHEREAS, Less than 20% of Americans feel that they are adequately trained in CPR[3]; and

WHEREAS, An increase in the rate of CPR training is associated with an increase in survival for sudden cardiac arrest[4]; and

WHEREAS, 37 states and the District of Colombia have some CPR mandate in schools[5]; therefore be it

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.

References

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Background

This resolution directs the College to draft model state legislation to assist chapters in advocating for mandatory CPR training in schools and work with other stakeholder organizations to draft and advocate for federal legislation and support to mandate CPR training in schools and increased CPR training for laypersons.

Each year more than 350,000 individuals will suffer a cardiac arrest outside of a hospital. Bystander CPR has been shown to have a positive impact on survival of out-of-hospital cardiac arrest victims. The amount of time that elapsed between the cardiac arrest and CPR being administered by a bystander is identified as a critical factor in survival rates. Studies show a survival rate of 12% and higher when bystander CPR was performed compared to below 5% when no bystander CPR was given.

The American Heart Association (AHA) has identified the benefits of CPR training in schools and developed a specially designed training program for this audience. There are many documented cases where school children have performed CPR successfully on both adults and other children. Many schools are already adopting CPR training into their required curriculum but it is not uniform or widespread currently.

ACEP has supported layperson CPR training for many years, starting with the first policy statement "Public Training in CPR" that was approved by the Board in 1984. The current policy statement "Public Training in Cardiopulmonary Resuscitation and Public Access Defibrillation" was last revised and approved in 2013. The College has also 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, the College 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.

Bystander CPR is a priority for the College and especially for EMS medical directors and EMS systems as they experience firsthand the benefits of early CPR performed by bystanders. The resolution would extend that focus to support increased CPR training, particularly in schools.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective A – 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.

Prior Council Action

None

Prior Board Action

June 2013 and January 2006, revised and approved the policy statement "Public Training in Cardiopulmonary Resuscitation and Public Access Defibrillation;" September 1999, revised and approved titled "Public Training in Cardiopulmonary Resuscitation and Public Access Defibrillation;" October 1994, revised and approved; originally approved April 1984 titled "Public Training in CPR."

Background Information Prepared by: Rick Murray, EMT-P
EMS & Disaster Preparedness Director

Deanna Harper, EMT-I
Coordinator, EMS & Disaster Preparedness

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

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RESOLUTION: 30(17)

SUBMITTED BY: James Antinori, MD, FACEP
John Bibb, MD, FACEP
Fred Dennis, MD, FACEP
Ramon Johnson, MD, FACEP
Lawrence Stock, MD, FACEP
California Chapter

SUBJECT: Demonstrating the Value of Emergency Medicine to Policy Makers & the Public

PURPOSE: Demonstrate the value of EM: 1) request EMF and EMRA to prioritize funding for EM faculty and resident research, competitions, and resident prizes for focused EM economic and operational material; 2) accelerate development of a multi-year public relations campaign; 3) utilize viral marketing techniques; 4) develop an online repository of PR materials; 5) develop specific public relations materials for legislators; and provide a report on these efforts to the 2018 Council.

FISCAL IMPACT: Budgeted committee, staff, and consultant resources. Additional funding (unknown amount) would be needed to expand the scope of current initiatives to demonstrate the value of emergency medicine. Costs are dependent on the type and scope of activities undertaken.

WHEREAS, Emergency Medicine (EM) in the United States has a unique medical business model in that all persons seeking care are evaluated and stabilized without regard for their ability to pay for care; and

WHEREAS, Acute care Emergency Departments (ED) provide medical care 24 x7 x365; and

WHEREAS, Healthcare premiums and costs including co-pays and deductibles are virtually unaffordable for a large number of payers including employers, the government and individuals; and

WHEREAS, Charges for ED services are predominately the facility component vs. the professional component by a ratio range of approximately 7:1 to 10:1; and

WHEREAS, Recent studies such as the Johns Hopkins study alleging price gouging are debated in the press without similar studies demonstrating the essential safety net that EDs provide.
http://www.hopkinsmedicine.org/news/media/releases/emergency_room_patients_routinely_overcharged_study_finds

WHEREAS, Social media is currently the most powerful means of reaching and influencing public opinion but the format favors sound bites and small pieces of information; and

WHEREAS, Legislators and their tech savvy staff are busy and suffer information overload and innovative and amusing electronic media may be more useful to reach them with our information; therefore be it

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.

Background

This resolution provides specific direction to ACEP to demonstrate the value of EM: 1) request EMF and EMRA to prioritize funding for EM faculty and resident research, competitions, and resident prizes for focused EM economic and operational material; 2) accelerate development of a multi-year public relations campaign; 3) utilize viral marketing techniques; 4) develop an online repository of PR materials; 5) develop specific public relations materials for legislators; and provide a report on these efforts to the 2018 Council.

ACEP's Public Relations Department employs multiple communications tools and campaigns to promote the value of emergency medicine to policymakers and general public audiences.

- ACEP's parody video (of the Cigna TV commercial) went viral, generating more than 300,000 views on YouTube and Facebook (using active social media ACEP members, Facebook ads, Forbes, and earned media with news stories appearing in the Wall Street Journal, New York Times and Kaiser Health News. The video promoted the value of "real" emergency physicians who must be prepared for anyone and anything. ACEP is filming another parody video during ACEP17 in Washington, DC.

- Saving Millions campaign. ACEP has conducted this campaign since 2013, starting with promotion of the results of the RAND report in 2013. The campaign was designed to promote the value of emergency medicine and to increase the visibility of emergency physicians as leaders in health care and in controlling health care costs. Advertising has appeared in policymaker publications, such as the *Hill* and *Roll Call*, and consumer publications, including daily newspapers. The messages of the campaign have been included in the briefing packets for ACEP members to distribute to legislators and their staff on Capitol Hill during the Leadership & Advocacy Conference. The infographic, video, and advertisements are at www.acep.org/SavingMillions and have been shared internally with ACEP's chapters and all members through the daily electronic email, plus PR spokespersons and 911 Network members.

  Press coverage in 2013 included news stories in the *New York Times*, *Health Leaders* and the Wall Street Journal MarketWatch. Radio stories aired in several major cities generated by a radio media tour with Dr. Alex Rosenau and Dr. Stephen Epstein. Additionally, Drs. Jay Kaplan, Bob O'Connor, Wes Fields and Stephen Epstein met with reporters of *Bloomberg News*, *The Los Angeles Times*, and *National Journal* to discuss the RAND results. The *Hill* also published an editorial by then ACEP President Dr. Andy Sama "Emergency Physicians Save More than Lives." ACEP also promoted through social media, including Twitter and YouTube.

  In 2014 and 2015, ACEP re-launched the Saving Millions campaign with a multi-media news release which embedded the content, messages, and infographic in thousands of websites. The campaign was featured on a 22-story electronic billboard in New York's Times Square. ACEP also published ads in *Politico* and *Roll Call* (driving people to the Saving Millions website) in conjunction with the Leadership & Advocacy Conference. The multi-media release included the Infographic — "Emergency Medicine is America's Most Essential Medical Specialty." ACEP also promoted the campaign through social media and an ad in the Boston Globe, in conjunction with *Scientific Assembly*.

  In 2016, ACEP reinvented the campaign and refreshed the website with new ads and updated the Infographic and video. ACEP promoted thru Twitter and YouTube https://www.youtube.com/watch?v=lsx3rnD9mbE.

  In 2017, ACEP promoted the updated campaign through web and print ads to policymakers in Washington, DC. The digital campaign was to drive awareness of key ACEP messaging on Capitol Hill and generate clicks to the Saving Millions page on ACEP's website. ACEP's exclusive sponsorship of TheHill.com healthcare content during an historic week in Congress for the Affordable Care Act provided an outstanding opportunity to reach decision makers looking for the latest ACA information. The actual impressions of 2.6 million exceeded expectations, resulting in more than 800 clips to ACEP's Saving Millions landing page in seven days.

- Each year ACEP conducts a marketing campaign to general public audiences to promote the value of emergency medicine. This year's campaign was about opioid abuse. The objectives of this campaign were to promote emergency physicians as experts and as leaders in finding solutions. The campaign tools included a press release, a flyer, website and web banner ads on Facebook, and generated results that exceeded estimates with a click- through rate of 3.15%, which is four times Facebook's benchmark for health care campaigns. It generated 12,000 click-throughs to ACEP's consumer website EmergencyCareforYou.org

- For examples of other campaigns promoting value of EM, visit ACEP's Newsroom on the ACEP Website under the Campaign tab (http://newsroom.acep.org/) and on the campaign tab of EmergencyCareforYou.org.

  In 2014, ACEP launched a campaign about educating the public about the differences between emergency care and urgent care and to promote the value of emergency care. It generated scores of news stories and an editorial by ACEP's president, which was published more than 25 times in newspapers across America.

  In 2016, ACEP launched a Top ER Tips for Mom's campaign.

  In 2017, ACEP's ongoing Fair Coverage campaign has generated scores of positive stories in news organizations including *Politico*, *Modern Healthcare*, NBC News, *Kaiser Health News*, USA Today Radio Network, *Washington Examiner*, *Fierce Healthcare*, *Becker's Hospital Review*, and Yahoo Finance, ACEP placed ads in the *Hill* publication (widely read by policymakers and staff in Washington, DC), generated more than 3.7 million impressions and about 8,000 click throughs to www.faircoverage.org. In 2016, ACEP published an ad in *USA Today.*

  The objectives of the campaign included neutralizing health insurance industry statements portraying medical providers as "predatory" billers. Coverage included CBS Radio, Medscape, *Forbes*, *HealthLeaders*, *Fierce Healthcare*, and *Kaiser Health News*. ACEP engaged 20 spokespersons who conducted 26 radio interviews that aired 733 times. The Audio News Release aired more than 6,100 times, reaching an estimated audience of 92.9 million.

  A major media campaign was conducted to promote fair payment for emergency care and the effects of the ACA on emergency departments. It generated significant national press coverage, including *The Wall Street Journal*, *USA Today* (front page), Fox News, and CNBC. The campaign also sparked an editorial response from former White House staffer Ezekiel Emanuel in *The New York Times*. Senator John Barroso (R-WY) referred to the poll results on the Senate floor, as part of discussions about the budget.

- In 2016-17, Public Relations Committee members conducted scores of news interviews, many promoting the value of emergency medicine and contributing to the more than 300,000 media hits (including the Cigna parody video) that ACEP achieved from July 1, 2016, to May 30, 2017. The quick turnarounds from committee members enables ACEP to be nimble in the fast-paced media environment where most reporters are on deadline in a very short timeframe, often only a few hours. Members offered advice and information in breaking news situations to help public relations staff refute myths and correct misinformation. Many committee members also participated in a "letters to the editor campaign" promoting ACEP's key fair coverage messages.

- Examples of Taking Advantage of Breaking News to Promote Value of EM

  In 2014, as the Ebola crisis unfolded, public relations staff focused media relations efforts at ACEP14 to promote the value of emergency medicine in responding to disasters. As a result, more than 50 reporters came to *ACEP14,* including television crews from CBS, ABC and NBC, with ACEP's public relations staff coordinating scores of interviews and filming against the backdrop of innovatED. Fox Business News did live shots from the convention floor and CBS did live shots outside the center.

  Promoted "I look like an ER Doc" Diversity Campaign with YouTube video and a press release.

  Promoted Safe Citizen Day on May 23, 2017, as part of EMS Week. This campaign was a direct result of Amended Resolution 29(14) Safe Citizen Day, which was assigned to the Public Relations Committee for implementation.

- ACEP filmed emergency physicians telling patient stories to promote the value of emergency medicine, which were produced into videos and posted on ACEP's YouTube Channel.

- Social Media

  ACEP's external Twitter feed — @EmergencyDocs — has grown to more than 12,000 followers, which include policymakers and national health policy reporters. News is tweeted every day to promote news that ACEP is issuing or a news story that is positive or meaningful about emergency medicine.

  ACEP's YouTube Channel focuses on policy and consumer issues. Most of the campaigns ACEP has conducted to promote the value of EM have associated videos, generating more than 400,000 views. https://www.youtube.com/user/EmergencyCareForYou

- ACEP's consumer website, EmergencyCareforYou.org, promotes the value of emergency medicine to general public audiences. Each month, ACEP produces a consumer press release on a health and safety topic, which also refreshes the content on this site. Traffic to ACEP's consumer website has doubled since January 2016. As part of this site, ACEP members write blogs on consumer topics. Top blogs in the past year include one on surprise billing (nearly 5,000 views), fading light of heroes (822 views), and holiday heart (640 views).

ACEP's commitment to demonstrating the value of emergency medicine continues to be a priority objective and is essential for the specialty. ACEP and EMF are currently working on a major grant proposal regarding the Value and Cost Effectiveness of Emergency Care, which will be discussed by the ACEP and EMF Board of Directors during their meetings at *ACEP17* in October.

ACEP Strategic Plan Reference

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

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted committee, staff, and consultant resources. Additional funding (unknown amount) would be needed to expand the scope of current initiatives to demonstrate the value of emergency medicine. Costs are dependent on the type and scope of activities undertaken

Prior Council Action

Amended Resolution 24(13) Promulgation of Emergency Medicine adopted. Directed ACEP to continue efforts to promulgate the value and role of emergency medicine.

Prior Board Action

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

Background Information Prepared by: Laura Gore
Public Relations Director

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, 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: 31(17)

SUBMITTED BY: Donald Stader, MD, FACEP
Erik Verzemnieks, MD

SUBJECT: Endorsement of Supervised Injection Facilities

PURPOSE: Work with the AMA in supporting the development of Medically Supervised Injection Facilities where patients can inject self-provided drugs under medical supervision and endorse such facilities as a public health intervention in areas affected by high IV drug use.

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

WHEREAS, The opioid epidemic has become a major cause of preventable death in America, with 33,000 Americans dying of opioid overdose in 2015 and overdose from all drugs now becoming the number one killer of Americans under the age of 50; and

WHEREAS, Heroin use and IV drug use has grown exponentially with the opioid epidemic causing increasing mortality from IV opioid use (12,000 deaths in 2015) and dramatic increases in morbidity (Hepatitis C, HIV, Soft Tissue Infections, Endocarditis, Epidural abscess, etc.) from poor injection technique and sharing injection materials; and

WHEREAS, According to the Centers for Disease Control and Prevention (CDC) injection drug use accounts for one in ten new HIV diagnosis and is the leading cause of new Hepatitis C virus (HCV) diagnosis which, according to the CDC, have increased 300% in the last seven years; and

WHEREAS, Of people who inject drugs, an estimated 40% share syringes and injection materials; and

WHEREAS, Every case of HIV, Hepatits C, soft tissue infection and overdose death is nearly 100% preventable with good injection technique and practices among people who inject drugs (PWID); and

WHEREAS, Supervised Injection Facilities (SIFs) represents a step of care above that of Syringe Service Programs (SSPs) and allow PWID to inject in a safe environment before a medical professional; and

WHEREAS, SIFs are currently active in 63 cities and 102 sites total and are extremely effective at reducing drug overdose and death, with no deaths occurring from overdose in any SIF during their entire history; and

WHEREAS, Numerous peer-reviewed scientific studies have proven the positive impacts of SIFs and these benefits include: reduced public disorder, reduced public injecting, and increased public safety as well as cost savings resulting from reduced disease, overdoses and need for emergency medical services, and increased preventive healthcare and drug treatment utilization; and

WHEREAS, SIFS have been shown not to increase community drug use, not increase initiation into injection drug use, and not increase drug-related crime; and

WHEREAS, The American Medical Association supports SIFs stating recently “In an effort to consider promising strategies that could reduce the health and societal problems associated with injection drug use, the AMA today voted to support the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision;” therefore be it

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.

Background

This resolution directs ACEP to join the American Medical Association in the development of pilot facilities where people can inject self-provided intravenous drugs under medical supervision, and to endorse such Supervised Injection Facilities (SIFs) as an effective public health intervention in communities affected by high IV drug use.

Resolution 37(17) Medically Supervised Injection Facilities is similar in that it addresses supervised injection facilities. Much of the background information is the same for both resolutions.

The abuse of, and addiction to, various opioids, both prescription medication and illegal substances, has become a serious global health problem. It is estimated that more than two million people in the United States suffer from a substance abuse disorder related to prescription opioids and another 500,000 are addicted to heroin.

The White House Office of National Drug Control Policy (ONDCP) has made the opioid abuse issue a top priority and is identifying additional opportunities for collaboration between government agencies and external stakeholders to combat this growing national crisis. On March 29, 2017, President Donald Trump signed an Executive Order establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis, with the commission chaired by Governor Chris Christie. In August 2017, President Trump indicated he would declare the opioid epidemic a national emergency though as of September 11, 2017, an official declaration is yet to be made.

The Centers for Disease Control and Prevention (CDC) recently reported that the 2015 age-adjusted rate of drug overdose deaths in the U.S. was more than 2.5 times the rate in 1999. This is part of a 16-year trend of increasing opioid overdose deaths that are directly related to overdoses from prescription opioids. The CDC also noted the percentage of opioid deaths involving heroin was triple the percentage in 2010. Since 1999, the amount of opioids sold has nearly quadrupled and deaths from prescription opioids have had a corresponding increase.

The concept of Medically Supervised Injection Facilities (MSIFs or SIFs) have been proposed as a public health intervention to help save lives by reducing overdoses, deaths, and preventable illnesses like HIV, Hepatitis C, and soft tissue infections. These facilities provide sterile injection equipment under medical supervision to prevent the sharing of syringes and injection materials, with many offering counseling and informational services as well. According to the Drug Policy Alliance, there are approximately 100 SIFs operating in 66 cities throughout the world, though none currently exist in the U.S. The establishment of SIFs in the U.S. remains a controversial topic as critics argue such policies endorse illicit drug use, encourage first-time drug use, and do not curb addiction or address drug-related crime, while supporters point to benefits like a decreased prevalence of preventable diseases as well as reduced overdose rates that help contribute to a reduced need for emergency services. There are also additional legal aspects regarding possession and use of illegal drugs and paraphernalia that occur at the federal, state, and local levels that will need to be addressed if SIFs are to be established in the U.S.

In 2017, the American Medical Association adopted a policy to support the development and implementation of pilot SIFs in the U.S. that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use (AMA Policy – Pilot Implementation of Supervised Injection Facilities, H-95.925 (2017)).

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.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, 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: 32(17)

SUBMITTED BY: New York Chapter

SUBJECT: Essential Medicines

PURPOSE: Designate essential emergency medications, request a meeting with FDA to ensure adequate supply of essential medicines at all times, work with other medical organizations to speak to government agencies and elected officials on urgent need, make developing federal legislation a priority for ACEP's legislative agenda, and submit a resolution on essential medicines to the AMA House of Delegates.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP position to federal lawmakers and to support development and introduction of legislation. Potential travel costs for ACEP members to conduct in-person meetings with FDA, approximately $1,000 per person per trip.

WHEREAS, The World Health Organization (WHO) has a definition of essential medicines which states "Essential medicines are those that satisfy the priority healthcare needs of the population and are intended to be available at all times in adequate amounts in the appropriate dosage forms;" and

WHEREAS, The WHO compiled a list of essential medicines that can be found at http://apps.who.int/medicinedocs/documents/s16198e/s161983.pdf; and

WHEREAS, The essential medications list has been tailored specifically for Emergency Medicine and EMS (provided as an addendum to this resolution); and

WHEREAS, U.S. hospitals and EMS systems continually suffer from national essential drug shortages frequently used in the care of critically ill patients, including but not limited to calcium gluconate and carbonate, atropine, epinephrine and D50, and other drugs available as pre-filed syringes; and

WHEREAS, Lack of availability constitutes a significant risk to patients; and

WHEREAS, Shortages last for months until significant productions resume; therefore be it

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.

Addendum – Emergency Medicine and EMS Essential Medications List:

- Antiallergics and Medicines used in Anaphylaxis
- Antidotes and other Substances used in Poisoning
- Anitconvulsants/ Antiepileptics
- Anti-infective Medicines
  - Anthelminties
  - Antibacterials: Beta Lactam Medicines, other Antibacterials, Antileprosy Medicines, Antituberculosis Medicines
  - Antifungal Medicines
  - Antiviral Medicines: Antiherpes, Antiretrovirals, Nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, protease inhibitors
  - Anitprotozoal Medicines: Anitamoebic and Antigiardiasis Medicines, Antileishmaniasis, Antimalarial (curative and prophylaxis), Anti-pneumocystosis and Anti-toxoplasmosis Medicines, Antirypanosomal Medicines
- Medications Affecting Coagulation
- Blood Products and Plasma Substitutes
- Cardiovascular medicines: Antianginal, Antiarrhythmic, Antihypertensive, Medicines used in Heart Failure, Vasoconstrictors (Sympathomimetics),
- Antithrombotic Medicines
- Diuretics
- Insulin and Other Antidiabetic Agents
- Thyroid Hormone and Antithyroid Medicines
- Vaccines: Diphtheria, tetanus and pertussis, Rabies inactivated tissue culture vaccine injection
- Emergent Psychotherapeutic Medicines
- Medicines Acting on the Respiratory Tract: Antiasthmatic and Chronic Obstructive Pulmonary Disease Medicines
- Solutions Correcting Water, Electrolyte, Acid-Base and Nutritional Disturbances: Solutions Correcting Water, Electrolyte and Acid-Base Disturbances (Oral and Parenteral), Intravenous Nutrition, Vitamins and Minerals
- General Anaesthetics and Oxygen: Local Anaesthetics, Perioperative Medications and Sedation for Short-Term Procedures
- Analgesics, Antipyretics, Non-Steroidal, Anti-Inflammatory Medicine

Background

This resolution calls for ACEP to consider medications used to treat or correct life-threatening conditions for which no adequate substitutes are available to be an essential emergency medication, request a meeting with the FDA to request adequate amounts of these medications be in supply at all times, to work collaboratively with other medical organizations to speak to government agencies and elected officials on the urgent need to address this lack of access, make developing and promoting federal legislation on this issue a priority for ACEP's legislative agenda, and submit a resolution on essential medicines for consideration to the AMA House of Delegates.

Resolution 34(17) Generic Injectable Drug Shortages is similar in that it addresses drug shortages. Much of the background information is the same for both resolutions.

Shortages of commonly-used but essential medications continue to grow and have become a more 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 2017) by the FDA include sterile injectables such as saline, epinephrine, and dextrose-filled syringes. These drug shortages can be further exacerbated by the "gray market," where distributors purchase any remaining drugs on the shortage list and then sell their stock at significantly higher prices.

Reasons cited for the increase in drug shortages include greater scrutiny on the manufacturing process and quality controls; however, additional factors include 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, among others. With that said, the root causes of shortages are often unclear.

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 is also 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 also 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 also developing bi-partisan, market-based solutions to lower drug prices in the United States.

In response to actions taken by the AMA House of Delegates at the 2015 Interim Meeting, the 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. The task force 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 summarized the work of the task force and described 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). 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.

ACEP Strategic Plan Reference

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

Objective F – Establish the value of emergency medicine as an important component of the health care system.

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP position to federal lawmakers and to support development and introduction of legislation. Potential travel costs for ACEP members to conduct in-person meetings with FDA, approximately $1,000 per person per trip.

Prior Council Action

Amended Resolution (13)15 ACEP and the Pharmaceutical Industry adopted. Directed ACEP to evaluate the expanding role and cost for pharmaceuticals affecting emergency medicine, identify and collaborate with interested parties/stakeholders, including pharmaceutical manufacturers, to assure 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 provide a report to the 2016 Council.

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 (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: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 33(17)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Immigrant and Non-Citizen Access to Care

PURPOSE: 1) Develop model hospital safe zone policy language opposing federal and state initiatives requiring physicians and healthcare facilities to refuse care or report suspected undocumented persons to immigration authorities. 2) Make the model available for physicians to access and present to their hospital systems. 3) Provide a "Safe Zone" statement in multiple languages relevant to the patient population.

FISCAL IMPACT: Budgeted committee and staff resources to develop model policy language. Additional costs (unknown amount) for translation services. The cost will depend on the number of languages for translation.

WHEREAS, Access to emergency medical care is critically important to both individual and public health; and

WHEREAS, The fear of immigration authorities has been shown to be highly predictive of epidemiologically significant delays in seeking care for patients with communicable diseases such as tuberculosis; and

WHEREAS, Early quarantine and treatment of communicable diseases such as Ebola can prevent an isolated case from becoming an epidemic, and emergency departments are likely places of first contact for such patients; and

WHEREAS, Access to emergency medical care is the only universally mandated form of health care in the US, and is thus a foundational element of the social and public health safety nets; and

WHEREAS, Emergency physicians are patient advocates with ethical and legal obligations to care for all patients; these obligations include a moral imperative to combat disparities in care; and

WHEREAS, Immigrants face significant disparities in health care outcomes; and

WHEREAS, The potential presence of federal immigration enforcement agents is likely to discourage immigrants from seeking care and thus worsen disparities in care for this population; and

WHEREAS, Hospital policies requiring federal immigration enforcement agents to obtain a warrant prior to entering a hospital or medical campus facility could help ameliorate fears which prevent immigrants from accessing care, particularly if effectively communicated to these populations; and

WHEREAS, ACEP affirms support for immigrants in its policy "Delivery of Care to Undocumented Persons," which "opposes federal and state initiatives which require physicians and health care facilities to refuse care to undocumented persons or to report suspected undocumented persons to immigration authorities" and expands upon this policy to strengthen and broaden it; therefore, be it

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.

Background

This resolution calls for the College to develop model hospital safe zone policy opposing federal and state initiatives that require physicians and healthcare facilities to refuse care or report suspected undocumented persons to immigration authorities. The model is to be available for physicians to access and present to their hospital systems. This resolution also calls for ACEP to provide a "Safe Zone" statement in multiple languages relevant to the patient population.

There has long been concern that undocumented immigrants do not seek medical care or report crimes due to fears of being reported to immigration officials and being deported. In 2011, US Immigration and Customs Enforcement (ICE) issued a memorandum on "Enforcement Actions at or Focused on Sensitive Locations." The document states, "This policy is designated to ensure that these enforcement actions do not occur at nor are focused on sensitive locations such as schools, and churches …" The ICE memorandum identifies hospitals as a sensitive location and outlines exceptions to enforcement actions at sensitive locations. The Department of Homeland Security also considers hospitals as sensitive locations and provides further guidance on enforcement actions at or focused on sensitive locations in its policy.

A bill was introduced into the California state senate to prevent state and local law enforcement agencies from enforcing immigration laws in "safe zones" that include hospitals. As currently written, this bill would not prohibit law enforcement from transferring violent offenders into federal custody. The bill is referred to as the California Values Act and is still under consideration. Similar legislation filed in Texas this year did not receive a hearing. In all, thirty-six states and the District of Columbia considered over 100 bills this year addressing sanctuary jurisdictions.

ACEP has two existing policies that address concerns raised in this resolution. The policy statement "Delivery of Care to Undocumented Persons" "...opposes federal and state initiatives which require physicians and health care facilities to refuse care to undocumented persons or to report suspected undocumented persons to immigration authorities." The policy statement "Non-Discrimination and Harassment" opposes all forms of discrimination and harassment against patients and emergency medicine staff of the basis of individual's race, age, …citizenship…" etc.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted committee and staff resources to develop model policy language. Additional costs (unknown amount) for translation services. The cost will depend on the number of languages for translation.

Prior Council Action

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted. It directed ACEP to produce a white paper addressing the impact of foreign nationals and develop proposals seeking legislative, regulatory, and/or judicial remedies for uncompensated health care services provided to foreign nationals in the ED.

Prior Board Action

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

April 2012, approved the policy statement "Non-Discrimination and Harassment;" previously approved October 2005 as "Non-Discrimination;" originally approved October 2005.

Substitute Resolution 29(01) Funding of Emergency Health Care for Foreign Nationals adopted.

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

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

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).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 34(17)

SUBMITTED BY: Rick Blum, MD, FACEP
Mark DeBard, MD, FACEP
Nicholas Jouriles, MD, FACEP
Brian Keaton, MD, FACEP
Robert Solomon, MD, FACEP
West Virginia Chapter

SUBJECT: Generic Injectable Drug Shortages

PURPOSE: 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.

FISCAL IMPACT: Budgeted staff and consultant 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, which 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 GPOs 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, are 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;" and

WHERAS, All of the multiple causative factors offered by the GPOs have been easily debunked and in February 2014, the 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 public and the medical community have largely been silent on this critical problem, primarily because they do not understand it and therefore have not achieved consensus on the root cause or the solution necessary; therefore be it

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.

Background

This resolution calls for 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.

Resolution 32(17) Essential Medicines is similar in that it addresses drug shortages. Much of the background information is the same for both resolutions.

Shortages of commonly-used but essential medications continue to grow and have become a more 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 2017) by the FDA include sterile injectables such as saline, epinephrine, and dextrose-filled syringes. These drug shortages can be further exacerbated by the "gray market," where distributors purchase any remaining drugs on the shortage list and then sell their stock at significantly higher prices.

Reasons cited for the increase in drug shortages include greater scrutiny on the manufacturing process and quality

controls; however, additional factors include 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, among others. With that said, the root causes of shortages are often unclear.

Additionally, the role of Group Purchasing Organizations (GPOs) in the drug pricing and shortage debate has received more 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," which noted the inherent conflict of interest created by the GPO safe harbor protections, and how 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. Further, many others have raised questions about how existing policies and incentives have contributed to skyrocketing costs for generic injectables and why shortages for common, essential drugs persist in throughout the country.

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 is also 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 also 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 also developing bi-partisan, market-based solutions to lower drug prices in the United States.

In response to actions taken by the AMA House of Delegates at the 2015 Interim Meeting, the 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. The task force 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 summarized the work of the task force and described 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). 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.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
Objective F – Establish the value of emergency medicine as an important component of the health care system.

Fiscal Impact

Budgeted staff and consultant resources.

Prior Council Action

Amended Resolution (13)15 ACEP and the Pharmaceutical Industry adopted. Directed ACEP to evaluate the expanding role and cost for pharmaceuticals affecting emergency medicine, identify and collaborate with interested parties/stakeholders, including pharmaceutical manufacturers, to assure 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 provide a report to the 2016 Council.

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 (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: James Cusick, MD, FACEP, Speaker
John McManus, MD, FACEP, Vice Speaker
Dean Wilkerson, JD, MBA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 35(17)

SUBMITTED BY: Undersea & Hyperbaric Medicine Section

SUBJECT: Legislation Requiring Hyperbaric Medicine Facility Accreditation for Federal Payment

PURPOSE: Work with the Undersea and Hyperbaric Medical Society and ACEP's Undersea and Hyperbaric Medicine Section to advocate that CMS require hyperbaric facilities be accredited to receive federal payment.

FISCAL IMPACT: Budgeted staff and consultant resources to convey ACEP's position to CMS and relevant regulators.

WHEREAS, Undersea and hyperbaric medicine is recognized by the American Board of Medical Specialties as a subspecialty of emergency medicine; and

WHEREAS, Fewer and fewer (now less than 50 of more than 1,400) hyperbaric centers are offering 24/7 emergency care for all approved indications; and

WHEREAS, Many hyperbaric centers that do not offer 24/7 emergency care are receiving profits through non-emergent (and sometimes non-indicated) treatments, which pulls patients and revenue from those centers struggling to offer 24/7 emergency availability to their patient populations; and

WHEREAS, It appears that CMS considers hyperbaric medicine to be overutilized and/or abused, which is evidenced by the identification of hyperbaric medicine as the number one priority on the 2017 OIG work plan; and

WHEREAS, It is unlikely that emergency applications of hyperbaric medicine are wasteful or overutilized; and

WHEREAS, Other medical societies, such as the American Academy of Sleep Medicine (AASM), have decreased waste and/or overutilization, as well as improved patient care, by requiring sleep center accreditation for federal payment; and

WHEREAS, While the Undersea & Hyperbaric Medical Society (UHMS) has an existing accreditation system, it is underutilized (only 205 of more than 1,400 hyperbaric medicine centers are accredited), likely due in part to lack of incentives; and

WHEREAS, Under a current proposal by the UHMS, supported by the ACEP Undersea & Hyperbaric Medicine Section, facility accreditation requirements would be bolstered to mandate (i) board-certified medical directors, (ii) expanded training requirements for all providers, and (iii) 24/7 emergency availability (or create partnerships with other 24/7 facilities); and

WHEREAS, If accreditation was required for federal payment, there would be a subsequent increase in demand for fellowship training and board certification in Undersea & Hyperbaric Medicine; and

WHEREAS, If federal payment was contingent on facility accreditation and training demand thus increased, the UHMS, the Council of [Undersea & Hyperbaric Medicine] Fellowship Directors (COFD), and ACEP could work to create new fellowship opportunities and improve training programs to help decrease non-indicated applications of undersea and hyperbaric medicine; and

WHEREAS, The UHMS plans to utilize funds collected through the accreditation program to support

fellowship training and hyperbaric medicine research to advance the aforementioned objectives; therefore be it

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.

Background

The resolution directs ACEP to work with the Undersea & Hyperbaric Medical Society (UHMS) and ACEP's Undersea & Hyperbaric Medicine Section to ask CMS to require that hyperbaric facilities be accredited to receive federal payment.

Under current policy, accreditation is not required by CMS for federal payments to be made to hyperbaric centers. According to UHMS, there are currently 203 accredited hyperbaric centers in the United States.

There is recent precedent for requiring accreditation for federal payment that is relevant to this resolution. In 2017, Local Coverage Determination (LCD) L36839 was issued by Wisconsin Physicians Services, a Medicare Administrative Contractor (MAC), that required sleep centers and staff credentials to be accredited by the American Academy of Sleep Medicine (AASM), The Joint Commission (TJC), or the Accreditation Commission for Health Care (ACHC). WPS indicated that this LCD was simply a clarification of existing policy, though some facilities were caught off guard by this revision, particularly those who were accredited by TJC, but had not specifically requested the ambulatory care accreditation.

It is worth noting that requiring accreditation may create additional burdens for facilities, both in terms of costs and the delays associated with the accreditation timeline, which can take as long as six months to complete. Additionally, the process for implementing this policy is worth considering as well. The MAC process of issuing Local Coverage Determinations has been subject to criticism from a wide variety of stakeholders, primarily due to a lack of transparency of how determinations are made and inconsistency in payment policies throughout the country. MACs have recently received more scrutiny from federal lawmakers as well, and the lessons learned from the WPS decision may be helpful for determining the most appropriate strategy for securing the changes sought by this resolution.

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
Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care

Fiscal Impact

Budgeted staff and consultant resources to convey ACEP's position to CMS and relevant regulators.

Prior Council Action

Resolution 20(16) Support & Advocacy for 24/7 Hyperbaric Medicine Availability adopted. Directed ACEP to work with Undersea and Hyperbaric Medical Society and the Divers Alert Network to support and advocate for improved 24/7 emergency hyperbaric medicine availability across the US to provide appropriate and timely care to patients in need.

Resolution 33(10) Support of Subspecialty Certification and Fellowships in Undersea and Hyperbaric Medicine adopted. Called for ACEP to support ABEM subspecialty certification in Undersea and Hyperbaric medicine (UHM) for physicians board certified in emergency medicine and promotion and development of ACGME accredited fellowship program sin UHM.

Prior Board Action

Resolution 20(16) Support & Advocacy for 24/7 Hyperbaric Medicine Availability adopted.

Resolution 33(10) Support of Subspecialty Certification and Fellowships in Undersea and Hyperbaric Medicine adopted.

October 2004, reviewed ACEPs liaison relationships with outside organizations. Members of the UHM Section were active members in the UHMS and the current liaison personally funded travel for liaison activities. The Board approved discontinuing funding for the liaison relationship.

November 1987, established an official liaison relationship with UHMS and the American College of Undersea and Hyperbaric Medicine.

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

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

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RESOLUTION: 36(17)

SUBMITTED BY: AAWEP Section
Emergency Medicine Residents' Association
Diana Fite, MD, FACEP
Sarah Hoper, MD, FACEP
Iowa Chapter
Fotini Manizate, MD
Missouri College of Emergency Physicians
Washington Chapter
Young Physicians Section

SUBJECT: Maternity and Paternity Leave

PURPOSE: Advocate for paid parental leave, develop a policy statement in support of paid parental leave, conduct an environmental survey, and develop a paper on best practices regarding maternity and paternity leave for emergency physicians.

FISCAL IMPACT: Budgeted committee and staff resources to develop a policy, develop a paper, and advocating for adoption of paid parental leave policies. Unknown costs for conducting an environmental survey (depends on the resources needed).

WHEREAS, the United States is one of six out of 193 countries in the United Nations that does not mandate paid maternity leave[1] and 50 countries provide six months or more of paid leave;[2] and

WHEREAS, 40% of American workers do not meet the requirements for 12 weeks of unpaid leave provided by the Family Medical Leave Act (FMLA) because they have not worked 1,250 hours in the past year or they do not work for an employer with more than 50 employees;[3] and

WHEREAS, Only 12% of workers in the private sector get paid maternity leave through their employers;[4] and

WHEREAS, 23% of surveyed women reported taking two weeks or less of maternity leave because they could not afford more;[5, 6] and

WHEREAS, Women with 12 weeks of paid leave are more likely to breastfeed for six months,[7] women with 12 weeks or more of paid maternity leave have lower rates of post-partum depression,[8] and paid maternity leave is associated with lower infant mortality rates;[9] and

[1] UNData. Maternity Leave. http://data.un.org/DocumentData.aspx?id=344
[2] Deahl, Jessica. Countries Around the World Beat the U.S. on Paid Parental Leave. NPR- All Things Considered. http://www.npr.org/2016/10/06/495839588/countries-around-the-world-beat-the-u-s-on-paid-parental-leave
[3] Dept of Labor. FMLA is Working. https://www.dol.gov/whd/fmla/survey/FMLA_Survey_factsheet.pdf
[4] Dept of Labor Factsheet: Paid Family and Medical Leave. https://www.dol.gov/wb/paidleave/PDF/PaidLeave.pdf
[5] Wang W, Parker K, Taylor P. Breadwinner Mom. Pew Research Center. http://www.pewsocialtrends.org/2013/05/29/breadwinner-moms/
[6] Dept of Labor Factsheet: Paid Family and Medical Leave. https://www.dol.gov/wb/paidleave/PDF/PaidLeave.pdf
[7] Mirkovic, K *et al.* Paid Maternity Leave and Breastfeeding Outcomes. Birth. Vol 43, Issue 3, September 2016, 233-239.
[8] Dagher, R *et al.* Maternity Leave Duration and Postpartum Physical Health: Implications for Leave Policies. Journal of Health Politics, Policy and Law, Vol. 39, No. 2, April 2014.
[9] Nandi, A *et al.* 2016. "Increased Duration of Paid Maternity Leave Lowers Infant Mortality in Low- and Middle Income Countries: A Quasi-Experimental Study," PLoS Medicine. March 29, 2016. http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001985.

WHEREAS, Fathers that take paternity leave have higher satisfaction with parenting,[10] are more engaged in the care of their children nine months after birth,[11,12,13] children with engaged fathers have fewer behavioral and mental health problems,[14] and longer paternity leave with fathers caring for young children is associated with higher cognitive test scores;[14,15] and

WHEREAS, Some academic emergency medicine programs provide paid maternity and paternity leave of differing number of weeks or days; and

WHEREAS, A few private emergency medicine practice groups have developed innovative ways to help with paid maternity and paternity leave that should be shared with other groups; and

WHEREAS, Despite the Equal Pay Act of 1963 prohibiting discrimination on account of sex in the payment of wages by employers~~,~~ there is still an approximately $20,000 wage gap between men and women in medicine even when adjusted for factors that may impact compensation; and

WHEREAS, Offering only paid maternity and not paternity leave may increase the wage gap; therefore be it

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.

Background

This resolution directs the College to advocate for paid parental leave, develop a policy statement in support of paid parental leave, conduct an environmental survey, and develop a paper on best practices regarding maternity and paternity leave for emergency physicians.

The Family and Medical Leave Act (FMLA) entitles eligible workers to take job-protected, unpaid leave of up to 12 weeks for the birth of a child or to care for a child within one year of birth. Those eligible for this protection are workers with at least1,250 hours of service during the previous 12 months at an employer with at least 50 employees. At least 14 states and some major cities have enacted laws that expand on the FMLA protections, most typically by increasing the length of leave allowed and/or expanding coverage to a larger number of employees.

At least four states have implemented paid parental leave programs. Typically funded by employee payroll taxes, these state programs mandate paid coverage of various lengths and amounts. For example, a New York law that goes into effect January 1, 2018, provides maximum leave benefit of 50% of an employee's weekly wage for up to eight weeks.

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[10] Linda Hass and C. Philip Hwang. 2008. "The Impact of Taking Parental Leave on Fathers' Participation in Childcare and Relationships with Children: Lessons from Sweden." Community, Work and Family 11(1): 85-104.
[11] Lenna Nepomnyaschy and Jane Waldfogel. 2007. "Paternity Leave and Fathers' Involvement with Their Young Children: Evidence from the American Ecls–B." Community, Work & Family 10(4): 427-453.
[12] Maria Del Carmen Huerta, et al. 2013. "Fathers' Leave, Fathers' Involvement and Child Development: Are They Related? Evidence from Four OECD Countries." OECD Social, Employment and Migration Working Papers, No. 140, retrieved from http://www.oecd-ilibrary.org/social-issues-migration-health/fathers-leave-fathers-involvement-and-child-development_5k4dlw9w6czq-en (last visited June 17. 2015).
[13] Sakiko Tanaka and Jane Waldfogel. 2007. "Effects of Parental Leave and Work Hours on Fathers' Involvement With Their Babies: Evidence from the Millennium Cohort Study." Community, Work and Family 10(4): 409-426.
[14] Huerta, et al (2013); Nepomnyaschy and Waldfogel (2007); Anna Sarkadi, et al. 2008. "Fathers Involvement and Children's Developmental Outcomes: A Systematic Review of Longitudinal Studies." Acta Pediatrica 97: 153-158; Erini Flouri and Ann Buchanan. 2002. "The Role of Father Involvement in Children's Later Mental Health." Journal of Adolescence 26: 63-78.
[15] Dept. of Labor Policy Brief, "Why Parental Leave for Fathers Is So Important for Working Families," June 16, 2016. https://www.dol.gov/asp/policy-development/PaternityBrief.pdf

Several cities also have mandatory paid parental leave programs for private employers. In 2016, San Francisco became the first major U.S. city to mandate fully paid parental leave, requiring employers with 20 or more employees to offer six weeks paid time off for new mothers and fathers.

Increasingly, private employers have voluntarily initiated or expanded paid parental leave programs, including several hospitals. New York Presbyterian Hospital recently expanded its leave policy to provide six to eight weeks of paid disability leave for the birth mother and an additional six weeks paid parental leave. Children's National Health System provides six to eight weeks paid maternity leave and two weeks paid paternity leave.

Several studies have concluded that extended paid maternity leave results in improved physical and mental health for the mother as well as health and developmental improvements for the child. While proponents claim the programs also improve worker morale, loyalty, and productivity, opponents raise concerns about the increase in taxation required to fund such programs and potential unintended consequences, such as employers becoming less likely to hire women due to concerns of higher costs and loss of productivity if new mothers can take extended periods of paid leave.

Regarding parental leave time for emergency physicians, ACEP first adopted a policy on "Parental Leave of Absence" in 1990. The current version of that policy statement, now entitled "Family Leave of Absence", states in part that:

> "Emergency physician groups, employers, and emergency medicine residency programs should have written policies that support family leaves of absence. These policies should apply to a personal serious illness, both parents for the birth or adoption of a child, the care of a seriously ill family member, or to situations involving either the safety or cohesion of the family (including mental health emergencies).
>
> The leaders of physician groups and residency programs, as well as employers, should actively support these policies by informing physicians of them and making their provisions available without undue delay or administrative burden.
>
> Flexible work schedules and the use of compensatory leave time (where applicable) should be made available to affected physicians whenever it is possible to do so without disrupting the availability of patient care."

In 2016, the AMA adopted a policy entitled "Parental Leave" (H-405.954), which states:

> "1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
> 2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments."

The initial resolution that led to this policy, Resolution 215 (I-16), asked the AMA to conduct the patient study described in Number 1 above, but the House of Delegates adopted a revised resolution that the AMA would encourage such a study.

Regarding the physician study referenced in the second Whereas statement, AMA staff indicated that a report was scheduled for presentation to the AMA Board of Trustees in September 2017. At the time this background was written, AMA staff indicated that the report would conclude that there is no information available related to FMLA's specific effect on physicians distinct from anyone else and trying to determine the impacts of various possible expansions of the FMLA on physicians in different practice environments would be highly speculative.

The AMA has an additional relevant policy, entitled "Paid Sick Leave" (H-440.823). That policy, adopted earlier in 2016, states:

> "Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time

off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome."

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective C – Promote member well-being and improve resiliency.

Fiscal Impact

Budgeted committee and staff resources to develop a policy, develop a paper, and advocating for adoption of paid parental leave policies. Unknown costs for conducting an environmental survey (depends on the resources needed).

Prior Council Action

Amended Resolution 44(88) Perinatal Leave for Emergency Physicians adopted. The resolution called for the College to develop educational guidelines for emergency physicians regarding maternal/paternal/adoption leave and associated issues for emergency physicians and emergency medicine residents.

Prior Board Action

April 2012, reaffirmed the policy statement "Family Leave of Absence;" previously revised and approved October 2006, September 1999, and April 1994; originally approved June 1990.

September 1988, Resolution 44(88) adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Policy and Finance

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

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: 37(17)

SUBMITTED BY: Larry Bedard, MD, FACEP
Susan Haney, MD, FACEP
Dan Morhaim, MD, FACEP

SUBJECT: Medically Supervised Injection Facilities

PURPOSE: 1) Support legalization, authorization, and implementation of Medically Supervised Injection Facilities in coordination with state and local health departments. 2) Support decriminalizing possession of illegal substances in such facilities with legal and liability protections for persons working or volunteering in such facilities.

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

WHEREAS, Heroin injection as a means of satisfying opioid dependence or use disorder has doubled nationally in the past decade; and

WHEREAS, The number of deaths attributed to heroin injection overdoses have quadrupled nationally since 2010; and

WHEREAS, Persons who inject drugs (PWID) are less likely to access health care or call emergency services in the case of lethal overdose in part due to fear of criminal penalties and are more likely to contract infectious diseases such as HIV, hepatitis C, and soft tissue infections; and

WHEREAS, Medically supervised injection facilities (MSIFs) are sites providing sterile injection equipment where adults may consume pre-obtained controlled substances under medical supervision in a hygienic facility; and

WHEREAS, In areas where they are established, MSIFs reduce the number of overdose deaths, reduce transmission rates of infectious disease, increase the number of individuals initiating substance use therapy, improve access to care for those that would not otherwise access the health care system, and to date have had no documented fatalities; and

WHEREAS, MSIFs effectively attract and provide services for PWID who are at greatest risk due to homelessness, daily use, and recent nonfatal overdose; and

WHEREAS, MSIFs do not increase overall illicit drug use, encourage drug use, or promote first-time drug experimentation; and

WHEREAS, MSIFs create significant health care savings due to averted infections and deaths and provide social benefits of reducing public injecting, syringe litter, and local crime including vehicle break-ins and thefts; and

WHEREAS, ACEP should make combating the opioid use epidemic one of its core priorities; therefore be it

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.

Background

This resolution directs ACEP to support the legalization, authorization, and implementation of Medically Supervised Injection Facilities (MSIFs or SIFs) in coordination with state and local health departments, and that ACEP support decriminalization of the possession of illegal substances in such facilities, as well as legal and liability protections for persons working or volunteering in such facilities.

Resolution 31(17) Endorsement of Supervised Injection Facilities is similar in that it addresses supervised injection facilities. Much of the background information is the same for both resolutions.

The abuse of, and addiction to, various opioids, both prescription medication and illegal substances, has become a serious global health problem. It is estimated that more than two million people in the United States suffer from a substance abuse disorder related to prescription opioids and another 500,000 are addicted to heroin.

The White House Office of National Drug Control Policy (ONDCP) has made the opioid abuse issue a top priority and is identifying additional opportunities for collaboration between government agencies and external stakeholders to combat this growing national crisis. On March 29, 2017, President Donald Trump signed an Executive Order establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis, with the commission chaired by Governor Chris Christie. In August 2017, President Trump indicated he would declare the opioid epidemic a national emergency though as of September 11, 2017, an official declaration is yet to be made.

The Centers for Disease Control and Prevention (CDC) recently reported that the 2015 age-adjusted rate of drug overdose deaths in the U.S. was more than 2.5 times the rate in 1999. This is part of a 16-year trend of increasing opioid overdose deaths that are directly related to overdoses from prescription opioids. The CDC also noted the percentage of opioid deaths involving heroin was triple the percentage in 2010. Since 1999, the amount of opioids sold has nearly quadrupled and deaths from prescription opioids have had a corresponding increase.

The concept of Medically Supervised Injection Facilities has been proposed as a public health intervention to help save lives by reducing overdoses, deaths, and preventable illnesses like HIV, hepatitis C and soft tissue infections. These facilities provide sterile injection equipment under medical supervision to prevent the sharing of syringes and injection materials, with many offering counseling and informational services as well. According to the Drug Policy Alliance, there are approximately 100 SIFs operating in 66 cities throughout the world, though none currently exist in the U.S. The establishment of SIFs in the U.S. remains a controversial topic as critics argue such policies endorse illicit drug use, encourage first-time drug use, and do not curb addiction or address drug-related crime, while supporters point to benefits like a decreased prevalence of preventable diseases as well as reduced overdose rates that help contribute to a reduced need for emergency services. There are also additional legal aspects with regard to possession and use of illegal drugs and paraphernalia that occur at the federal, state, and local levels that will need to be addressed if SIFs are to be established in the U.S.

This resolution also directs ACEP to support the decriminalization of the possession of illegal substances in MSIFs, as well as legal and liability protections for persons working or volunteering in such facilities. Decriminalization is also a controversial topic, and providing new legal and liability protections adds a layer of complexity throughout the policymaking process at both the state and local levels.

In 2017, the American Medical Association adopted a policy to support the development and implementation of pilot SIFs in the U.S. that are designed, monitored and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use (AMA Policy – Pilot Implementation of Supervised Injection Facilities, H-95.925 (2017)).

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.

Fiscal Impact

Budgeted committee, staff, and consultant resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

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

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).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 38(17)

SUBMITTED BY: Connecticut College of Emergency Physicians
Emergency Medicine Residents' Association
Geriatric Emergency Medicine Section

SUBJECT: Prescription Drug Pricing

PURPOSE: Create a policy statement: 1) recognizes how the threat of unaffordable prescription drug prices affects patients; 2) supports Medicare drug price negotiation in Part D; 3) supports importation of prescription drugs; 4) supports value-based pharmaceutical pricing; and 5) work with the AMA to support regulatory and legislative efforts.

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

WHEREAS, Per capita prescription drug spending in the United States is the highest in the world[1]; and

WHEREAS, Spending for prescription drugs constitutes nearly one-fifth of total health care costs in the United States[1]; and

WHEREAS, The price of prescription drugs continues to rapidly increase, outpacing spending increases for other health care expenditures[1]; and

WHEREAS, Cost-related medication non-adherence is associated with increased emergency department utilization[2]; and

WHEREAS, Prices continue to skyrocket for medications necessary for the prehospital treatment of life-threatening conditions, such as naloxone for opioid overdose[3] and epinephrine auto-injectors for anaphylaxis[4], where cost-related unavailability may lead to unnecessary preventable death; and

WHEREAS, The Medicare Modernization Act of 2003 created Medicare Part D, which currently pays for 30% of all national prescription drug expenditures, but prohibits the Secretary of the Department of Health and Human Services (HHS) from negotiating prices[1]; and

WHEREAS, The majority of Americans believe that lowering the cost of prescription drugs should be a top health care priority[5]; and

WHEREAS, Consistent with public opinion[6], the American Medical Association has adopted policies to encourage prescription drug price and cost transparency[7], to support negotiation of drug prices under Medicare Part D[8], to allow wholesalers and pharmacies to import prescriptions drugs[9], and to support the creation of objective, independent entities to determine value-based prices of pharmaceuticals[10]; therefore be it

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.

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Background

The resolution calls for ACEP to create a policy statement that: 1) recognizes how the threat of unaffordable prescription drug prices affects patients; 2) supports Medicare drug price negotiation in Part D; 3) supports importation of prescription drugs; 4) supports value-based pharmaceutical pricing; and 5) work with the American Medical Association to support regulatory and legislative efforts to address these issues.

The rising costs of prescription drugs is a multifaceted problem that has garnered greater attention from patients, providers, and lawmakers over the past several years. A 2016 report in the *Journal of the American Medical Association* (JAMA) found that per-capita prescription drug spending in the U.S. has increased at rates "far beyond the consumer price index." The report cites market exclusivity as the most important factor, with the main method of reducing prices – the availability of generic drugs – subject to years of intentional delays. The report also indicates another key contributor to drug spending is physician prescribing choices when cheaper alternatives are available. Many have also pointed to the growth in spending on new specialty or breakthrough drugs as a major contributing factor in overall drug spending in the U.S.

Others note factors like the rapid growth of pharmacy benefit managers (PBMs) and a lack of transparency about their role in negotiating drug prices and providing rebates, with questions about conflicts of interest arising as more PBMs have been acquired by insurers or pharmacy companies. And while pharmaceutical manufacturers often cite the high costs of research and development as a factor in pricing determinations, there appears to be little independent evidence that these costs account for drug prices.

Efforts to curb spending growth and reduce drug prices are varied. The resolution calls for price negotiation in Medicare Part D, which was prohibited through a "noninterference" provision when the program was established in the Medicare Modernization Act (MMA) of 2003. While calls to allow for price negotiation have been a common policy position for many Democrat legislators, Republican lawmakers have largely opposed such efforts. However, as candidate, and now as President, Donald Trump also voiced support for direct price negotiation throughout the Medicare program. This line of thinking appears to be popular among the public as well – the Kaiser Family Foundation notes that this policy is supported by 82 percent of the public, including 68 percent of Republicans.

However, previous estimates from the nonpartisan Congressional Budget Office (CBO) suggest that allowing Medicare to negotiate prices would have a negligible effect on federal spending.

This resolution also calls for the importation of prescription drugs, which is not currently allowed under U.S. law. Supporters point to lower patient costs in other countries for the same drugs available in the U.S. as a substantial benefit for consumers. For opponents of importation, safety and efficacy are the predominant concerns, as it becomes more difficult to monitor the supply chain and ensure the quality of the drugs. While President Trump has in the past declared support for importation, influential members of his administration, including Health & Human Services Secretary Tom Price, MD, and Food & Drug Administration Commissioner Scott Gottlieb, are on record as longtime opponents of drug importation.

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 also 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 also developing bi-partisan, market-based solutions to lower drug prices in the United States. Additionally, the ACEP Foundation also worked with Pfizer in 2010 as a supporter of the Partnership for Prescription Assistance to ensure that emergency department patients know that assistance is available, especially for those who are uninsured, unemployed, or on fixed incomes.

The AMA has multiple policies addressing this issue: Pharmaceutical Cost H-110.987; Cost of Prescription Drugs H-110.997; Price of Medicine H-110.991; Reducing Prescription Drug Prices D-110.993; Prescription Drug Prices and Medicare D-330.954; Prescription Drug Importation and Patient Safety D-100.983; and Incorporating Value into Pharmaceutical Pricing H-110.986.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted committee, staff, and consultant resouces.

Prior Council Action

Amended Resolution (13)15 ACEP and the Pharmaceutical Industry adopted. Directed ACEP to evaluate the expanding role and cost for pharmaceuticals affecting emergency medicine, identify and collaborate with interested parties/stakeholders, including pharmaceutical manufacturers, to assure 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 provide a report to the 2016 Council.

Prior Board Action

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

Background Information Prepared by: Ryan McBride, MPP
Senior Congressional Lobbyist

Margaret Montgomery, RN, MSN
Practice Management Manager

Craig Price, CAE
Senior Director, Policy and Finance

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

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: 39(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: Prohibition on ACEP Interference in State Legislative Activities

PURPOSE: Develop a policy addressing ACEP involvement in state level regulatory and legislative initiatives separate from a chapter's request or a conflict with ACEP policy and present that policy for discussion at the 2018 Council meeting.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, ACEP is the premier professional organization representing the practice and specialty of Emergency Medicine and is among one of the best organizations in the country in promoting the specialty and interests of Emergency Medicine, and the patients we serve, at the national level; and

WHEREAS, One of the greatest strengths of the national organization, ACEP, is the vibrant, independent, active state chapters that can best represent the interests of the local practicing Emergency Physicians at the grassroots state level; and

WHEREAS, One of the key strengths of any professional organization is the ability to be responsive and connected to the grassroots members and their issues; and

WHEREAS, Many of the autonomous state chapters maintain active organizations that are connected to the national organization but are best able to actively and effectively represent their members' interests and issues at the state level; and

WHEREAS, Many of the state chapters have their own policy efforts with their own state legislative agendas, connections, and relationships, including collaborative efforts with their own state medical associations; and

WHEREAS, There is remote history where ACEP, and/or its elected leaders, have interfered, given conflicting messages, and/or contradicted state legislative efforts resulting in great disruption and confusion in state policy and legislative efforts; and

WHEREAS, It is not appropriate for ACEP to supersede state level policy and legislative efforts or overrule state policy agendas; therefore be it

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.

Background

This resolution calls for ACEP to develop a policy addressing ACEP's involvement in state regulatory and legislative activities when not requested to do so by the state chapter and when there is no formal and explicit ACEP policy

conflict. The resolution also directs ACEP to present the policy for consideration and comment at the 2018 Council meeting.

There are 53 ACEP chapters with varying resource levels, staffing models, and engagement in state advocacy efforts. Approximately half of the state chapters contract with lobbyists. ACEP members and chapters work frequently with state medical society lobbyists or related interest groups to address legislative and regulatory issues impacting emergency medicine. ACEP leaders and staff provide a variety of resources to state chapters, including materials related to ACEP policies and interests, legislative information, political intelligence, state public policy grants, public relations resources, assistance with letters and talking points for use with policymakers, and policy expertise to assist chapters with their advocacy efforts. ACEP also works collaboratively with a variety of national interests to facilitate collaboration on both the national and state level. National ACEP does not contract with registered state level lobbyists in any state.

While ACEP offers assistance and support for chapter advocacy efforts, the scope and direction of state legislative and regulatory activity is at the direction of the chapter. In the vast majority of cases, all parties agree on the position that should be taken on legislation impacting emergency medicine. Occasionally, differences of opinion arise over how complex legislation may impact emergency medicine practice. State chapters will sometimes experience internal debate on how or whether to approach particular legislation, or on very rare occasions, differences of majority opinion may arise between state and national ACEP leadership. In 2017, the Texas College of Emergency Physicians (TCEP) determined to monitor legislation related to maintenance of certification (MOC) without taking a formal, public position. National ACEP leadership was urged by other national organizations to act on its own and formally take a position on the state legislation. Ultimately, after consulting with TCEP leaders, ACEP decided not to engage in efforts regarding the legislation.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
- Objective A - Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.
- Objective C – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
- Objective E – Achieve meaningful liability reform at the state and federal levels.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

None

Prior Board Action

May 2017, the Executive Committee discussed a request from the American Board of Emergency Medicine to intervene in the pending Texas legislation on maintenance of certification and send email messages to legislators to block the bill from a vote. There was consensus that ACEP should not act to lobby against the Texas legislation. The Board ratified the actions of the Executive Committee at their June 2017 meeting.

April 2017, discussed the Senate bill in Texas regarding MOC.

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

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

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).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 40(17)

SUBMITTED BY: Indiana Chapter

SUBJECT: Reimbursement for Emergency Services

PURPOSE: 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.

FISCAL IMPACT: Budgeted committee, staff, and consultant resources. Additional travel expenses of approximately $5,000 to meet in person with Anthem. Additional unknown expenses if legal action is initiated.

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, The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires Emergency Departments to provide a medical screening examination including stabilization and treatment regardless of ability to pay to all patients who present themselves to the Emergency Department requesting medical care; and

WHEREAS, ACEP supports the "prudent layperson" definition of an emergency medical condition as one in which a person who possess an average knowledge of health and medicine and might anticipate serious impairment to their health; and

WHEREAS, The range of emergency medical conditions experienced by patients seen in emergency departments is extremely variable and difficult to recognize by patients; and

WHEREAS, Anthem has announced intention to deny reimbursement for Emergency Medical services when Anthem defines the condition as non-emergent and has requested that providers direct patients to care sites with lower levels of service; and

WHEREAS, The value of emergency medical services cannot be defined as a presenting symptomatic complaint or final diagnosis; and

WHEREAS, The Indiana chapter of ACEP supports ACEP in endeavors to ensure access to care for all patients; therefore be it

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.

Background

This resolution directs ACEP to continue to uphold federal prudent layperson laws (PLP), advocate for patients to prevent any negative clinical or financial impact caused by the lack of reimbursement for emergency medical services, and partner with affected states and the AMA on these issues. It also calls on ACEP to 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.

History of Prudent Layperson Federal and State Laws

The first PLP law was enacted in the state of Maryland in 1993. Three years later, the National Association of Insurance Commissioners (NAIC) drafted the Managed Care Provider Network Adequacy and Contracting Model Act (Model Act) which included the PLP standard. This step recognized the need to require the provision of coverage for emergency services based upon presenting symptoms rather than the ultimate diagnosis. The Model Act differs only slightly from the PLP in the Patient Bill of Rights, part of the 2010 Affordable Care Act (ACA) passed by the 111th Congress. The NAIC model includes the appropriate "concept" of a PLP that applies to patients with presenting symptoms rather than subsequent final diagnosis to the emergency department. As of July 1, 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, however individual insurers have continued to try to reduce payments for emergency care they deem to be non-emergent.

Challenging the Anthem Policy on Retrospective Denials and Down Coding

Anthem has rolled out a policy in Georgia, Indiana, Kentucky, and Missouri, that retrospectively denies coverage for ED services providing care for conditions they deem not to be actual emergencies and that could have been effectively treated in a lower acuity setting. Since May 2017, ACEP has been actively monitoring and challenging the policy and has been protesting an extensive list of diagnoses that Anthem deems to be non-emergent. For ED use, Anthem recommends the following; “You should always go to the ER if you believe your life or health is in danger. However, for less severe injuries or illnesses, the ER can be expensive and wait times can average over 4 hours”; although, the policy lists conditions that may require immediate screening for more serious diagnoses.

ACEP sent a letter to Anthem’s President and CEO Joseph Swedish in August 2017 asking him to immediately cease their policy, citing PLP violations. In that letter, ACEP provided data from a study that showed of nearly 35,000 unique ED visits, 6.3% of visits were determined to have primary care–treatable conditions based on discharge diagnosis, yet the chief presenting complaints reported for these ED visits were the same chief complaints reported for 88.7% of all ED visits. Of these visits, 11.1% were serious enough to be identified at ED triage as needing immediate emergency care, and 12.5% required hospital admission. The letter also challenged the nature of the cases Anthem exempted from the policy; patients 13 years of age or younger, patients directed to the ED by a physician, patients not

within 15 miles of an urgent care center, and/or the visit occurs on a Sunday or major holiday, as being arbitrary or unclear. It closes by expressing concern about patients with true emergencies that could delay needed care because of fear that they would be stuck with large bills.

As of the writing of this background material, ACEP's Washington, DC Office staff initiated a public relations campaign to push back on Anthem's policy in the media and proposed to the ACEP Board a comprehensive plan to involve third party stakeholders, while simultaneously seeking relief from congressional and state legislature leaders. On the regulatory front, ACEP is considering a meeting with the Department of Health & Human Services (DHHS) and the Center for Consumer Information & Insurance Oversight (CCIIO) at the national level and encouraging chapters to involve their state insurance commissioners in the fight. CCIIO is charged with helping implement many reforms of the ACA and oversees the implementation of the provisions related to private health insurance.

ACEP will also develop a toolkit to reach out to third-party stakeholders to begin an ACEP-led outreach to all impacted groups to ensure a coordinated approach and encourage information sharing and a unified message. Congressional and state legislative activity has focused on identifying legislative champions to lead various efforts to halt implementation of the policy. For example, Congressional pressure on the Anthem plan in their state, Congressional pressure on the insurance commissioner within their state to limit enforcement, Congressional outreach to DHHS or CCIIO to encourage their action, and a Hill briefing (panel of emergency physicians, consumer representative, impacted patient). In the states, ACEP is working with chapters to identify champions in the state legislatures and/or governors' offices who might have influence with the insurance commissioner, develop op-eds in key markets to influence state lawmakers, and work with chapters to encourage impacted constituents to write to their legislators.

To support all of this work, efforts are being made to track and collect payment denials by Anthem in states where the policy has taken effect. Billing companies, ED groups, and Academic Chairs in those states were asked to report any data or observations of denials that violate the prudent layperson standard. The ACEP DC office launched a website to collect patient stories of denials, and is beginning to publicize it more broadly. Finally, ACEP will continue to explore legal options to prevent Anthem from enforcing this policy, including possible injunctions.

Current AMA Policy on Prudent Layperson

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. (Directive to Take Action)

The AMA sent a letter 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 Strategic Plan Reference

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

Fiscal Impact

Budgeted committee, staff, and consultant resources. Additional travel expenses of approximately $5,000 to meet in person with Anthem. Additional unknown expenses if legal action is initiated

Prior Council Action

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.

Resolution 52(95) Managed Care Plans - Access to Urgent/Emergent Care referred to the Board of Directors, due to ongoing efforts in support of United States House of Representatives bill H.R. 2011. This resolution called for the College to urge managed care organizations to adopt a “prudent layperson” definition to ensure access to timely emergency care for all subscribers.

Substitute Resolution 39(90) Amendments to COBRA adopted. This resolution called for the College to expand its position statement on the definition of bona fide emergency to include reference to the fact that medical evaluation is necessary to ascertain if a bona fide emergency exists and is mandated by federal patient transfer laws.

Substitute Resolution 49(86) Patient Transfer adopted. This resolution called for the College to develop and make available support materials for chapters to deal with the assessment, management, and transfer of patients and that the College continue to work toward resolution of those elements of COBRA that deal unfairly with emergency physicians.

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted. Directed that as government entities mandate statutory access to emergency services, such statutes ensure a mechanism for optimal physician payment.

Prior Board Action

April 2017, approved the revised policy statement "Fair Coverage When Services are Mandated;" reaffirmed April 2011 and September 2005 with the title "Compensation When Services are Mandated;" originally approved September 1992.

April 2017, approved the revised policy statement "Prior Authorization;" revised and approved October 1998; originally approved November 1987.

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

Referred Resolution 28(15) Standards for Fair Payment of Emergency Physicians assigned to the ACEP/EDPMA Joint Task Force on Reimbursement.

April 2014, revised and approved the policy statement "Third-Party Payers and Emergency Medical Care;"revised and approved June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

Resolution 38(05) Proper Payment Under Assignment of Benefits adopted

Amended Resolution 34(02) Funding for EMTALA-Mandated Physician Services adopted.

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

Referred Amended Substitute Resolution 24(98) HMO Practices assigned to the Federal Government Affairs Committee and the Emergency Medicine Practice Committee.

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

Resolution 43(97) Prudent Layperson Legislation adopted.

Substitute Resolution 18(96) EMTALA and Health Care Insurance Entities adopted.

Substitute Resolution 39(90) Amendments to COBRA adopted.

Substitute Resolution 49(86) Patient Transfer adopted

Substitute Resolution 26(84) Statutory Mechanism for Compensation adopted.

Background Information Prepared by: David A. McKenzie, CAE, Reimbursement Director
Adam Krushinskie, MPA, Reimbursement Manager

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

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: 41(17)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Reimbursement for Hepatitis C Virus Testing Performed in the ED

PURPOSE: Encourage adoption of state laws that expand reimbursement for HCV testing to additional settings, including the emergency department.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, An estimated 3.2 million people in the United States are currently living with chronic Hepatitis C Virus (HCV) infection, 50% of whom may not even be aware of their condition and remain undiagnosed; and

WHEREAS, Patients with chronic HCV infection are at risk of developing cirrhosis, hepatocellular carcinoma, and extra-hepatic complications leading to significant costs to the healthcare system and patient; and

WHEREAS, Patients born during 1945-1965 comprise about 75% of the current HCV cases in the United States and a significant number of these patients have comorbid conditions including intravenous drug use; and

WHEREAS, The Emergency Department oftentimes functions as a safety net for those patients who otherwise may not have access to healthcare; and

WHEREAS, There is effective treatment to cure HCV infection, especially those diagnosed at early stages of fibrosis; and

WHEREAS, The evidence is adequate to conclude that screening for HCV is considered a grade "B" recommendation by the U.S. Preventive Services Task Force (USPSTF) and CMS will cover screening for HCV when ordered within the context of a primary care setting for adults at high risk for HCV infection and for those who were born from 1945 through 1965[1]; and

WHEREAS, For the purposes of national coverage determination (NCD), Emergency Departments, as well as inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are explicitly not considered primary care settings appropriate for testing[1]; and

WHEREAS, HIV testing previously faced similar scrutiny, and it is currently accepted that Emergency Departments are an ideal location for routine and/or non-risk based testing for patients; and

WHEREAS, Not all states currently allow for reimbursement for laboratory testing for certain conditions, including HCV testing, outside of the primary care setting; therefore be it

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.

References

1. https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=272

Background

This resolution calls for ACEP to encourage the adoption of state laws that expand reimbursement for Hepatitis C Virus (HCV) testing to additional settings, including the emergency department.

Current Reimbursement Policies

Reimbursement for HCV testing has been determined by CMS and the U.S. Preventative Services Task Force (USPSTF) to cover only primary care physicians who can assess the patient's history as part of the annual wellness visit in a patient's comprehensive prevention plan. Acceptance of HCV as a reimbursable screening test for preventative care by CMS and the USPSTF is strictly limited to the primary care setting. For professional billing requirements to be met, HCPCS code G0472 (HCV screening) must be submitted by one of the following provider specialties: General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, Pediatric Medicine, Geriatric Medicine, Certified Nurse Midwife, Nurse Practitioner, Certified Clinical Nurse Specialist, or Physician Assistant – Emergency Medicine is not included.

The USPSTF recommends offering one-time screening for HCV infection in adults born between 1945 and 1965. Since this population comprises 75% of all current HCV cases, coverage for testing has been provided mainly by government programs such as Medicaid and Medicare.

Medicare, which provides health care insurance for much of the covered population group already 65 and older, will only cover HCV screening tests without coinsurance or deductibles if they are ordered by a primary care physician or practitioner. In June 2014, CMS issued a National Coverage Determination based on the USPSTF recommendation for HCV testing that covers one-time testing for those covered by traditional Medicare. Medicare Advantage plans are also required to offer screening and cannot charge deductibles, copays or coinsurance; however, they are limited to primary care visits.

Medicaid coverage of screening is highly dependent on HCV testing being medically necessary and whether a state has elected to cover preventive services such as screenings without cost-sharing being applicable. The Social Security Act requires state Medicaid programs (including managed care programs) to cover medically necessary lab services with the option to cover screening on a regular basis. Medicaid expansion plans under the ACA, beginning in 2014, cover screening without cost-sharing. Two types of state reimbursement policies for Medicaid apply, with some states covering routine HCV screening by primary care providers, while others cover only screening based on medical necessity, with only reimbursement for lab services covered in full.

For those not covered by Medicare or Medicaid, private insurance offers periodic screening for those "at risk" and one-time testing for those born between 1945-1965. The ACA required most individual and group market plans to cover screening; however, this only applies to plans enacted after June 25, 2014. Many grandfathered plans do not offer screening coverage.

Current State Laws and Regulations

Although no states currently allow for or enforce provisions in their statutes or regulations for reimbursement of HCV screening, six states have statutes requiring or recommending offering a screening test. Actions in other states have largely been symbolic, with signed resolutions and proclamations to create awareness of HCV testing in "baby boomers" and other at-risk populations.

California, Connecticut, Massachusetts, and Washington require primary care physicians to offer HCV screening to anyone born between 1945-1965. New York goes a step further and requires offering testing in in-patient facilities, outpatient facilities, and in the emergency department.

Colorado recommends health care providers offer HCV screenings to patients born between 1945-1965, but does not require reimbursement by payers. The statute only applies to services rendered by a primary care physician and is limited to patients not previously screened, not currently being treated for a life-threatening illness, and not lacking capacity to consent to a screening test.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

None

Prior Board Action

June 2017, approved the revised policy statement "Bloodborne Pathogens in Emergency Medicine" (which includes HCV); revised and approved April 2011, April 2004, and October 2000 with the revised title, "Bloodborne Infections in Emergency Medicine;" originally approved September 1996 with the title "HIV and Bloodborne Infections ion Emergency Medicine."

Background Information Prepared by: Adam Krushinskie, MPA
Reimbursement Manager

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

2017 Council Meeting
Reference Committee Members

Reference Committee C
Emergency Medicine Practice
Resolutions 42-55

John H. Proctor, MD, MBA, FACEP (TN), Chair
Enrique R. Enguidanos, MD, FACEP (WA)
Heather A. Heaton, MD, FACEP (MN Alt)
Marianna Karounos, DO, FACEP (NJ Alt)
Michael D. Smith, MD, MBA, CPE, FACEP (LA Alt)
James M. Williams, DO, MS, FACEP (TX)

Margaret Montgomery, RN, MSN
Loren Rives, MNA

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: 42(17)

SUBMITTED BY: Arizona College of Emergency Physicians

SUBJECT: ACEP Policy Related to Cannabis

PURPOSE: Directs 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.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, "Cannabis use remains a critical issue in the United States"[1]; and

WHEREAS, Although some may argue the untoward consequences of broadened availability of medical cannabis (such as accidental ingestion by children and others) is increasing, that could be said of any medication and fortunately most medical cannabis formulations have relatively low toxicity; and

WHEREAS, There are no legitimate medically recognized uses of marijuana, cannabis, synthetic cannabinoids, and similar substances in emergency care; and

WHEREAS, There is now sufficient evidence regarding the untoward negative medical, social, societal and economic impact of non-medical (e.g. recreational) use of cannabis and related compounds[1, 2, 3, 4, 5, 6]; and

WHEREAS, The legalization, decriminalization, and efforts to promote the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances has resulted in broader availability leading to untoward long-term effects (such as transition to more serious illicit substance abuse) and increased toxicity due to various enhanced production techniques[1, 2, 3, 4, 5, 6] ; therefore be it

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.

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/

Background

This resolution calls for the College to not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and to not support the non-medical use of marijuana, cannabis, synthetic cannabinoids, and similar substances.

The American Academy of Pain Medicine in their 2013 policy, "Position on Research into the Use of Cannabinoids for Medical Purposes," states: "The lack of rigorous scientific and clinical research leave both physicians and patients alike at a disadvantage when considering the potential risks and benefits of cannabinoids as medicine…." The AAPM does not have a policy on participation in a pain management program and concurrent use of cannabinoids.

The AMA policy, "Cannabis for Medicinal Use H-95.952," …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. "…the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods ... 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."

The AMA policy, "Cannabis - Expanded AMA Advocacy D-95.976," supports education of the media and legislators on the health effect of cannabis, urges legislatures to delay initiating full legalization of marijuana use until there is further research "on the public health, medical, economic and social consequences of use of cannabis." The policy further calls for warning labels "… on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States."

From 2009 to 2016 the College has received eleven Council resolutions related to advocacy, treatment, legalization, regulation, and decriminalization of marijuana. Nine of these resolutions were not adopted by the Council and two were referred to the Board. Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use was assigned to the Emergency Medicine Practice Committee, the Ethics Committee, the Medical Legal Committee, and the Public Health & Injury Prevention Committee to review and provide a recommendation to the Board regarding any further action on the resolution. While many supported the decriminalization of possession of small amounts of marijuana, the majority did not support ACEP addressing this issue. In June 2017, The Board approved the recommendation from these three committees to take no further action on the referred resolution.

Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED was also assigned to the Emergency Medicine Practice Committee (EMPC) to review and provide a recommendation to the Board. This resolution called for 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. In June 2017, the Board approved the committee's recommendation to take no further action on Resolveds 1, 2, and 4 and approve their recommendations for Resolved 3 (assign to the Toxicology Section or other body for additional work to address intentional intoxications and accidental exposure) 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 data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication.

Two other resolutions related to marijuana have been submitted to the 2017 Council:

- 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders
- 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board. This resolution called for 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. This resolution called for adoption and support of 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, 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.

June 2017, approved the Emergency Medicine Practice Committee's recommendations regarding Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED.to take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolveds 3 and 5.

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

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

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: 43(17)

SUBMITTED BY: AAWEP Section
Larry Bedard, MD, FACEP
Nicole Berwald, MD, FACEP
Leila Getto, MD, FACEP
Susan Haney, MD, FACEP
Bernard Lopez, MD, FACEP
Tracy Sanson, MD, FACEP
Vicken Totten, MD, FACEP
Evangeline Sokol, MD, FACEP
Mary Westergaard, MD, FACEP

SUBJECT: Expanding ACEP Policy on Workforce Diversity in Health Care Settings

PURPOSE: Expand the policy statement "Workforce Diversity in Health Care Settings" to more clearly identify the diverse groups and promote inclusion of qualified individuals with additional diverse characteristics.

FISCAL IMPACT: Budgeted committee and staff resources:

WHEREAS, Attaining diversity with well qualified physicians in emergency medicine that reflects our multicultural society is a desirable goal; and

WHEREAS, ACEP has a longstanding commitment to workforce diversity in health care settings; and

WHEREAS, ACEP currently has a Diversity & Inclusion Task Force, examining how ACEP can promote diversity and inclusion within emergency medicine by engaging colleagues, identifying and breaking down barriers, and highlighting the effects of diversity and inclusion on patient outcomes as a path to improving these outcomes;[1] and

WHEREAS, The inclusion of diversity and inclusion is an important part of ACEP's strategic plan;[2] and ACEP's Board of Directors is now working "to promote and facilitate diversity, inclusion, and cultural sensitivity" as an integral part of the ACEP strategic plan; and

WHEREAS, Current ACEP policy confines its description of workforce diversity to include qualified individuals who reflect only the ethnic and racial diversity in our nation;[3] and

WHEREAS, The ACEP Diversity & Inclusion Task Force has identified numerous additional minority groups that contribute to the diversity, resilience, well-being, and quality of patient care in emergency medicine; and

WHEREAS, The Task Force has identified five initial focus groups (age, gender, race/ethnicity, sexual orientation, and religion) but plans to pursue other groups in the future and recognizes that there are other forms of diversity that extend far beyond the obvious visual distinctions;[4] and

WHEREAS, ACEP's existing policy statement "Workforce Diversity in Health Care Settings" provides a highly visible and concise platform to both engage our membership and declare ACEP's ongoing commitment to recognizing and understanding the importance of diversity and inclusion in <u>all</u> of emergency medicine (including both academic and clinical); therefore be it

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.

References

1. Parker, Rebecca Bollinger; Stack, Stephen J; Schneider, Sandra M. Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians' Future Success. *Ann Emerg Med*. 2017; 6: 714 - 717.
2. ACEP Strategic Plan for 2017-2020, Available at: https://www.acep.org/uploadedFiles/ACEP/About_Us/About_ACEP/Strategic Plan 2017-2020 Summary.pdf. Accessed July 27, 2017.
3. ACEP Policy on Workforce Diversity in Healthcare Settings (Approved 2001; Reaffirmed 2007 & 2013): Available at: https://www.acep.org/clinical---practice-management/2017-policy-compendium. Accessed July 27, 2017.
4. Bouchard, Scott. ACEP Promotes Diversity in Emergency Medicine Through Initiatives, Task Force. *ACEP Now.* 2017; Volume 36, Issue 2, 10. Available at: http://www.acepnow.com/article/acep-promotes-diversity-emergency-medicine-initiatives-task-force/. Accessed July 27, 2017.

Background

This resolution calls for the College to expand its policy statement "Workforce Diversity in Health Care Settings" to more clearly identify the diverse groups and promote inclusion of qualified individuals with additional diverse characteristics. The draft language to amend the current policy is provided.

The College approved its first policy on workforce diversity in the health care setting in 2001. Since that time, the policy has been reaffirmed twice, and most recently in June 2013.

The Board of Directors, the Council Nominating Committee, and the Council officers, have long acknowledged the need – and their desire – for diversity and inclusion within ACEP at all levels of leadership within national ACEP and its chapters. In 2011, the Leadership Development Group (LDAG) was created to identify and mentor potential leaders within ACEP. Their role is also to serve as a resource to members and component bodies in their development of future leaders. The LDAG and the Nominating Committee are deeply committed to increasing diversity in leadership.

A Diversity Summit was convened by ACEP in April 2016 to discuss diversity and inclusion and a task force was appointed in June 2016 with the following objectives:

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

The Diversity & Inclusion Task Force has 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. They are also performing a survey to look at the diversity within current

leadership positions in the field. These will become baseline data and will be compared to data in the future as ACEP continues diversity and inclusion initiatives.

Additionally, in response to Amended Resolution 7(16) Diversity in Emergency Medicine Leadership, a Leadership Diversity Task Force was appointed with 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 the Council's 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.

The task force plans to present their recommendations to the Board of Directors in April 2018.

In the 2016-17 committee year, 14 of ACEP's 27 committees were assigned objectives addressing diversity and inclusion. Many of these objectives are specific to workplace diversity and inclusion. The Diversity & Inclusion Task Force has served as a resource to all committees as they have worked on their assigned objectives.

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 committee and staff resources.

Prior Council Action

Amended Resolution 7(16) Diversity in Emergency Medicine Leadership adopted. Directed the Board of Directors to develop strategies to increase diversity within the ACEP Council and its leadership and provide a report to the Council on effective means of implementation.

Resolution 32(05) Code of Ethics for Emergency Physicians adopted. Called for the College to expand its policy statement "Code of Ethics for Emergency Physicians" to include additional language stating that "emergency medical treatment should not be based on gender, age, race, socioeconomic status, sexual orientation, real or perceived gender identity, or cultural background."

Prior Board Action

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

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

Resolution 32(05) Code of Ethics for Emergency Physicians adopted.

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

Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice & Academics

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

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: 44(17)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Guidelines for Opioid Prescribing in the Emergency Department

PURPOSE: Encourage electronic medical record providers to incorporate easy-to-use prescription monitoring programs into their electronic medical record products; discourage mandates for screening all emergency department patients for opioid use; and promote development of national guidelines to assist emergency physicians in their practice of prescribing opioids for acute pain.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Fatal drug overdose has increased more than six-fold in the past three decades and now claims the lives of over 47,000 Americans every year and opioids, both prescription and illicit, are responsible for the majority of these deaths; and

WHEREAS, The death rate from prescription opioid-associated overdose nearly quadrupled from 1999 to 2013; and

WHEREAS, Emergency physicians should consider non-opioid and other alternative therapies; and

WHEREAS, Emergency physicians should limit the amount prescribed to less than seven days; and

WHEREAS, Emergency physicians should not prescribe long-acting opioids such as extended-release morphine or methadone unless coordinated with an outpatient provider; and

WHEREAS, Emergency physicians should not fill prescriptions for lost or missed doses of opioids; and

WHEREAS, Emergency physicians should be strongly urged to consult state-based prescription monitoring programs (PMPs); therefore be it

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.

Background

This resolution calls for the College to: encourage electronic medical record providers to incorporate easy-to-use prescription monitoring programs (PMPs) into their electronic medical record products; strongly discourage mandates for screening all emergency department patients for opioid use; and promote development of national guidelines to assists emergency physicians in their practice of prescribing opioids for acute pain.

ACEP continues to address the issues of pain management, diversion of controlled substances for non-medical purposes, and the increasing number of prescription drug overdose deaths. ACEP offers resource information for members and chapters and serves as the central repository for sharing information, such as state activities related to opioid prescribing.

The ACEP policy statement "Health Information Technology" supports emergency physician involvement in the evaluation, selection, configuration, and implementation of health information technology and emergency department information systems.

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.

This clinical policy, which is available on the ACEP Web site at http://www.acep.org/clinicalpolicies/, was highlighted in several communications to the membership, and was published in *Annals of Emergency Medicine* in October 2012. The guideline identifies some of the state and chapter activities that have already occurred related to opioid prescribing in the ED. The guideline was also distributed to all ACEP chapters and to The Joint Commission for their information.

The Emergency Medicine Practice Committee was assigned an objective for the 2016-17 committee year to "Work with the Pain Management Section to compile and develop resources for opiate free emergency departments." They have developed a template for compiling resources on a variety of alternatives to opioids for the treatment of pain in the ED. Drafts have been developed for nitrous oxide, ketamine for acute and chronic pain, trigger point injections, femoral nerve blocks, sphenopalantine ganglion blocks for migraine and buprenorphine in the ED. The plan is to format the resources into an app for easy access by members in the clinical setting. These resources will also be

available on the ACEP website. Additional resource development is planned with a focus on alternatives to opioids for the treatment of pain for patients in the ED.

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.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

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 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 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. 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

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 18(13) Creation and Federal Funding of a National Prescription Monitoring Program 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.*

Amended Resolution 29(10) Prescription Electronic Monitoring adopted.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

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

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: 45(17)

SUBMITTED BY: New York Chapter

SUBJECT: Group Contract Negotiation to End-of-Term Timeframes

PURPOSE: 1) Establish a recommendation for appropriate timeframes for initiation of contract renewal discussions and contract negotiation deadlines to end of coverage. 2) Oppose sudden, abrupt changes in contract groups without time for adequate transition and training.

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

WHEREAS, Outsourcing clinical services is increasing in United States Hospitals; and

WHEREAS, Emergency medicine is one of the top five most outsourced patient care services; and

WHEREAS, Sudden abrupt changes in clinical staff and leadership are a patient safety concern; and

WHEREAS, Sudden changes in staffing can affect the education and training of staff; therefore be it

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.

Background

This resolution calls for ACEP to establish a recommendation for appropriate timeframes for initiation of contract renewal discussions and contract negotiation deadlines to end of coverage and to oppose sudden, abrupt changes in contract groups without time for adequate transition and training

The disruptive contract transition for ED physicians at Summa Health in Akron, Ohio caused the emergency medicine community to re-evaluate the contract transition process. While such situations are relatively rare, they are nothing new. However, this particular event involved multiple EDs, including the main hospital with an emergency medicine residency program, placing patient care and the residency program in jeopardy.

In reviewing the situation and steps to prevent similar occurrences, an ACEP task force was appointed with an objective to produce an information paper outlining best practices in contract transitions as a guide to members and interested parties and to include information on realistic timelines for RFPs and preservation of the residency program with no adverse impact on the residents. The task force includes representatives from key constituencies such as: Emergency Medicine Practice Committee, Academic Affairs Committee, Democratic Group Practice Section, Council of Emergency Medicine Residency Directors, Emergency Medicine Residents' Association, an emergency physician with hospital administration experience, and a few at-large members with contract expertise. The resulting information paper will include best practices for timeframes for initiation of contract renewal discussions and will be accompanied by targeted messages for ACEP members, medical directors and group owners, and the American Hospital Association and hospital administrators.

The Board reviewed the draft information paper "ED Physician Group Staffing Contract Transition," in June 2017. The paper is being finalized based on comments provided by the Board and another draft will be distributed to the Board for review. The final information paper will be provided to the Council and will be available on the ACEP Website.

ACEP Strategic Plan Reference

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

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

The Council has discussed and adopted many resolutions regarding ED contracts. The following resolutions are germane to the situation that occurred at Summa Health.

Amended Resolution 20(00) "Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups" adopted. Directed ACEP to endorse the right to have due process provisions in contracts between physicians and hospitals, health systems, health plans and contract groups.

Amended Resolution 49(94) "Information on Contract Issues" adopted. Directed ACEP to continue efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Prior Board Action

June 2017, reviewed the draft information paper "ED Physician Group Staffing Contract Transition."

January 27, 2017, issued a statement on rapid transitions of ED contracts.

January 2017, discussed concerns regarding the residency program at Summa Health.

Amended Resolution 20(00) "Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups" adopted.

Amended Resolution 49(94) "Information on Contract Issues" adopted.

Background Information Prepared by: David A. McKenzie, CAE
Reimbursement Director

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

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RESOLUTION: 46(17)

SUBMITTED BY: California Chapter
Washington Chapter
Wilderness Medicine Section

SUBJECT: Impact of Climate Change on Patient Health and Implications for Emergency Medicine

PURPOSE: Research and develop a policy to address impact of climate change on the patient health and well-being. Utilize the policy to guide future research, training, advocacy, preparedness, migration practices, and patient care.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, There is scientific consensus that the world's climate is changing, with 2016 being the warmest year in history, and future projections indicating further acceleration in these changes; and

WHEREAS, Climate change will likely affect human health in a number of indirect and direct ways, including extreme weather events, shifting vector-borne epidemics, rising sea levels, resource scarcity, population displacement, and contaminants in air, water, and soil; and

WHEREAS, Such change has been shown to increase the incidence of many conditions seen in the ED, including exacerbations of respiratory, cardiovascular, and renal disease; mental health emergencies; shifting infectious disease burden; injuries from extreme weather; and trauma from interpersonal violence; and

WHEREAS, The patients who rely disproportionately on the ED – those at the extremes of age, the socially marginalized, and patients with multiple comorbidities – are most vulnerable to the evolving effects of climate change; and

WHEREAS, Emergency Medicine providers, by virtue of our craft, and the fact that we are highly represented among those who manage the nation's emergency care infrastructure – from prehospital systems, to disaster response activities, to health system coordination – will be serving at the front lines of catastrophic extreme weather events, newly emerging and/or spreading infectious diseases, and population displacement associated with a changing climate; and

WHEREAS, Several other prominent medical organizations including, but not limited to, the World Health Organization, the American Medical Association, the American College of Physicians, the American Academy of Pediatrics, the American Lung Association, and the American Public Health Association have put forward policy statements regarding the impacts of climate change on human health, safety, and security; therefore be it

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.

Background

This resolution calls for the College to 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 to guide future research, training, advocacy, preparedness, migration practices, and patient care.

Climate change can be a controversial topic. However, both domestic and global organizations are currently addressing the effect of climate change on public health, disaster response, disease prevalence and clinical implications. This involves research and response to direct and indirect medical impact related to climate change.

The World Association for Disaster and Emergency Medicine (WADEM) released the WADEM Climate Change Position Statement on April 24, 2017. It states; "Climate change is affecting disaster risk and disaster impact. WADEM recognizes climate change as an issue of global concern. It is WADEM's responsibility to support the capacity of emergency management, humanitarian and health professionals to address the disaster impacts of climate change." The statement also supports "cooperation among and between multidisciplinary professionals involved in research, education, management and practice in pre-hospital, emergency, public health and disaster care." The final recommendations include:

- Recognizing the importance of climate change due to its influence on frequency and severity of natural hazards, and on disasters of natural, public health related, and conflict causes;
- -Recognizes all disaster and emergency professionals and organizations adopt a risk-based approach to emergency planning that prepares for and enhances resilience to climate change effects…"

The U.S. Global Change Research Program established by Presidential Initiative in 1989 and mandated by Congress in 1990 to "assist the Nation and the world to understand, assess, predict and respond to human-induced and natural process of global change." Their 2016 report, The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment, examines climate change on human health in the US including temperature-related death and illness; air quality impacts; vector-borne diseases; water-related illness; food safety, nutrition and distribution; mental health and well-being and populations of concern.

The American Medical Association (AMA) 2014 policy, Global Climate Change and Human Health H-135.938, "supports the findings for the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change …..These climate changes will create conditions that affect public health, with disproportional impact on vulnerable populations…" Further the 2016 AMA policy, AMA Advocacy for Environmental Sustainability and Climate H-135.923, calls for the AMA to support efforts "to promote environmental sustainability and other efforts to halt global climate change." The AMA also reaffirmed their policy, Stewardship of the Environment H-135.973, that "…encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; …encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation."

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Patrick Elmes, EMT-P
EMS & Disaster Preparedness Manager

Margaret Montgomery, RN, MSN
Practice Management Manager

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, 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: 47(17)

SUBMITTED BY: Jack Handley, MD, FACEP
Charles Pilcher MD FACEP

SUBJECT: Improving Patient Safety Through Transparency in Medical Malpractice Settlements

PURPOSE: 1) Develop a policy to reduce medical errors 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 and others as appropriate. 2) Support elimination of non-disclosure clauses in pre-trial settlements of medical malpractice lawsuits. 3) Report progress to the 2018 Council.

FISCAL IMPACT: Budgeted staff resources and approximately $4,000 for analysis of the NPDB data (if the data is available).

WHEREAS, Improving patient safety requires the elimination of mistakes; and

WHEREAS, Our most egregious mistakes become medical malpractice lawsuits; and

WHEREAS, Our least defensible lawsuits are settled before trial, almost always with a non-disclosure or confidentiality clause; and

WHEREAS, A confidentiality clause generally prohibits only the disclosure of the parties involved and the amount of the settlement yet is interpreted as a "gag order" that inhibits the disclosure of all elements of a case; and

WHEREAS, "Mistakes are meant for learning, not repeating," and medical malpractice lawsuits – won or lost – are a valuable resource for physician education and improvements in patient safety; and

WHEREAS, Patients report medical errors and pursue lawsuits "so that this won't happen to someone else" as often as they do seeking compensation for their loss; and

WHEREAS, Confidential pre-trial settlements of such lawsuits suppress both the learnings available from these events and the injured patient's goal to improve safety for other patients; and

WHEREAS, To improve safety, other industries have taken a position of transparency and active disclosure of defects or errors that, if not disclosed, would lead to subsequent harm to others, e.g., the automotive industry (via the NHTSA), the aviation industry (via the NTSB), and product manufacturers (via the CPSC); and

WHEREAS, Allowing physicians to learn from pre-trial settlements will 1) improve patient safety by reducing the number of mistakes and 2) reduce the cost and stress of malpractice lawsuits by preventing error in the first place; therefore be it

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.

Background

This resolution directs ACEP to develop a policy to reduce medical errors 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. It further asks that ACEP actively support the elimination of non-disclosure clauses in pre-trial settlements of medical malpractice lawsuits. It asks for ACEP to report progress on this objective at the ACEP annual meeting in 2018.

The primary question is whether the appropriate data is available.

The National Practitioner Data Bank (NPDB) requires reporting of any "payment for the benefit of a health care practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or judgment for medical malpractice against that practitioner." Individuals who pay their settlements out of personal funds do not need to report.

The data is available through a public use data file. This free file contains 1,317,232 cases, which represents reported cases since September 1, 1990. The data file is updated quarterly. Each file has up to 54 variables that include year of the report, state, age of practitioner, specific malpractice allegation, severity of alleged malpractice injury, payment amount, adverse action classification, basis for action, etc. NPDB also codes for specialties (among them emergency medicine) but does not provide that information in the public use data file. This information may be available through a request for specific data. Because of the size of the file, it requires SPSS or other statistical software. However, the information available is unlikely to provide the details of the case necessary to provide the information needed to improve care.

The majority of settlements involve a non-disclosure agreement which limits access to the case details. Access to this data is limited to insurance companies, some of whom have analyzed their individual databases.

A private company, MedPro Group produces a free annual report Malpractice Claims Data and Risk Analysis. Its 2016 report analyzes the aggregated data from emergency medicine claims opened between 2005 and 2014, in cases where an emergency physician was the primary provider responsible for the service. The report provides information around claim type (diagnosis related, medication related, treatment related, other), and specific diagnosis (infection, cardiac, etc.). It provides information on key risk factors such as poor patient assessment, failure to reevaluate prior to discharge and poor tracking systems that prevent post-discharge tests from reaching the patient or physician. The report provides detailed information on each of these factors along with risk mitigation strategies.

Another company, CRICO Strategies, provides similar reports broken down by the type of error. Its report for emergency medicine analyzes 1300 medical malpractice cases and provides information about the errors made and strategies for mitigating risk. Similar reports are available from Physician Insurers Association of America, which includes demographic data, and The Doctor's Company. In 2013, the Medical-Legal Committee compared data from CRICO, The Doctor's Company, and Physician Insurers Association of America. The data was often quite general and did not permit a granular analysis. The report provided some information about the patient condition (chest pain, abdominal pain, etc.), the allegation (missed/delayed diagnosis, medication related, etc.), and claim (history and physical exam, ongoing monitoring of clinical status, etc.).

If ACEP can obtain permission to receive a report from NPDB specific for emergency medicine, the report would likely need to be outsourced for analysis on a quarterly basis.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Emergency Care
Objective E – Achieve meaningful liability reform at the state and federal levels.

Goal 2 – Enhance Membership Value and Member Engagement
Objective C – Promote member well-being and improve resiliency.

Fiscal Impact

Budgeted staff resources and approximately $4,000 for analysis of the NPDB data (if the information is available).

Prior Council Action

None

Prior Board Action

October 2013, reviewed the information paper, Summary of Malpractice Claim Data & Trends from Three Sources.

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

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

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American College of Emergency Physicians®
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RESOLUTION: 48(17)

SUBMITTED BY: Forensic Medicine Section
William Green, MD, FACEP
Michael L. Weaver, MD, FACEP
Ralph Riviello, MD, FACEP
Heather Rozzi, MD, FACEP
William Smock, MD

SUBJECT: Non-Fatal Strangulation

PURPOSE: Work with other organizations to develop educational resources and programs related to evaluation and management of non-fatal strangulation, develop a policy statement on its seriousness, and develop a clinical practice guideline.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Intimate partner violence (IPV) and sexual assault (SA) are serious public health problems; and

WHEREAS, Many IPV and SA victims seek treatment in the emergency department; and

WHEREAS, Non-fatal strangulation is a form of asphyxia characterized by external pressure on the neck, closing the blood vessels or airway; and

WHEREAS, Studies indicate that 23-68% of female domestic violence victims and up to 35% of sexual assault victims will experience strangulation; and

WHEREAS, Strangulation is an indicator of the escalation of violence and associated with increased risk of serious injury and even death in cases of IPV; and

WHEREAS, Strangulation has been identified as one of the most lethal forms of IPV and SA; and is used to exert power over a victim by taking from them control of their own body; and

WHEREAS, When strangled, unconsciousness and anoxic brain injury may occur within seconds and death within minutes; and

WHEREAS, Oftentimes, even in fatal cases, there is no external evidence of injury from strangulation, yet because of underlying brain damage due to hypoxia during the strangulation assault, victims may have serious internal injuries or consequences, including death, even days, or weeks later; and

WHEREAS, Many emergency medicine providers lack specialized training and knowledge to identify the signs and symptoms of strangulation, often only focusing on visible or airway injuries, and to properly evaluate and manage the non-fatal strangulation patient. This lack of training has led to the minimization of this type of violence, exposing victims to potential serious, short- and long-term health consequences, permanent brain damage, and increased likelihood of death; and

WHEREAS, There are no specific guidelines or recommendations regarding the emergency department management of the non-fatal strangulation victim including, history taking, physical examination, radiographic imaging, treatment, disposition, and documentation; therefore be it;

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.

Background

This resolution calls for ACEP to work with other pertinent organizations to develop educational resources and programs for evaluation and management of non-fatal strangulation, and for ACEP to develop a policy statement on the seriousness of non-fatal strangulation and a clinical practice guideline for the evaluation and treatment of non-fatal strangulation in the emergency department.

The "2016 Model of the Clinical Practice of Emergency Medicine," developed by seven emergency medicine organizations, lists core patient conditions that present to emergency departments: https://www.acep.org/Search.aspx?filter=acep&searchtext=Model%20of%20the%20Clinical%20practice%20of%20Emergency%20Medicine&folderpath=ACEP/Clinical%20and%20Practice%20Management/policy%20statements/. Item 18.1.9.4 Neck trauma, strangulation is listed as a disorder for which patient acuity could be critical, emergent, or lower acuity. Patient acuity level is fundamental to determining the priority and sequence of tasks to manage the patient.

Clinical signs and symptoms of non-fatal strangulation vary from patient to patient and may not appear for 24-36 hours, while the absence of external neck injuries does not exclude strangulation, all of which can make it difficult to identify this injury.

As an adjunct to the ACEP policy statement, "Management of the Patient with the Complaint of Sexual Assault," ACEP's Forensic Medicine Section prepared the handbook, "Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient" that is available on the ACEP Web site, https://www.acep.org/Clinical---Practice-Management/Management-of-the-Patient-with-the-Complaint-of-Sexual-Assault/. Chapter 16 of the handbook is titled "Strangulation." This chapter addresses the challenges, physiology, mechanisms, definitions, pathophysiology, clinical symptoms and caveats, clinical findings, clinical evaluation, management, and documentation related to strangulation. There are also examples of a documentation chart for non-fatal strangulation cases, medical release form and questions to ask the victim.

The International Association of Forensic Nurses has developed a position statement on non-fatal strangulation and a documentation toolkit; both available on their Web site: http://www.forensicnurses.org/page/STOverview. The Emergency Nurses Association has a Topic Brief, "An Overview of Strangulation Injuries and Nursing Implications."

There is a paucity of research evidence related to the evaluation and treatment of non-fatal strangulation in the emergency department. A review of PubMed revealed two useful studies (one a cross-sectional study and the other a case-control study) related to the etiology of non-fatal strangulation. Further research is needed to provide evidence for the development of an evidence-based clinical practice guideline on this topic.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective B – Provide robust communications and educational offerings, including novel delivery methods.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Rhonda Whitson, RHIA
Clinical Practice Manager

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

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RESOLUTION: 49(17)

SUBMITTED BY: Alaska Chapter
Government Services Chapter
New Mexico Chapter
Ohio Chapter
Oregon Chapter
South Carolina College of Emergency Physicians
Washington Chapter

SUBJECT: Participation in ED Information Exchange and Prescription Drug Monitoring Systems

PURPOSE: Collaborate with Veterans Health Affairs, the Department of Defense, and Indian Health Services and potentially legislatures regarding participation in state PDMPs and real-time electronic exchange of patient information.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Patients of the Veterans Health Affairs (VHA), Department of Defense (DoD), and Indian Health Services (IHS) deserve the constant, quality care where ever they access emergency care; and

WHEREAS, The VHA and DoD provide care for nearly 20 million beneficiaries and IHS an additional 2.2 million beneficiaries; and

WHEREAS, Prescription Drug Monitoring Programs (PDMPs) have become prevalent throughout much of the country; and

WHEREAS, Both health and financial benefits have been realized with real time Emergency Department information sharing systems that push data (such as care plans, safely concerns, ED utilizations, and in some state PDMP information) to emergency departments; and

WHEREAS, Real time information sharing of care plans and ED utilization is becoming increasingly prevalent and is now legislated or required in numerous states including Washington, Oregon, Alaska, and New Mexico; and

WHEREAS, DoD, VHA, and IHS emergency departments do not currently all consistently participate in PDMPs or ED information exchange programs even where it is state-mandated; and

WHEREAS, DoD, VHA, and IHS have spent significant time and money to combat the opioid crisis and create care plans for their beneficiaries that are not available outside their systems; and

WHEREAS, Beneficiaries of DoD, VHA, and IHS still may go to any emergency department and these hospital systems are key players in the emergency care environment; therefore be it

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.

Background

The resolution calls upon the College 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.

Currently, 49 states (Missouri being the exception) have prescription drug monitoring programs. Because state governments do not have jurisdiction over the above referenced federal entities, state laws related to PDMPs and electronic health records do not apply to those entities. This has created information gaps relative to patients receiving care through those entities.

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. EDIE is currently available in 13 states and CMT continues to pursue participation in other states.

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.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

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

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. Directed ACEP to work with other stakeholders to create a best practice-based, federally funded, nationally accessible PDMP and oppose mandatory query of PDMP data for ED patients.

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

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

April 2016, approved a corporate sponsor agreement and exclusive partnership with CMT for promotion of the implementation of a nationwide Emergency Department Information Exchange Program.

October 2014, reviewed the information paper "Health Information Exchange in Emergency Medicine" and it was published in *Annals of Emergency Medicine.*

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

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

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: 50(17)

SUBMITTED BY: Hawaii Chapter

SUBJECT: Promoting Clinical Effectiveness in Emergency Medicine

PURPOSE: Create a Clinical Effectiveness Committee responsible for identifying, assessing, and promoting evidence-based cost-effective emergency medicine practice.

FISCAL IMPACT: 50% FTE staff, in-person meeting at *Scientific Assembly.* $100,000 recurrent annual expense.

WHEREAS, The American College of Emergency Physicians (ACEP) is a leader amongst medical specialties and an advocate for our patients and cost-effective health care; and

WHEREAS, The Organization for Economic Cooperation and Development (OECD) reports that in 2016 the United States expenditure on health, as a percent of gross domestic product, was 17.2% (OECD, 2017); and

WHEREAS, ACEP has previously investigated and commented on value based care as per the Value Based Emergency Care (VBEC) Task Force (2009) (ACEP, 2009); and

WHEREAS, ACEP partnered with Choosing Wisely in 2013 to create a list of tests and procedures that may not be cost effective (ACEP, 2013); and

WHEREAS, Other medical organizations maintain recommendations that impact emergency physicians such as the "Appropriateness Criteria" published by the American College of Radiology (ACR, 2017); and

WHEREAS, ACEP has 27 committees, none of which are focused on cost effective quality care (ACEP, 2016); therefore be it

RESOLVED, That ACEP create a Clinical Effectiveness Committee that is responsible for identifying, assessing, and promoting evidence-based, cost-effective emergency medicine practices.

References

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ACEP. (2013, October 14). *ACEP Announces List of Tests As Part of Choosing Wisely Campaign.* Retrieved July 19, 2017, from https://www.acep.org/Clinical---Practice-Management/ACEP-Announces-List-of-Tests-As-Part-of-Choosing-Wisely-Campaign/.

ACEP. (2016). *ACEP Committees.* Retrieved July 19, 2017, from https://www.acep.org/Content.aspx?id=23014.

ACR. (2017). *ACR Quality-Safety/Appropriateness-Criteria.* Retrieved July 19, 2017, from https://www.acr.org/Quality-Safety/Appropriateness-Criteria.

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Background

This resolution calls for ACEP to create a new Clinical Effectiveness Committee responsible for identifying, assessing, and promoting evidence-based cost-effective emergency medicine practice.

Cost effectiveness analysis weighs the benefits of a treatment or testing modality for a population. This rigorous analysis includes factors such as the cost and outcome of screening (identification of false positives and false negatives), treatment and mortality. It is a very effective tool, when done with precision, to guide clinicians and determine best practices for a population. Such cost effective analysis has led to recommendations by the U.S. Preventive Services Task Force for prostate cancer screening.

The American College of Radiology has embarked on a high profile cost effectiveness analysis for imaging with their Appropriateness Criteria. Using large panels of radiologists and representatives from stakeholder organizations, ACR has developed cost effective approaches to many common conditions. ACEP has participated in several of these panels**.** The results of those analyses have formed the basis of ACR Select, which is now required in some hospitals for ordering images.

ACEP's clinical policies have long been one of the more popular products of the College, and among the most frequently downloaded documents. These policies are created by an expert panel who review and grade the literature and answer specific question regarding preferred practice guidelines. These reviews may cover effectiveness, but rarely consider cost as a variable.

Though not a formal cost effectiveness program, the Emergency Quality Network (E-QUAL) offers analysis and recommendations for cost effective treatment. The Network offers learning collaboratives in three main areas: sepsis, reducing avoidable imaging (low back pain, minor head injury, pulmonary embolism, and renal colic) and low risk chest pain. The network offers a toolkit with best practices and sample guidelines, as well as access to benchmarking data. It provides free CME and meets the CMS Improvement Activity requirements of the new CMS Quality Payment Program (MIPS). Any ACEP member may join the network for free. The network is financed through a CMMI grant. Additional modules may be added. The E-QUAL Network may be a reasonable alternative to a cost effectiveness committee.

Cost effective analysis may provide a basis to control cost while improving outcomes. However, the analysis is based on what is best for a population, not necessarily what is best for the individual. For example, the recommendations from the US Preventive Services Task Force regarding prostate cancer screening will reduce the number of unnecessary biopsies and the morbidity and even occasional mortality associated with false positive screenings. However, the individual whose cancer was detected in situ may view this recommendation differently. It is said that every test (or treatment) has a 'U curve' of effectiveness. On the right side of the U are the individuals who benefit from the test. In the middle are those who neither benefit nor are harmed. On the left side of the U are the individuals who are harmed, either by the test/procedure itself, or by unnecessary follow-up testing. Cost effectiveness analysis attempts to analyze this U curve.

ACEP has made some recommendations to reduce cost through its Choosing Wisely recommendations. Though not based primarily on true cost-effectiveness criteria, these are recommendations to reduce testing. While the literature was thoroughly reviewed by the expert panel, final selection was based on consensus.

A cost effectiveness program would require effort by ACEP similar to what is expended on clinical policies. Currently, the clinical policies process requires two FTE ACEP staff with an eventual output of 6-8 clinical policies per year.

ACEP Strategic Plan Reference

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

Fiscal Impact

50% FTE staff member and in-person meeting at *Scientific Assembly.* Approximately $100,000 recurrent annual cost.

Prior Council Action

Resolution 15(12) Choosing Wisely Campaign not adopted. Called for the College to formally join the Choosing Wisely Campaign.

Prior Board Action

June 2014, approved the second list of ACEP Choosing Wisely recommendations (6-10)

June 2013, approved ACEP Choosing Wisely recommendations (1-5)

June 2012, approved the recommendation from the review panel to not join the Choosing Wisely campaign.

October 2011, approved the action taken to decline the invitation to join the Choosing Wisely campaign.

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

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

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RESOLUTION: 51(17)

SUBMITTED BY: Texas College of Emergency Physicians

SUBJECT: Retirement or Interruption of Clinical Emergency Medicine Practice

PURPOSE: 1) Study and evaluate mechanisms to support practicing emergency physicians to recognize potential physical and emotional limitations to clinical practice, educate members about alternatives and opportunities for temporary interruption of active clinical practice including mechanisms for reintegration back into clinical practice, and support members considering career transitions including retirement. 2) Develop resources and communicate career transition opportunities, including support for members who believe they are being restricted from practice for discriminatory reasons as regulated by established federal equal employment opportunity discrimination laws.

FISCAL IMPACT: Budgeted staff resources and $20,000 for in-person task force meeting.

WHEREAS, Emergency Medicine is a highly regarded and vitally important clinical specialty and the practice of Emergency Medicine requires physical stamina, a broad range of clinical knowledge and the cognitive ability to immediately provide essential procedural skills in a busy, sometimes chaotic, workplace; and

WHEREAS, The physical and intellectual demands on Emergency Physicians require that individual practitioners know their limits and recognize when, for physical, cognitive, emotional or other reasons, they may no longer be prepared to handle, whether for short term or extended term, the demands required of a clinical shift; and

WHEREAS, The Emergency Medicine workforce has a bimodal distribution with a more experienced, longer serving, peak of physicians nearing the traditional retirement age, which may raise questions regarding this group's physical stamina and cognitive veracity; and

WHEREAS, Discrimination based purely upon physical characteristics which cannot be controlled by the individual, including race, ethnicity and age, is not acceptable in the American workplace in general and thereby extends to the Emergency Medicine workforce; and

WHEREAS, There are a variety of reasons individuals may temporarily suspend their clinical practice or choose to permanently retire from clinical practice; therefore be it

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.

Background

This resolution asks ACEP to study and evaluate mechanisms to support practicing emergency physicians to 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. In addition, it asks ACEP to 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.

Emergency medicine developed as a specialty in the 60s and 70s, a time when medical school enrollment increased, the Baby Boomers were in college and graduate school, and resident education was interrupted by the doctor draft during the Vietnam War. At that same time, emergency departments went from being staffed by moonlighting residents – or with nurses who called in physicians from home as needed – to full-time professional staff, some of whom had actually completed EM residencies. When the specialty was recognized in 1979, there was a bolus of physicians who grandfathered into the specialty. That bolus of individuals is now at or approaching traditional retirement age. Like other physicians of their era, they continue to work, and will continue for a longer period of time with support from their specialty and colleagues.

ACEP has developed several resources for the aging physician. Early resolutions recognized that some physicians would be impaired or disabled for a period of their career, and that the College should support these individuals and their return to work. A reduced cost retirement membership category was created in 2008 in the hopes of retaining those individuals as members of the College.

In 1990 (reaffirmed in 1994, 1999, 2006, 2013), the College issued a policy statement on physician impairment. In that policy, ACEP promotes early intervention and treatment for the impaired physician. It also supports assistance in returning the physician to practice once recovered and licensed.

In 2009, and reaffirmed in 2015, the College developed a policy on the needs of physicians in pre-retirement years. The policy recognized that these physicians could continue to contribute, but could make a greater contribution with some considerations to the practice environment such as reducing circadian stress, reducing night shifts, additional recovery time after night shifts, shorter shift length, and shift to administrative/teaching duties.

In 2006, the Well-Being Committee formed the Aging Physician Task Force with the dual aims of enhancing the careers of emergency physicians in the latter stages of their professional lives and facilitating the transition of emergency physicians from active practice to semi-or full retirement. In 2010, ACEP published "A Primer for Emergency Physicians in Pre-retirement Years" which is still available on the website. This primer contains sections on transitioning to retirement, dealing with partnership concerns, managing shift work/stress/burnout, health screening/diet/exercise, as well as opportunities for volunteer work, travel and education. There is a checklist at the end of the document that allows the user to outline their personal journey to retirement.

In 2006-07, ACEP funded a section grant to survey 1,000 ACEP members over the age of 55. The response rate was 80%. The study found a significant decrease in the ability of respondents to manage the stress of practice (recovery from night shifts, less ability to manage heavy patient loads, emotional exhaustion at the end of shift, etc.). Additionally, about half of the respondents expressed concerns about financial preparedness and loss of identity after retirement. Despite the perceived toll of clinical shifts, the vast majority of respondents believed they were as competent (or even more competent) in handling complicated clinical problems, performing common procedures, and empathizing with patients as they were in the past. (Goldberg R, Thomas H, Penner L. Issues of concern to emergency physicians in pre-retirement years: a survey. *J Emerg Med*. 2011;40:706-713)

This survey led to the development of the ACEP policy statement, "Considerations for Emergency Physicians in Pre-Retirement Years." (approved in 2009 and reaffirmed in 2015). This policy outlined accommodations that may be appropriate for emergency physicians in the pre-retirement years of their career.

ACEP recently partnered with the Society for Academic Emergency Medicine (SAEM) and the American Board of Emergency Medicine (ABEM) to conduct a focused survey of emergency physicians who are nearing or at retirement age, or who have already transitioned from clinical practice. This survey, conducted by Gloria Kuhn, DO, FACEP,

assessed respondents' emotional and financial preparedness for retirement as well as explored their post-retirement activities. The study has been published in the *American Journal of Emergency Medicine.*

Resolution 46(15) Transitioning Out of Medical Practice was assigned to the Well-being Committee (WBC). The WBC reviewed the Emergency Medicine Practice Committee's paper on careers outside of the emergency department and additional information on opportunities in education, subspecialties, and event medicine. The revised information paper, "Hospital Employment and Careers Outside the ED" is available on the ACEP Website.

The new Wellness Book has an excellent chapter on retirement. The Well-being Committee also has a list of resources for physicians throughout various stages of their career and life.

In response to Amended Resolution 6(16) Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians, another Aging Physician Task Force was created, in collaboration with the American Board of Emergency Medicine, to assess resources and provide recommendations to aid in the assessment of competency and improve practice for older physicians. A report from the task force is expected by October 2017 and will be made available to the Council.

Nearly half of all physicians in the U.S. are over the age of 50. As a result of an aging workforce, some employers have begun to assess the competency of older physicians. Several programs are available, though few are evidence based. Mandatory assessments based solely on age raise questions of age discrimination.

In 2015, the American Medical Association (AMA) began a process to develop guidelines and screening modalities to assess the ability of older physicians to continue to practice. Their Council on Medical Education has produced research that demonstrates that physicians beyond the age of 60 can demonstrate some 'differences in performance'. In addition, the report suggests that older physicians have a harder time incorporating new knowledge into practice. Clearly physicians are affected by aging to different degrees and show cognitive decline at different ages. Therefore, the AMA suggests that some type of cognitive and physical screening begin between the ages of 65 and 70.

Age is not the only factor that can affect performance. Prolonged absences from practice, or transitioning to a new practice setting (complex pediatric patients, low resource rural practice), may require education and procedural practice. ACEP provides several courses for physicians re-entering the workforce, or who need additional procedural practices. Among these are the *Emergency Medicine Academy*, cadaver and other skill labs at *Scientific Assembly,* and the *Advanced Pediatric Assembly*.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement
Objective A – Increase total membership and membership retention.
Objective C. Promote member well-being and improve resiliency.

Fiscal Impact:

Budgeted staff resources and $20,000 for in-person task force meeting.

Prior Council Action

Amended Resolution 6(16) Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians adopted. Called for ACEP to create a task force to study issues specific to senior/late career emergency physicians.

Resolution 46(15) Transitioning Out of Medical Practice adopted. It directed ACEP to develop and provide resources for members transitioning out of the clinical practice of emergency medicine.

Prior Board Action

Amended Resolution 6(16) Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians adopted.

June 2016 and November 2015, reviewed the information paper, "Hospital Employment and Careers Outside the Emergency Department."

Resolution 46(15) Transitioning Out of Medical Practice adopted.

June 2015, approved the policy statement, "Considerations for Emergency Physicians in Pre-Retirement Years," originally approved June 2009.

October 2013 approved the policy statement, "Physician Impairment." Previously approved October 2006; Reaffirmed September 1999; Approved April 1994, Originally approved September 1990.

March 2010, reviewed the information paper, "A Primer for Emergency Physicians in Pre-retirement Years."

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Associate Executive Director, Policy, Practice, & Academics

Reviewed by: James Cusick, MD, FACEP, Speaker
John McManus, MD, 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: 52(17)

SUBMITTED BY: Donald Stader, MD, FACEP
Erik Verzemnieks, MD

SUBJECT: Support for Harm Reduction and Syringe Services Programs

PURPOSE: Endorse syringe services programs, promote access to these programs for people who inject drugs, educate members on harm reduction techniques and the importance of EDs partnering with local syringe services programs for patients who inject drugs.

FISCAL IMPACT: Budgeted committee and staff resources. Other costs are dependent on the extent of the promotional and educational activities.

WHEREAS, The opioid epidemic has become a major cause of preventable death in America, with 33,000 Americans dying of opioid overdose in 2015 and overdose from all drugs now becoming the number one killer of Americans under the age of 50; and

WHEREAS, Heroin use and IV drug use has grown exponentially with the opioid epidemic causing increasing mortality from IV opioid use (12,000 deaths in 2015) and dramatic increases in morbidity (Hepatitis C, HIV, Soft Tissue Infections, Endocarditis, Epidural abscess, etc.) from poor injection technique and sharing injection materials; and

WHEREAS, According to the Centers for Disease Control and Prevention (CDC) injection drug use accounts for one in ten new HIV diagnosis and is the leading cause of new Hepatitis C virus (HCV) diagnosis which, according to the CDC, have increased 300% in the last seven years; and

WHEREAS, Of people who inject drugs, an estimated 40% share syringes and injection materials; and

WHEREAS, Every case of HIV, Hepatitis C, soft tissue infection and overdose death is nearly 100% preventable with good injection technique and practices among people who inject drugs (PWID); and

WHEREAS, Emergency Departments and clinicians are on the front lines of the opioid and IV drug use epidemic, caring for most patients who overdose or experience complications of IV drug use; and

WHEREAS, Most emergency clinicians have never learned harm reduction practices and are not closely partnered with Syringe Services Programs (SSPs) in their communities; and

WHEREAS, SSPs provide sterile needles, syringes, and other drug preparation equipment and disposal services, along with risk reduction counselling, HIV and viral hepatitis screening and treatment referral, substance use disorder counseling and treatment referral, and recovery support services; and

WHEREAS, SSPs have not been found to increase drug use; and

WHEREAS, SSPs are supported by the CDC, World Health Organization, American Civil Liberties Union, and the American Medical Association and are identified by the Surgeon General of the United States as an effective manner to combat disease transmission and drug abuse; therefore be it

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.

Background

This resolution calls for the College to endorse syringe services programs, promote access to these programs for people who inject drugs and to educate members on harm reduction techniques and the importance of EDs partnering with local syringe services programs for patients who inject drugs.

On its HIV and Injection Drug Use web page, the CDC states that HIV diagnosis among persons who inject drugs (PWID) declined 48% from 2008 to 2014, but injection drug use (IDU) in nonurban areas has created prevention challenges and new populations are at-risk. In 2015, 6% of the 39,513 diagnoses of HIV in the US were attributed to IDU. The number of new cases of hepatitis C increased from 16,500 in 2011 to 30,500 in 2014. Most of the new cases are attributed to IDU.

According to the CDC, syringe services programs (SSP) are community-based programs that provide comprehensive harm-reduction services which can include sterile needles, syringes, and other injection equipment; safe disposal containers for needles and syringes; HIV testing and linkage to treatment; education about overdose prevention and safer injection practices; referral for substance use disorder treatment; referral to medical, mental health and social services and tools to prevent HIV, STDs and viral hepatitis. The CDC website noted that persons who inject drugs can access sterile needles and syringes through SSPs and through pharmacies without a prescription. Laws vary by state concerning over-the-counter sales of syringes but barriers exist even in states where such sales are legal. A study published in the *Journal of the American Pharmacist Association* in January 2015 found that only 21% of 248 attempts to purchase syringes at community pharmacies in two California counties were successful, despite the fact that the law allows anyone 18 years or older to purchase syringes from a community pharmacy without a prescription. One of the study authors noted that there appeared to be "a widely held belief among pharmacists and staff that selling syringes to people who inject drugs promotes drug use."

In February 2011, the Health and Human Services Department determined that there is scientific evidence supporting the important public health benefits of SSPs, and that a demonstration needles exchange program would be effective in reducing drug abuse and the risk of HIV infection among injection drug users. Federal funding for states and local communities is available under limited circumstances to support certain components of SSPs.

The Council and the Board adopted Resolution 21(16) Best Practices for Harm Reduction Strategies. It directed ACEP to 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 to provide educational resources to ED providers for improving direct referral of substance use disorder patients to treatment. This resolution was assigned to the Emergency Medicine Practice Committee to work with the Public Health and Injury Prevention Committee to "Develop an information paper on the transition of care for patients seen in the ED with substance abuse issues (eg, "warm handoffs," sobering centers, prescribing Suboxone etc.)." The information paper will be submitted to the Board for review in October. The focus of this paper is on screening for opioid use disorders, ED management of withdrawal, and transitioning patients out of the ED, including medication assisted therapy and linkages to treatment.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective A – 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. Other costs are dependent on the extent of the promotional and educational activities.

Prior Council Action

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.

Prior Board Action

June 2017, approved the revised policy statement "Bloodborne Pathogens in Emergency Medicine;" previously titled "Bloodborne Infections in Emergency Medicine" approved April 2011, April 2004, and October 2000; originally approved September 1996 with the title "HIV and Bloodborne Infections in Emergency Medicine."

Resolution 21(16) "Best Practices for Harm Reduction Strategies, Including Warm Handoffs in the ED" adopted.

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

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

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RESOLUTION: 53(17)

SUBMITTED BY: Georgia College of Emergency Physicians

SUBJECT: Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders

PURPOSE: Directs 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.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Cannabidiol (CBD), one of the active cannabinoids found in cannabis sativa (marijuana), which unlike tetrahydrocannabinol (THC), is believed not to have intoxicating or psychotropic effects due to its low affinity for central nervous system cannabinoid type I (CB1) receptors; and

WHEREAS, CBD appears to inhibit glutamate release resulting in downregulation at glutamatergic synapses which may contribute to lowering seizure thresholds; and

WHEREAS, Antidotal reports and limited studies of children with a history of intractable seizures, such as those due to Dravet syndrome and Lennox-Gastaut syndrome, which are unresponsive to currently available anti-elliptic medications have had significant improvement following use of CBD; and

WHEREAS, There has been little formal research meeting current scientific standards because of previous federal restrictions allowing for studies as to the potential risks and benefits of CBD in children for seizure control; and

WHEREAS, The National Institutes of Health have approved scientifically valid studies, and the Food and Drug Administration Center for Drug Evaluation and Research (CDER) has approved Investigation New Drug (IND) applications for phase 2/3 clinical trials for CBD for children with certain intractable seizure disorders; therefore be it

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.

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9. Zuardi AW, Crippa JA, Hallak JE, et al. A critical review of the antipsychotic effects of cannabidiol: 30 years of a translational investigation. Curr Pharm Des. 2012;18(32):5131-40.

Current Clinical Trials (www.clinicaltrials.gov)

A. Cannabidiol (CBD) and Pediatric Epilepsy (NCT02447198), University of Colorado, Denver.
B. Epidiolex and Drug Resistant Epilepsy in Children (CBD) (NCT02397863), Augusta University
C. Study of Cannabidiol for Drug-Resistant Epilepsies (NCT03014440), Children's Hospital of Pittsburgh, Geisinger Clinic
D. Treatment of Drug Resistant Epilepsy (Cannabidiol) (NCT02461706), University of Florida

Background

This resolution calls for 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 currently available anti-elliptic medications.

Most states have passed laws approving the use of medical marijuana. Only four states, Idaho, South Dakota, Nebraska, and Kansas, do not have laws enacted on medical marijuana. Some states have tightly controlled medical marijuana statutes and have CBD-specific laws that allow for the use of cannabis extracts that are high in CBD and low in THC.

Legal Medical Marijuana States – CBD Specific

States with CBD Specific laws	Signed	Qualifying Condition
Alabama	2014	Debilitating epileptic conditions
Florida	2014	Cancer, muscle spasms, seizures, terminal illness (>12 mo.)
Georgia	2015	AIDS, Alzheimer's, amyotrophic lateral sclerosis, autism, cancer, Crohn's, hospice care patients, mitochondrial disease, multiple sclerosis, Parkinson's, sever or end state peripheral neuropathy, seizure disorder, sickle cell disease, Tourette's
Indiana	2017	Treatment resistant epileptic conditions, including Dravet syndrome and Lennox-Gastaut syndrome
Iowa	2014	AIDS/HIV, amyotrophic lateral sclerosis, cancer, cancer-related chronic pain, Crohn's disease, multiple sclerosis, Parkinson's, intractable epilepsy, terminal illness, untreatable pain
Kentucky	2014	Intractable epilepsy
Mississippi	2014	Intractable epilepsy
Missouri	2014	Intractable epilepsy
North Carolina	2014	Intractable epilepsy
Oklahoma	2015	Pediatric epilepsy
South Carolina	2014	Dravet syndrome, Lennox-Gastaut syndrome, refractory epilepsy
Tennessee	2014	Intractable epilepsy
Texas	2015	Intractable epilepsy*
Utah	2014	Intractable epilepsy
Virginia	2015	Intractable epilepsy
Wisconsin	2014 - expanded	Any "medical condition" for which a physician recommends it
Wyoming	2015	Intractable epilepsy (defined as epilepsy that "does not respond to other treatment options")

**The Texas law was signed in 2015; the language of the law calls for a physician's prescription rather than a doctor's recommendation, as it is written in other state laws.*

This level of legislative activity on the part of most of the nation's states appears to challenge the Drug Enforcement Agency's position of listing marijuana as a Schedule I drug with "no currently accepted medical use and a high potential for abuse."

- In July of 2017, the Senate Appropriates Committee passed an amendment to add a clause to the 2018 Commerce, Justice, Science and Related Agencies budget that would block the Department of Justice (DOJ) from using federal funds to prosecute state-legal medical marijuana operations. This is in line with the current protections under the Rohrabacher-Farr amendment (H.R. 2578), voted on annually, which has similar protections for the use of state-legal medical marijuana.
- In May 2017, President Trump signed H. R. 244 into law. This contained a provision (Division B, section 537) that the DOJ would not use funds to prevent implementation of medical marijuana laws by states and territories. However, there are mixed messages from the Administration on its stance of enforcing laws regarding illegal drugs and conflicts between state and federal law.
- The National Academies of Sciences, Engineering and Medicine conducted a comprehensive study on the health effects of therapeutic and recreational cannabis use, looking at research publications since 1999. One of the recommendations in their report, published in January 2017, called for developing a comprehensive evidence base on the effects of cannabis use including prioritized research streams for unstudied and understudied health endpoints, such as epilepsy in pediatric populations.
- On July 19, 2016, the Drug Enforcement Administration (DEA) denied a petition to initiate rulemaking proceedings to reschedule marijuana from Schedule I of the CSA to any other schedule.
- In fiscal year 2015, the NIH supported 281 projects totaling over $111 million on cannabinoid research. Within this investment, 49 projects ($21 million) examined therapeutic properties of cannabinoids, and 15 projects ($9 million) focused on CBD (Cannabidiol). Cannabinoid research is supported broadly across NIH Institutes and Centers (ICs), with each IC supporting research specifically focused on the impact of cannabinoids on health effects within their scientific mission.
- In 2015, the American Academy of Pediatrics reaffirmed their policy statement opposing legalization of marijuana for recreational or medical use. In their statement, the AAP opposed medical marijuana outside of the usual FDA approval process of pharmaceutical products, but supported the further study of pharmaceutical cannabinoids.
- The AMA policy remains against marijuana legalization, but in 2013, they reaffirmed their policy *Cannabis for Medicinal Use H-95.*952 which calls for further and well-controlled studies of marijuana and cannabinoids in patients with serious conditions for its medical utility. The AMA also supports reducing criminal penalties and urges Congress and the DEA to review the status of marijuana as a Schedule I controlled substance, noting it would support rescheduling if doing so would facilitate research. According to its 2014 advocacy statement on cannabis, the AMA urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic, and social consequences of use of cannabis and, instead, support the expansion of such research. The AMA will also increase its efforts to educate the press, legislators, and the public regarding its policy position that stresses a "public health," as contrasted with a "criminal," approach to cannabis.
- President Obama did not legalize marijuana at the national level, but in 2009 a Department of Justice memo from the Attorney General to the nation's U.S. Attorneys advised them not to expend federal resources to prosecute individuals in states that have legalized medical marijuana.
- The Institute of Medicine's 1999 study concluded that THC, the active ingredient in marijuana, may have medicinal potential and should be subjected for further research.

ACEP Strategic Plan Reference

None.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Since 2009, there have been 16 resolutions submitted to the Council regarding the use of marijuana. None of these resolutions have pertained to research in the use of cannabidiol in the treatment of pediatric seizure disorders.

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 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

None.

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

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

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: 54(17)

SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, MD, FACEP

SUBJECT: Use of Cannabis as an Exit Drug for Opioid Dependency

PURPOSE: 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.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The United States is in the midst of a historic, opioid dependency epidemic, resulting in opioid overdose deaths of tens of thousands of people annually; and

WHEREAS, 75% of opioid dependent patients began their dependency with the use of prescription opioids such as Oxycontin, Percodan and Vicodin; and

WHEREAS, On January 12, 2017, the National Academies of Science, Engineering, and Medicine released the publication "The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research;" and

WHEREAS, This publication, which reviewed over 10,700 abstracts and article published between 1999 and 2015 on cannabis, found conclusive/substantial evidence for cannabis as an effective treatment for chronic pain and spasticity symptoms in multiple sclerosis and moderate evidence for treatment of fibromyalgia; and

WHEREAS, Research at the University of San Diego found cannabis to be effective in treating neuropathic pain; and

WHEREAS; States that have legalized medicinal cannabis saw a 24.8 % reduction of opioid overdose deaths; and

WHEREAS, Additional research found that many patients who use medical cannabis for pain decrease or eliminate their use of opioids; and

WHEREAS, In states where medical cannabis is legal, many pain management programs automatically eliminate patients solely because they test positive for cannabis on random drug tests, even when recommended by their personal physician; therefore be it

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.

Background

This resolution directs the College 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 recommended by their physician.

The American Academy of Pain Medicine, in their 2013 policy, "Position on Research into the Use of Cannabinoids

for Medical Purposes," states: "The lack of rigorous scientific and clinical research leave both physicians and patients alike at a disadvantage when considering the potential risks and benefits of cannabinoids as medicine…." The AAPM does not have a policy on participation in a pain management program and concurrent use of cannabinoids.

The AMA policy, "Cannabis for Medicinal Use H-95.952," "…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." "…the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods." "... 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."

The AMA policy, "Cannabis - Expanded AMA Advocacy D-95.976," supports education of the media and legislators as to the health effect of cannabis, urges legislatures to delay initiating full legalization of marijuana use until there is further research "on the public health, medical, economic and social consequences of use of cannabis." The policy further calls for warning labels "… on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States."

ACEP has several policy statements regarding pain/pain management, but none specific to the use of marijuana.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Since 2009, there have been 16 resolutions submitted to the Council regarding the use of marijuana/cannabis. None of these resolutions have pertained to chronic pain patients in a pain management program being eliminated from the program solely because they use cannabis recommended by their physician. Several resolutions have been submitted regarding decriminalization of marijuana for personal and medical use.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. This resolution called for adoption and support of 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 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, 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.

April 2017, approved policy statement "Optimizing the Treatment of Acute Pain the Emergency Department."

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

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

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

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: 55(17)

SUBMITTED BY: Howard Mell, MD, FACEP
Missouri College of Emergency Physicians

SUBJECT: Workplace Violence

PURPOSE: Develop actionable guidelines and measures to ensure safety in the ED; work with local, state and federal bodies for protections and endorsement of violations of guidelines to protect patients and staff from violence in the workplace; and create model legislative and regulatory language that can be shared with state chapters.

FISCAL IMPACT: Budgeted staff time and resources

WHEREAS, Recent news of multiple events against Emergency Department personal have continued to show evolving safety issues for Emergency Department patients and staff; and

WHEREAS, ACEP has the "Protection from Violence in the Emergency Department" policy statement approved by the ACEP Board of Directors January 1993 and most recently revised and approved April 2016, has published an Emergency Department Violence Fact Sheet, has published a case study for legislative lobbying use, and includes the topic in its Emergency Department Directors Academy; and

WHEREAS, In the several states, laws are being enacted specifically to address Emergency Department workplace violence and establish penalties for these acts (e.g., GA); and

WHEREAS, The Joint Commission, via a Sentinel Event Alert and via its Resource page at Joint Commission Resources, advocates for Emergency Department personnel safety measures; and

WHEREAS, Other governmental efforts, including the Centers for Disease Control and Prevention National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration have recognized the current dangers of violence in the Emergency Department as a health and safety issue; therefore be it

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 addressing workplace violence.

Background

This resolution calls for the College to develop actionable guidelines and measures to ensure safety in the ED; work with local, state and federal bodies for protections and endorsement of violations of guidelines to protect patients and staff from violence in the workplace; and create model legislative and regulatory language that can be shared with

state chapters.

The Government Accountability Office published in March 2016 a report on Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence. The GAO identified three areas of improvement for the Department of Labor's Occupational Safety and Health Administration (OSHA). Among the issues identified was an acknowledgement that there are no OSHA standards that **require** employers to implement workplace violence prevention programs. Voluntary guidelines have been issued. OSHA can issue warnings to employers, but they are not required to take corrective action. While inspections have increased since 2010, only 86 were conducted in 2014. OSHA has not assessed the results of its efforts to address workplace violence in health care settings.

The GAO report identifies nine states (CA, CT, IL, MA, MD, NJ, NY, OR, WA) that have enacted laws that require health care employers to have a workplace violence prevention program. The OSHA Voluntary Guidelines outline components of an effective workplace violence prevention program. Seven of the nine states that have enacted these laws meet all the components as outlined by OSHA.

The Joint Commission notes in the rationale for the Environment of Care Standard (EC.01.01) that workplace violence is an example of a security risk. Hospitals are required to implement a process to identify safety and security risks that could affect patients, staff and others coming to the hospital (EC.02.01.01 EP.1) and are required to take action to minimize or eliminate the risks.

A significant majority of states have statutes creating enhanced penalties for persons guilty of assault against health care personnel generally or against emergency health care personnel, in particular. However, many of these laws referencing emergency care are specific to emergency services technicians and personnel and do not apply to physicians.

The American Medical Association has model legislation, "Concerning Assault of Emergency Health Care Workers" that includes physicians in its definition of "emergency health care workers."

ACEP has a long history of developing policies and resources for members addressing workplace violence prevention and enforcement of protections for emergency care providers and the patients they care for. The current ACEP policy statement "Protection from Violence in the Emergency Department" outlines specific hospital responsibilities, including ED security systems based on institution-specific risk assessment, ongoing assessment of security systems, coordination with local law enforcement, written protocols with employee input, education for staff, mandatory reporting, and zero tolerance policies, in addition to post-event support and pursuit of enforcement and prosecution. The first ACEP policy on workforce safety was adopted in 1993.

In 2016, the ACEP Public Health & Injury Prevention Committee (PHIPC) developed an information paper "ED Violence: An Overview and Compilation of Resources." This paper defines workplace violence, the magnitude of the problem, risk factors, prevention strategies, approaches to dealing with potentially violent individuals, in addition to available resources. In 2015, the PHIPC developed an information paper on the "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED." This information paper was developed in response to Substitute Resolution 21(14) "ED Mental Health Information Exchange" and reviews tools for assessing patient violence risk. In 2014, the PHIPC developed an information paper "Hospital-based Violence Intervention Programs" to promote awareness of evidence-based solutions for violence reduction and resources for these programs. A compilation of educational programs and resources titled "Violence in the Emergency Department: Resources for a Safer Workplace" is also available on the ACEP Website. This page is a compilation of CME lectures, podcasts, *Annals* articles, and policies.

ACEP Strategic Plan Reference

Goal 1 – Reform and Improve the Delivery System for Acute Care
Objective D – Develop and implement solutions for workforce issues that promote and sustain quality and

patient safety.
Goal 2 – Enhance Membership Value and Member Engagement
Objective C – Promote member well-being and improve resiliency.

Fiscal Impact

Budgeted staff time and resources.

Prior Council Action

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted. This resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Substitute Resolution 21(14) Emergency Department Mental Health Information Exchange adopted. This resolution called for ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence and devise strategies to help emergency care providers with stakeholders to mitigate patients' risk of self-directed for interpersonal harm and investigate the feasibility and functionality of sharing patient information under HIPAA.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

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. It 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. It directed ACEP to develop a policy statement that its members support the concept of a violence free society and to make every effort to educate its 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. It 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

May 2016, reviewed the information paper, "Emergency Department Violence: An Overview and Compilation of Resources."

April 2016, approved the revised policy statement "Protection from Violence in the Emergency Department;" previously revised June 2011 and April 2008 titled "Protection from Physical Violence in the Emergency Department Environment;" reaffirmed October 2001 and October 1997; originally approved January 1993 as "Protection from Physical Violence in the Emergency Department."

November 2015, reviewed the information paper, "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED."

August 2014, reviewed the information paper "Hospital-Based Violence Intervention Programs."

June 2013, reaffirmed the policy statement "Violence-Free Society;" previously revised and approved January 2007; reaffirmed October 2000; and originally approved January 1996.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Programs adopted.

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

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians 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.

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