American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

INTRODUCTION

2021 Annual Council Meeting
Friday Evening, October 22 through Sunday, October 24, 2021
Westin Boston Seaport District Hotel and Boston Convention & Exhibition Center (BCEC)

Background information has been prepared on the resolutions that were submitted by the deadline. Please review the resolutions and background information in advance of the Council meeting. 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.

Asynchronous testimony on all resolutions assigned to a Reference Committee will open no later than September 23. An announcement with the link to the 2021 resolutions will be posted on the Council engagED as soon as testimony is open. Asynchronous testimony is open to all members. After clicking on the link provided:

- login with your ACEP username and password.
- the list of resolutions will display
- click the resolution of interest
- scroll to the bottom to submit your comment

When commenting please include the following:

1. Whether you are commenting on behalf of yourself or your component body (i.e., chapter, section, AACEM, CORD, EMRA, or SAEM).
2. Whether you are commenting in support of the resolution, opposed to the resolution, or suggesting an amendment.
3. Any additional information to support your position.
4. Please keep your comments concise so as to not exceed an equivalent of 2 minutes of oral testimony.

Comments posted as online testimony are prohibited from being copied and pasted as comments in other forums and/or used in a manner in which the comments could be taken out of context. By participating in this online testimony for the Council meeting, you hereby acknowledge and agree to abide by ACEP's Meeting Conduct Policy.

Asynchronous testimony will close at 12:00 noon Central time on Thursday, October 14. Comments from the online testimony will be used to develop the preliminary Reference Committee reports. The preliminary report will be distributed to the Council on Monday, October 18 and will be the starting point for the live Reference Committee debate during the Council meeting in Boston on Saturday, October 23.

Visit the Council Meeting Web site: https://acep.elevate.commpartners.com/ to access all materials and information for the Council meeting. The resolutions and other resource documents for the meeting are located under the "Document Library" tab. You may download and print the entire Council notebook compendium, or individual section tabs from the Table of Contents. You will also find separate compendiums of the Council officer candidates, President-Elect candidates, Board of Directors candidates, and the resolutions. 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 Boston!

Your Council officers,

Gary R. Katz, MD, MBA, FACEP
Speaker

Kelly Gray-Eurom, MD, MMM, 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

2021 Council Meeting
Reference Committees

Reference Committee A – Governance & Membership
Resolutions 10-24

Michael McCrea, MD, FACEP (OH), Chair
Kathleen Clem, MD, FACEP (FL)
Debra Fletcher, MD, FACEP (LA)
John M. Gallagher, MD, FACEP (KS)
Ken Holbert, MD, FACEP (TN)
Thom Mitchell, MD, FACEP (TN)

Maude Surprenant Hancock
Laura Lang, JD

Reference Committee B – Advocacy & Public Policy
Resolutions 25-41

Ashley Booth-Norse, MD, FACEP (FL), Chair
Erik Blutinger, MD, MSc, (NY)
Paul Kozak, MD, FACEP (AZ)
Catherine Marco, MD, FACEP (OH)
Howard K. Mell, MD, CPE, FACEP (IL)
Thomas J. Sugarman, MD, FACEP (CA)

Jeff Davis
Ryan McBride, MPP

Reference Committee C – Emergency Medicine Practice
Resolutions 42-59

L. Carlos Zapata, MD, FACEP (NY) Chair
Purva Grover, MD, FACEP (OH)
Jonathan Hansen, MD, FACEP (MD)
Jeffrey Linzer, MD, FACEP (GA)
Eric Maur, MD, FACEP (NC)
Sandra Williams, DO, FACEP (TX)

Travis Schulz, MLS, AHIP
Kaeli Vandertulip, MBA, MSLS, AHIP

Reference Committee D – Scope of Practice & Workforce
Resolutions 60-77

Abhi Mehrotra, MD, FACEP (NC) Chair
William Falco, MD, FACEP (WI)
Daniel Freess, MD, FACEP (CT)
Todd Slesinger, MD, FACEP (FL)
Odetolu Odufuye, MD, FACEP (D&I Section)
Scott Pasichow, MD, MPH (YPS)

Adam Krushinskie, MPA
Harry Monroe

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Vidor E. Friedman, MD, FACEP *Florida College of Emergency Physicians*	
2	Commendation for William P. Jaquis, MD, MSHQS, FACEP *Maryland Chapter*	
3	Commendation for Gary R. Katz, MD, MBA, FACEP *Ohio Chapter*	
4	Commendation for Margaret M. Montgomery, RN, MSN *Isabel Barata, MD, FACEP* *Robert De Lorenzo, MD, FACEP* *Dan Freess, MD, FACEP* *Alan Heins, MD, FACEP* *Antony Hsu, MD, FACEP* *Jon Mark Hirshon, MD, FACEP* *Ryan Keay, MD, FACEP* *Robin Polansky, MD, FACEP* *Lynne Richardson, MD, FACEP* *Sandra Schneider, MD, FACEP* *John Sy, MD, FACEP* *Michael Turturro, MD, FACEP* *Bradford Walters, MD, FACEP* *Arlo Weltge, MD, FACEP* *Critical Care Medical Section* *Medical Directors Section* *Pain Management & Addiction Medicine Section* *Undersea & Hyperbaric Medicine Section*	
5	In Memory of Catherine Agustiady-Becker, DO *New York Chapter* *Virginia College of Emergency Physicians*	
6	In Memory of Heide J. Lako-Adamson, MD *North Dakota College*	
7	In Memory of Joseph Litner, MD, PhD, FACEP *Government Services Chapter*	
8	In Memory of Paul S. Auerbach, MD, MS, FACEP *California Chapter*	
9	In Memory of Samuel C. Slimmer, Jr., MD, FACEP *Pennsylvania College of Emergency Physicians*	
10	Board of Directors Action on Council Resolutions - Bylaws Amendment *District of Columbia Chapter* *North Carolina College of Emergency Physicians* *Virginia Chapter* *West Virginia Chapter*	A

Resolution #	Subject/Submitted by	Reference Committee
11	Eligibility for Retired Membership - Bylaws Amendment *Membership Committee* *Board of Directors*	A
12	Permitting Bylaws Amendments on the Unanimous Consent Agenda – Council Standing Rules Amendment *Sara Chakel, MD, FACEP* *Michael McCrea, MD, FACEP* *Scott Pasichow, MD, MPH* *Paul Pomeroy, MD, FACEP* *Todd Slesinger, MD, FACEP, FCCM, FCCP* *James Thompson, MD, FACEP* *Larisa Traill, MD, FACEP* *Nicole Veitenger, DO, FACEP*	A
13	ACEP President-Elect Selected Directly by Members *Louisiana Chapter*	A
14	Establishing a Young Physician Position on the ACEP Nominating Committee *Young Physician Section*	A
15	Member Determined Council Representation *Louisiana Chapter*	A
16	ACEP Group Membership *John C. Moorhead, MD, FACEP* *Christopher Strear, MD, FACEP*	A
17	Fair Emergency Physician Employment Contract Template *Louisiana Chapter*	A
18	Change to ACEP Conflict of Interest Statement *Howard K. Mell, MD, MPH, FACEP* *Phillip Luke LeBas, MD, FACEP*	A
19	Clear and Complete Conflict of Interest Disclosure at the Council Meeting *Louisiana Chapter*	A
20	Creation of the Social Emergency Medicine Association *Howard K. Mell, MD, MPH, FACEP* *Taylor Nichols, MD*	A
21	Diversity, Equity, and Inclusion *Ramon Johnson, MD, FACEP* *Nicholas Jouriles, MD, FACEP* *Marcus Wootern, MD* *Yvette Calderon, MD, FACEP* *Diversity, Inclusion, & Health Equity Section*	A
22	Expanding Diversity & Inclusion in Educational Programs *New York Chapter*	A
23	Media Marketing of Value of Emergency Medicine Board Certification *Louisiana Chapter*	A
24	More Focused College *Louisiana Chapter*	A

Resolution #	Subject/Submitted by	Reference Committee
25	ACEP Report Card *John C. Moorhead, MD, FACEP* *Christopher Strear, MD, FACEP*	B
26	Advocacy for Syringe Services Programs and Fentanyl Test Strips *Ohio Chapter* *Pennsylvania College of Emergency Physicians*	B
27	Conditional Support for Medicare-for-All *Larry Bedard, MD, FACEP* *Gregory Gafni-Pappas, DO, FACEP* *Cai Glushak, MD, FACEP* *Michael Gratson, MD, MHSA, FACEP* *James Maloy, MD* *Jacob Manteuffel, MD, FACEP* *James Mitchiner, MD, MPH, FACEP* *Charles Pattavina, MD, FACEP* *Megan Ranney, MD, MPH, FACEP* *Rachel Solnick, MD, MSc* *Robert Solomon, MD, FACEP* *Peter Viccellio, MD, FACEP* *Bradford Walters, MD, FACEP*	B
28	Consumer Awareness Through Classification of Emergency Departments *Paul Kivela, MD, FACEP* *California Chapter* *Delaware Chapter* *Florida College of Emergency Physicians* *Maryland Chapter*	B
29	Downcoding *Florida College of Emergency Physicians* *Illinois College of Emergency Physicians* *Minnesota College of Emergency Physicians* *Missouri College of Emergency Physicians*	B
30	Unfair Health Plan Payment Policies *Douglas P. Brosnan, MD, JD, FACEP* *Bing S. Pao, MD, FACEP* *Thomas Jerome Sugarman, MD, FACEP* *California Chapter* *Michigan College of Emergency Physicians* *Missouri Chapter*	B
31	Employment-Retaliation, Whistleblower, Wrongful Termination *Olga Gokova, MD, FACEP* *Rebecca B. Parker, MD, FACEP* *Amish Shah, MD, FACEP* *Arizona College of Emergency Physicians*	B
32	Firearm Ban in EDs Excluding Active Duty Law Enforcement *Chris Barsotti, MD, FACEP* *Sarah Hoper, MD, MD, FACEP* *James C. Mitchiner, MD, MPH, FACEP* *Alexandra Nicole Thran, MD, FACEP* *Vermont Chapter* *American Association of Women Emergency Physicians Section* *Diversity Inclusion & Health Equity Section*	B

Resolution #	Subject/Submitted by	Reference Committee
33	Formation of a National Bureau for Firearm Injury Prevention *California Chapter* *DC Chapter* *Maryland Chapter* *Massachusetts College of Emergency Physicians* *New York Chapter* *North Carolina College of Emergency Physicians* *Vermont Chapter*	B
34	Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas *Ohio Chapter* *Pennsylvania College of Emergency Physicians*	B
35	Preserving Rural Emergency Care in Rural Critical Access Hospitals and Rural Emergency Hospitals *Rural Emergency Medicine Section*	B
36	Mitigating the Unintended Consequences of the CURES ACT *New York Chapter*	B
37	Physician Pay Ratio *Louisiana Chapter*	B
38	Prehospital Oversight and Management of Patients Experiencing Hyperactive Delirium with Severe Agitation *Kevin E. McVaney, MD* *Stephen J. Wolf, MD, FACEP* *Colorado Chapter*	B
39	Recommit to Lessening Opioid Deaths in America *Ohio Chapter* *Pennsylvania College of Emergency Physicians*	B
40	Reimbursement for Naloxone Distributed from Emergency Departments *Missouri Chapter* *Ohio Chapter* *Pennsylvania College of Emergency Physicians*	B
41	Take Home Naloxone Programs in Emergency Departments *Donald E. Stader, MD, FACEP* *Nathan M. Novotny* *John Spartz* *Emergency Medicine Residents' Association* *Colorado Chapter* *New Jersey Chapter* *Massachusetts College of Emergency Physicians* *Pain Management & Addiction Medicine Section* *Social Emergency Medicine Section*	B
42	Administration of COVID-19 Vaccines in the Emergency Department *Laura Janneck, MD, FACEP* *Nikkole Turgeon, BS* *Social Emergency Medicine Section*	C
43	Autonomous "Shared Governance" Due Process *Paul D. Kivela, MD, MBA, FACEP* *California Chapter*	C

Resolution #	Subject/Submitted by	Reference Committee
44	Caring for Transgender and Gender Diverse Patients in the Emergency Department *Lauren Apgar, DO* *Leslie Gailloud* *Logan Jardine, MD, MPH* *Hannah Janeway, MD* *Social Emergency Medicine Section*	C
45	ED Performance Measures Data for Small, Rural, and Critical Access Hospital EDs *Quality Improvement & Patient Safety Section* *Massachusetts College of Emergency Physicians* *Rhode Island Chapter* *Wisconsin Chapter*	C
46	Effects of EM Practice Ownership on the Costs and Quality of Emergency Care *Stephen Epstein, MD, MPP, FACEP* *Jay Mullen, MD, FACEP*	C
47	Family and Medical Leave *Megan Dougherty, MD, FACEP* *Sarah Hoper, MD, JD, FACEP* *Iowa Chapter* *Vermont Chapter* *American Association of Women Emergency Physicians*	C
48	Financial Incentives to Reduce ED Crowding *Stephen Epstein, MD, MPP, FACEP* *Thomas J. Sugarman, MD, FACEP*	C
49	Forced EMS Diversion *New York Chapter*	C
50	Harms of Marijuana *Michael Carius, MD, FACEP* *Ronee Lev, MD, FACEP* *Gregory Shangold, MD, FACEP* *Thomas J. Sugarman, MD, FACEP* *Connecticut College of Emergency Physicians* *Rhode Island Chapter*	C
51	Medical Bill of Rights for Detained and Incarcerated persons While Receiving Emergency Medical Care *Georgia College of Emergency Physicians*	C
52	Standardization of Medical Screening Exams of Arrested Persons Brough to the ED *Utah Chapter*	C
53	Reporting of Injuries Suspected or Reported to be Resulting from Law Enforcement Actions *Taylor Nichols, MD* *Alexander Schmalz, MD, MPH* *Kevin Durgun, MD* *California Chapter* *Young Physicians Section*	C
54	Understanding the Effects of Law Enforcement Presence in the Emergency Department *Social Emergency Medicine Section*	C
55	Patient Experience Scores *New York Chapter*	C

Resolution #	Subject/Submitted by	Reference Committee
56	Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities *Diversity, Inclusion, & Health Equity Section* *District of Columbia Chapter*	C
57	Social Determinants of Health Screening in the Emergency Department *Nikkole J. Turgeon, BS* *Anna G. Wright, MD* *Dominique Gelmann* *Betty Chang, MD, FACEP* *Daniel B. Gingold, MD, MPH* *Social Emergency Medicine Section*	C
58	Updating and Enhancing ED Buprenorphine Treatment Training and Support *Missouri Chapter* *Pennsylvania College of Emergency Physicians*	C
59	Use of Medical Interpreters in the Emergency Department *Laura Janneck, MD, FACEP* *Nikkole Turgeon, BS* *Social Emergency Medicine Section*	C
60	Accountable Organizations to Resident and Fellow Trainees *Emergency Medicine Residents' Association (EMRA)*	D
61	Advocating for a Required Emergency Medicine Rotation at All U.S. Medical Schools *Pennsylvania College of Emergency Physicians*	D
62	Support of Telehealth Education in Emergency Medicine Residency *Emergency Medicine Residents' Association* *Pennsylvania College of Emergency Physicians*	D
63	Physician-Led Team Leader Training *Government Services Chapter*	D
64	Rural Emergency Medicine Education and Recruitment *Rural Emergency Medicine Section*	D
65	Rural Providers Support and a Call for Data *Rural Emergency Medicine Section*	D
66	ACEP Promotion of the Role of the Emergency Physician *Howard K. Mell, MD, MPH, CPE, FACEP* *Illinois College of Emergency Physicians*	D
67	Patient Informed Consent *Emergency Medicine Workforce Section*	D
68	Patient's Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth *Louisiana Chapter* *Emergency Telehealth Section*	D
69	Workforce Transparency *Louisiana Chapter*	D
70	Creation of Specialized Scope Expansion Advocacy Teams for State Level Advocacy *Government Services Chapter*	D

Resolution #	Subject/Submitted by	Reference Committee
71	Emergency Medicine Workforce by Non-Physician Practitioners *Emergency Medicine Workforce Section*	D
72	Fair Compensation to Emergency Physicians for Collaborative Practice Agreements & Supervision *Louisiana Chapter*	D
73	Offsite Supervision of Nurse Practitioners and Physician Assistants *Emergency Medicine Residents' Association* *Ohio Chapter* *Pennsylvania College of Emergency Physicians* *Young Physicians Section*	D
74	Regulations by state medical Boards of All Who Engage in Practice of Medicine *Emergency Medicine Workforce Section*	D
75	Required Clinical Experience for Emergency Nurses *Pennsylvania College of Emergency Physicians*	D
76	Standards for Non-Residency Trained Physicians and Mid-Levels to Work in Emergency Medicine *Maryland Chapter*	D
77	Workforce Fairness *Louisiana Chapter*	D

Late Resolutions

78	In Memory of Leon L. Haley, Jr., MD, MHSA, CPE, FACEP, FACHE *Florida College of Emergency Physicians* *Diversity, Inclusion, & Health Equity Section*	

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 1(21)

SUBMITTED BY: Florida College of Emergency Physicians

SUBJECT: Commendation for Vidor E. Friedman, MD, FACEP

WHEREAS, Vidor E. Friedman, MD, FACEP, served the College with complete dedication while serving on the Board of Directors 2012-2020 and in his roles as Secretary-Treasurer 2016-17, Vice President 2017-18, President-Elect June-October 2018, President 2018-19, and Immediate Past President 2019-20; and

WHEREAS, Dr. Friedman brought the depth and breadth of his experience to his role on the Board of Directors, facilitated several key initiatives for ACEP, and appointed many task forces to address key issues affecting the practice of emergency medicine; and

WHEREAS, During his tenure on the Board of Directors, Dr. Friedman was committed to improving the practice of emergency medicine and the lives of emergency physicians; and

WHEREAS, Dr. Friedman was instrumental in enhancing ACEP's involvement in international emergency medicine by creating an International Emergency Medicine Committee; and

WHEREAS, Dr. Friedman led ACEP's efforts to hire a new executive director by appointing an Executive Directors Search Committee and served as the Board Liaison to the committee; and

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

WHEREAS, Dr. Friedman served on the Board of Trustees of the Emergency Medicine Foundation 2011-16 and as its chair in 2015, and continues to support his commitment to emergency medicine research through his contributions and participation in the Wiegenstein Legacy Society; and

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

WHEREAS, Dr. Friedman demonstrated leadership through chapter involvement as a member of the Florida College of Emergency Physicians and served on the Board of Directors 2003-19 and as President 2011-12; and

WHEREAS, In all his meetings and travels, Dr. Friedman represented the College with diplomacy, integrity, and honor; and

WHEREAS, Dr. Friedman has been a mentor, friend, and role model to numerous individuals and will continue to serve the College and the specialty of emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Vidor E. Friedman, MD, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 2(21)

SUBMITTED BY: Maryland Chapter

SUBJECT: Commendation for William P. Jaquis, MD, MSHQS, FACEP

WHEREAS, William P. Jaquis, MD, MSHQS, FACEP, has been an extraordinary and dedicated leader while serving on the Board of Directors 2012-2021 and in his roles as Secretary-Treasurer 2015-16, Vice President 2016-17, President-Elect 2018-19, President 2019-20, and Immediate Past President 2020-21; and

WHEREAS, Dr. Jaquis, during his tenure on the ACEP Board of Directors and as President, participated in numerous visionary efforts, including the Future of Emergency Medicine Summit, and appointed many task forces to address key issues affecting the practice of emergency physicians; and

WHEREAS, Dr. Jaquis led ACEP during the COVID-19 pandemic and championed the creation of multiple policies and resources to assist in treating patients and for the safety and well-being of emergency physicians and the public; and

WHEREAS, Dr. Jaquis has been a staunch advocate for preserving reimbursement for emergency physicians and ensure that the "No Surprises Act" represents a reasonable and favorable solution for emergency physicians; and

WHEREAS, Dr. Jaquis maintained an active clinical schedule while serving on the ACEP Board of Directors; and

WHEREAS, Dr. Jaquis has shown exemplary leadership and outstanding service with his tireless efforts and expertise on various committees, task forces, sections, the Council, and Board of Directors; and

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

WHEREAS, Dr. Jaquis has expressed his commitment to the Emergency Medicine Foundation and emergency medicine research through his contributions and participation in the Wiegenstein Legacy Society; and

WHEREAS, Dr. Jaquis demonstrated leadership through chapter involvement and served on the Maryland Chapter Board of Directors 2004-17 and as President 2015-16; and

WHEREAS, Dr. Jaquis has represented the College with honor and distinction and is a role model of commitment and productivity; and

WHEREAS, Dr. Jaquis will continue to be involved and committed to the practice of emergency medicine and to ACEP's mission; therefore be it

RESOLVED, That the American College of Emergency Physicians commends William P. Jaquis, MD, MSHQS, FACEP, for his outstanding service, leadership, commitment to the College and the specialty of emergency medicine, and to the patients we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 3(21)

SUBMITTED BY: Ohio Chapter

SUBJECT: Commendation for Gary R. Katz, MD, MBA, FACEP

WHEREAS, Gary R. Katz, MD, MBA, FACEP, has served the American College of Emergency Physicians with honor, distinction, and dedication as Council Vice Speaker 2017-19 and Council Speaker 2019-21; and

WHEREAS, Dr. Katz represented the Council at Board of Directors' meetings during his terms as Vice Speaker and Speaker; and

WHEREAS, Dr. Katz was a leader in managing the evolving ways of conducting the business of the Council and was instrumental in coordinating efforts and enhancing the productivity within the Council, including creation of the asynchronous testimony process; and

WHEREAS, Dr. Katz expertly and efficiently led the Council by implementing the virtual Council meeting in 2020 to allow the Council to complete its work despite the challenges caused by the COVID-19 pandemic; and

WHEREAS, Dr. Katz expertly and efficiently led the Council by implementing the virtual Council meeting in 2020 to continue to advance the work of the Council despite the challenges caused by the COVID-19 pandemic; and

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

WHEREAS, Dr. Katz is respected for his integrity, objectivity, parliamentary skills, and the mentorship he provided to numerous councillors from across the College; and

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

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

WHEREAS, Dr. Katz was the recipient of the Council's Horizon Award in 2011; and

WHEREAS, Dr. Katz has maintained an active presence in the Ohio Chapter and served on the Board of Directors 2008-15 and 2018-21 and as president 2009-10; and

WHEREAS, Dr. Katz has shown exemplary leadership and outstanding service with his participation on several committees and task forces of the College and is a recognized leader and advocate for the specialty; and

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

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 4(21)

SUBMITTED BY:

Isabel Barata, MD, FACEP
Robert Delorenzo, MD, FACEP
Dan Freess, MD, FACEP
Alan Heins, MD, FACEP
Antony Hsu, MD, FACEP
Jon Mark Hirshon, MD, FACEP
Ryan Keay, MD, FACEP
Robin Polansky, MD, FACEP
Lynne Richardson, MD, FACEP
Sandra Schneider, MD, FACEP
John Sy, MD, FACEP
Michael Turturro, MD, FACEP
Bradford Walters, MD, FACEP
Arlo Weltge, MD, FACEP
Critical Care Medical Section
Medical Directors Section
Pain Management & Addiction Medicine Section
Undersea & Hyperbaric Medicine Section

SUBJECT: Commendation for Margaret Montgomery, RN, MSN

WHEREAS, Margaret Montgomery, RN, MSN, has served in multiple roles within the American College of Emergency Physicians since joining ACEP in February 2000 including staff liaison for the Public Health & Injury Prevention Committee, the Emergency Medicine Practice Committee, and the following sections: Critical Care Medicine, Medical Directors, Pain Management & Addiction Medicine, and Undersea & Hyperbaric Medicine; and

WHEREAS, Ms. Montgomery has facilitated the development of more than 200 policy statements, Policy Resource and Education Papers (PREPs), and information papers that are reviewed and approved by the Board of Directors and her work not only enhanced the committees and sections but also helped ACEP members provide better care for their patients; and

WHEREAS, Ms. Montgomery has had a positive influence and contributed in ways great and small to the development of dozens of leaders within ACEP including ACEP presidents, Council officers, Board members, committee and section chairs, fellow staff members, ACEP fellows, and emergency medicine residents; and

WHEREAS, Ms. Montgomery has been an infallible resource to ACEP members regarding countless issues related to the administration of emergency care and thus has had a positive impact on the provision of emergency care to our patients; and

WHEREAS, Ms. Montgomery embodies the following attributes: steadfastness, professionalism, energetic nature, diplomacy, passion, productiveness, insightfulness, dedication, trustworthiness, determination, and last but not least a great sense of humor; and

WHEREAS, Ms. Montgomery has served many through the following roles: expert drafter, intellectual, mentor, magical being, leader, true friend, role model, family, and pillar of balance; and

WHEREAS, Ms. Montgomery has been key to the success of the Public Health & Injury Prevention Committee and the Emergency Medicine Practice Committee, her organization and leadership was fundamental, and she provided the framework for the committee chairs to be successful; and

WHEREAS, Ms. Montgomery was the consistent presence and guide that specifically helped the Critical Care Medicine Section maintain perseverance in its goals and humanity in its objectives and she kept this wild and visionary group on track to accomplish so many great things from board certification status to mentoring up and coming young emergency medicine intensivists in their journey and without her, the great ideas from the members of this section would have remained as ideas forever – she helped visions become reality through her historic knowledge, institutional memory, and keen insight as to how to effect change; and

WHEREAS, Ms. Montgomery provided direction, inspiration, and guidance, as well as nurturing the strengths and talents of the committee chair and members to achieve the objectives; and

WHEREAS, Ms. Montgomery retired effective July 1, 2021, after more than 21 years of exemplary service; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Margaret Montgomery, RN, MSN, for her outstanding service and commitment to the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 5(21)

SUBMITTED BY: New York Chapter ACEP
Virginia College of Emergency Physicians

SUBJECT: In Memory of Catherine Agustiady-Becker, DO

WHEREAS, The specialty of emergency medicine and the Virginia College of Emergency Physicians (VACEP) lost a rising physician leader, compassionate physician, colleague, and friend in Catherine Agustiady-Becker, DO who passed away tragically and unexpectedly on May 3, 2021, at the age of 37; and

WHEREAS, Dr. Agustiady-Becker was a distinguished graduate of the SUNY at Buffalo and the University of New England College of Osteopathic Medicine and completed her emergency medicine residency at the University of Buffalo; and

WHEREAS, Dr. Agustiady-Becker was respected for her compassionate care of her patients and clinical acumen and she appreciated the diversity of emergency medicine and the unique opportunity she had to care for different patients at the time when they needed it most; and

WHEREAS, Dr. Agustiady-Becker was dedicated to physician leadership and was a rising leader in VACEP and emergency medicine; and

WHEREAS, Dr. Agustiady-Becker was a former VACEP leadership and advocacy fellow where she engaged and worked to develop a mentorship platform within the College; and

WHEREAS, Dr. Agustiady-Becker was not only dedicated to her patients, but to changing the policies and practices of emergency medicine for the greater good; and

WHEREAS, Dr. Agustiady-Becker was devoted to physician wellness and balance between professional development and family life; and

WHEREAS, Dr. Agustiady-Becker wrote with candor about her experiences as an emergency physician and the challenges all physicians face and wrote eloquently of her love of the practice of emergency medicine; and

WHEREAS; Dr. Agustiady-Becker was a world traveler and avid outdoors-woman who loved to hike; and

WHEREAS, Above all, Dr. Agustiady-Becker was a devoted mother and wife to her three boys and her husband, Jacob, and a devoted daughter to her mother who was a role model to her; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with gratitude and honors the many contributions made by Catherine Agustiady-Becker, DO, as one of the rising stars in emergency medicine; and be it further

RESOLVED; That the American College of Emergency Physicians extends to her husband, Jacob, her sons Wyatt, Theodore, and Quentin, her extended family, colleagues, and friends our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the countless patients and physicians across the country whom she served selflessly.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: North Dakota Chapter

SUBJECT: In Memory of Heidi J. Lako-Adamson, MD

WHEREAS, Emergency medicine lost a passionate emergency physician and advocate for emergency medical services with the untimely death of Heidi J. Lako-Adamson on March 31, 2021; and

WHEREAS, Dr. Lako-Adamson received her medical degree from the University of North Dakota School of Medicine and Health Sciences and completed her emergency medicine residency at Regions Hospital in St. Paul, Minnesota; and

WHEREAS, Dr. Lako-Adamson became an EMT and paramedic prior to medical school and worked as a paramedic while attending medical school; and

WHEREAS, Dr. Lako-Adamson served as Medical Director for Fargo-Moorhead Ambulance and numerous rural emergency medicine services; and

WHEREAS, Dr. Lako-Adamson served her community for 13-years as emergency medicine physician, volunteer physician for sporting teams, public health officer, and marathon medical director; and

WHEREAS Dr. Lako-Adamson was recognized for her deep passion for rural EMS, which earned her great respect and admiration from EMS providers; and

WHEREAS, Dr. Lako-Adamson will be missed by her friends and colleagues who were privileged to know her and appreciated her strength of character and zeal for emergency medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Heidi J. Lako-Adamson, MD, and extends condolences and gratitude to her husband, Mark, for her service to the specialty of emergency medicine and to patient care.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 7(21)

SUBMITTED BY: Government Services Chapter
Louisiana Chapter
Washington Chapter

SUBJECT: In Memory of Joseph Litner, MD, PhD, FACEP

WHEREAS, The specialty of emergency medicine and the Government Services Chapter of the American College of Emergency Physicians (GSACEP) lost an emergency medicine trailblazer, compassionate physician, government services leader, emergency medicine faculty, colleague, and friend in Joseph Litner MD, PhD, FACEP, who passed away on May 18, 2021, at the age of 75; and

WHEREAS, Dr. Litner received his doctor of philosophy and medical degree from Queen's University in Ontario, Canada and completed his residency in emergency medicine at Charity Hospital in New Orleans, Louisiana; and

WHEREAS, Dr. Litner practiced emergency medicine for more than four decades in Louisiana, Mississippi, and Washington state accumulating more than 100,000 hours of direct emergency patient care; and

WHEREAS, Dr. Litner remained dedicated and committed to the field of EMS leading him to serve as medical director for multiple units throughout the country for more than 40 years; and

WHEREAS, Dr. Litner served his country faithfully, selflessly, and honorably as a federal government employee for more than 15 years, always devoted to the education of military medical officers, advancement of military medicine, and those we serve; and

WHEREAS, Dr. Litner served in numerous teaching positions, educating and mentoring countless medical students, interns, and residents while serving as faculty at Charity Hospital in New Orleans, LA, and Madigan Army Medical Center in Tacoma, WA; and

WHEREAS, With his expertise, Dr. Litner was an appointed Board Examiner by the American Board of Emergency Medicine for 14 years; and

WHEREAS, Above all, Dr. Litner was a devoted family man, pioneer in the field of emergency medicine, astute clinician, and a passionate educator, and to quote his obituary, "He was blessed with a brilliant mind, an insatiable thirst for knowledge...He was kind, loyal and generous to a fault and an outrageously funny raconteur with a larger-than-life personality who filled the room."; and

WHEREAS, Dr. Litner dedicated his life to his family, friends, and patients; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the magnanimous life of Joseph Litner, MD, PhD, FACEP, on the states of Washington, Mississippi, Louisiana, and the Government Services Chapter of ACEP; therefore be it

RESOLVED That the American College of Emergency Physicians and the Government Services Chapter acknowledge the huge loss and bereavement of his many colleagues and friends, but above all, extend condolences to his beloved wife of more than 40 years, Maria Hugi, MD, FACEP, and their precious children, David and Jonathan.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 8(21)

SUBMITTED BY: California Chapter

SUBJECT: In Memory of Paul S. Auerbach, MD, MS, FACEP

WHEREAS, The specialty of emergency medicine lost a longtime ACEP member, a beloved leader, and a wilderness medicine pioneer when Paul S. Auerbach, MD, FACEP, passed away on June 23, 2021 at 70 years of age; and

WHEREAS, After graduating from medical school at Duke University, Dr. Auerbach completed his emergency medicine residency at what is now Ronald Reagan UCLA / Olive View UCLA Medical Center; and

WHEREAS, Dr. Auerbach joined ACEP in 1984, and quickly became involved in research and education; and

WHEREAS, Dr. Auerbach was an Editorial Board member for Annals of Emergency Medicine from 1987 to 1991; and

WHEREAS, Wilderness medicine as we know it would not be possible without Dr. Auerbach's groundwork; and

WHEREAS, Dr. Auerbach was a pioneer in the field of wilderness medicine and worked hard to continue paving the way for education and advancement of the specialty; and

WHEREAS, A champion of wilderness medicine as a distinct area of emergency medicine, Dr. Auerbach became the editor for the *Journal of Wilderness Medicine* from 1990 to 1995 and then wrote what is considered by many to be the definitive textbook on the practice, *Wilderness Medicine*; and

WHEREAS, Dr. Auerbach also authored *Medicine for the Outdoors* and was co-author of *Enviromedics: The Impact of Climate Change on Human Health and Field Guide to Wilderness Medicine*; and

WHEREAS, Globally renowned in both emergency medicine and wilderness medicine, Dr. Auerbach worked not only to support educating others for the greater good, but also led many initiatives for relief in remote areas and partnerships around the world, ultimately working to make the world a better place; and

WHEREAS, Dr. Auerbach had a special relationship with Nepal and was part of a team that built a much-needed hospital there; and

WHEREAS, Dr. Auerbach was a strong supporter of the Wilderness Medicine Section, as well as MedWAR (Medical Wilderness Adventure Race) which carried over with his continued support of the EMRA MedWAR since it began in 2016; and

WHEREAS, Dr. Auerbach was always willing to put in the time to help anyone and get his hands dirty if it was going to advance education or help others; and

WHEREAS, Dr. Auerbach's legacy is most obvious in the arena of wilderness medicine, his dedication and commitment to the specialty spanned many arenas; and

WHEREAS, In 1999, Dr. Auerbach was awarded ACEP's Judith E. Tintinalli Award for Outstanding Contribution in Education, one of the College's highest leadership honors; and

WHEREAS, Dr. Auerbach served on several ACEP task forces, including the Sports Related Head Injury Task Force and the High Threat Emergency Care Task Force; and

WHEREAS, Dr. Auerbach was an officer of the Emergency Medicine Foundation's (EMF) Board of Trustees and was EMF's Secretary/Treasurer in 2020; and

WHEREAS, Dr. Auerbach demonstrated his dedication to EM research by joining the EMF Mentor Circle and funding the Climate and Emergency Medicine Research Grant; and

WHEREAS, Dr. Auerbach was most recently the Redlich Family Professor Emeritus in the Department of Emergency Medicine at the Stanford University School of Medicine, and Adjunct Professor of Military/Emergency Medicine at the F. Edward Hébert School of Medicine of the Uniformed Services University of the Health Sciences; and

WHEREAS, Dr. Auerbach was a member of the Council on Foreign Relations, and served on the National Medical Committee for the National Ski Patrol System; and

WHEREAS, Dr. Auerbach was a first responder to the earthquakes in Haiti (2010) and Nepal (2015); and

WHEREAS, Dr. Auerbach was a visiting scholar at the National Center for Disaster Medicine and Public Health and previously Chief of the Divisions of Emergency Medicine at Vanderbilt University and Stanford University; and

WHEREAS, Dr. Auerbach's brilliance, sense of humor, innovation, adventurous spirit, energy, and compassion will be deeply missed but always remembered; and

WHEREAS, Dr. Auerbach is whom many refer to as the "Father of Wilderness Medicine" and he certainly helped make all this possible; we are forever indebted to him and grateful for his hard work; therefore be it

RESOLVED, That the American College of Emergency Physicians and the California Chapter extend to the family of Paul S. Auerbach, MD, MS, FACEP, gratitude for his tremendous service to emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 9(21)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Samuel C. Slimmer, Jr., MD, FACEP

WHEREAS, The specialty of emergency medicine lost a distinguished leader and pioneer when Samuel C. Slimmer Jr., MD, FACEP, passed away December 21st, 2020, at the age of 81; and

WHEREAS, Dr. Slimmer graduated from Reading Central Catholic High School in 1957, St. Joseph's University in 1961, and Temple University School of Medicine in 1965; and

WHEREAS, Dr. Slimmer completed his internship training in 1966 at The Reading Hospital (now Tower Health); and

WHEREAS, Dr. Slimmer helped establish the first emergency medicine physician group at The Reading Hospital in 1967; and

WHEREAS, Dr. Slimmer served as the medical director of the emergency department at The Reading Hospital, The Pottsville Hospital, and Warne Clinic (now Lehigh Valley Schuylkill South) for many years; and

WHEREAS, Dr. Slimmer served as the president of the Schuylkill County Medical Society; and

WHEREAS, Dr. Slimmer was one of the original members of ACEP joining in 1968; and

WHEREAS, Dr. Slimmer was recognized in 2018 as one of the longest tenured members of ACEP; and

WHEREAS, Dr. Slimmer was given the Special Recognition Award by the Pennsylvania College of Emergency Physicians (PACEP) in 2019 for service and contributions to the specialty; and

WHEREAS, Dr. Slimmer retired in 2018, having spent 51 years practicing emergency medicine; and

WHEREAS, We owe a tremendous amount of gratitude to him for his unassailable commitment and dedication to the specialty, particularly in early years when many did not give it the respect it deserved, thus forging a path for all who came after him; and

WHEREAS, Dr. Slimmer was a loving and proud father and grandfather; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Samuel C. Slimmer, Jr., MD, FACEP, who was a pioneer in the specialty and dedicated himself to his patients, to his profession, and to his family, and be it further

RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency Physicians extends to his son Samuel J., daughter-in-law Kelly, daughter Lara, and granddaughters Ellianna and Eily gratitude for his tremendous service as one of the first emergency physicians, as well as for his dedication and commitment to the specialty of emergency medicine.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Meeting
Reference Committee Members

Reference Committee A – Governance & Membership
Resolutions 10-24

Michael McCrea, MD, FACEP (OH), Chair
Kathleen Clem, MD, FACEP (FL)
Debra Fletcher, MD, FACEP (LA)
John M. Gallagher, MD, FACEP (KS)
Ken Holbert, MD, FACEP (TN)
Thom Mitchell, MD, FACEP (TN)

Maude Surprenant Hancock
Laura Lang, JD

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 10(21)

SUBMITTED BY: District of Columbia Chapter
North Carolina College of Emergency Physicians
Virginia Chapter
West Virginia Chapter

SUBJECT: Board of Directors Action on Council Resolutions

PURPOSE: Amends the Bylaws to include reporting requirements to the Council regarding the disposition of all resolutions considered by the Council and reporting requirements for all resolutions adopted and referred by the Council.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The Council has the right and responsibility to advise and instruct the Board of Directors by means of resolutions; and

WHEREAS, The Board of Directors has a duty to act on resolutions adopted by the Council; and

WHEREAS, The College would benefit from timely updates and increased transparency regarding the Board of Directors' actions on Council resolutions; therefore be it

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 8 – Board of Directors Action on Resolutions, be amended to read:

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

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

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

The ACEP Council Speaker and Vice Speaker or their designee shall provide to the College a written summary of the Council meeting within 14 calendar days of the adjournment of the Council meeting. This summary shall include:

1. **An executive summary of the Council meeting.**
2. **A summary and final text of each passed and referred resolution.**

Thereafter, the Board of Directors shall provide to the College written and comprehensive communication regarding the actions taken and status of each adopted and referred resolution. A summary of the Board of Directors' intent, discussion, and decision for each referred resolution shall be included. These communications shall be provided at 30 calendar day intervals until these communications demonstrate that no further Board action is required according to the Bylaws listed previously in this section.

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

Background

This resolution amends the Bylaws to include reporting requirements to the Council regarding the disposition of all resolutions considered by the Council and reporting requirements for all resolutions adopted and referred by the Council.

An executive summary of all resolutions considered by the Council and a summary of all resolutions adopted by the Council that require Board action, including the final text of each resolution, is currently provided to the Council within 30 days of the Council meeting. Last year, the report was provided to the Council the same day that the resolutions were acted on by the Board of Directors. This report could easily be updated to include the final language of all adopted Council Standing Rules resolutions and all referred resolutions.

Implementation of most resolutions is completed within the first year of adoption. Some resolutions may require two years for implementation. For example, a resolution may require funding that is not available in the current fiscal year budget when the resolution is adopted, and a budget modification is not feasible. Additional work on the resolution may be accomplished in the third year since adoption while other resolutions, such as federal and state advocacy resolutions, may require even longer to achieve implementation.

Each year the Council Steering Committee reviews the implementation actions on resolutions during their January meeting to ensure that the will of the Council is followed in implementing the resolutions. Their review includes actions on resolutions from the most recent Council meeting and the two years prior resolutions. This requirement is codified in the Council Standing Rules, "Policy Review" section, as directed by Substitute Resolution 30(90) Resolution Review:

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

Beginning in 1992, a report on implementation of resolutions from the two years prior was provided to the Council. In 2003, the Steering Committee directed that the reports include implementation actions on a three-year rolling basis. For example, the actions on 2002, 2001, and 2000 were reviewed by the Steering Committee and written reports were provided to the Council. The reports included the Council Standing Rules resolutions and the referred resolutions. The reports were also available in the Council area of the ACEP website.

The actions on resolutions reports are updated again prior to the Council meeting to include any additional action that may have occurred since the reports were developed in January. The written reports of actions on resolutions for the three years prior are then provided to the Council and include the most up to date information regarding implementation of the resolutions.

The Council and the Board of Directors adopted Amended Resolution 12(15) Searchable Council Resolution Database, which directed ACEP to create a web-based searchable database for Council resolutions. ACEP's internal database of all resolutions since 1972 was used to develop the framework for this new database for access by all members in the Council area of the ACEP website. The Actions on Council Resolutions includes the original resolution, background information, Council action, testimony in the Reference Committee, Board action, and implementation action for each resolution. The search function includes a global search across all resolutions and a

search capability in a particular year. All resolutions since 1994 are now available and the implementation action for all resolutions since 2013 has been added. Development of this resource is very time consuming and staff will continue to work on it until all resolutions since 1972 have been added.

As mentioned previously, staff update actions on resolutions on a three-year rolling basis in January and again prior to the Council meeting each year. This resolution requests that "a summary of the Board of Directors' intent, discussion, and decision for each referred resolution shall be included." The "intent and "discussion" by the Board is not available since only the decision about the resolution is recorded in the minutes. Minutes of Board meetings are not transcripts and only include the topic and the actions of the Board.

Additionally, the resolution requests that "These communications shall be provided at 30 calendar day intervals until these communications demonstrate that no further Board action is required according to the Bylaws listed previously in this section." Implementation of a resolution can take many months and sometimes multiple years to complete depending on the action required. Compliance with the requirement to report on all outstanding resolutions every 30 days, versus when key milestones are reached, would require reallocation of staff resources from other projects.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 12(15) Searchable Council Resolution Database adopted. Directed ACEP to create a web-based searchable database for Council resolutions.

Substitute Resolution 30(90) Resolution Review adopted. Revised the Council Standing Rules to include a periodic review of previous resolutions adopted by the Council and the Board of Directors and provide an annual report to the Council.

Prior Board Action

Amended Resolution 12(15) Searchable Council Resolution Database adopted.
Substitute Resolution 30(90) Resolution Review adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY: Membership Committee
Board of Directors

SUBJECT: Eligibility for Retired Membership

PURPOSE: Bylaws amendment to establish a maximum of 280 working hours annually for eligibility for retired status.

FISCAL IMPACT: Reduced dues revenue from retired dues vs. regular member dues.

WHEREAS, The number of emergency physicians nearing retirement has increased significantly since the founding of the College; and

WHEREAS, Most retired emergency physicians do not work clinically at all, some still work an occasional shift, or volunteer doing medical work; and

WHEREAS, It is in the interests of the College to maintain these physicians as members with their many years of dedication to the College and rich experience in emergency medicine; therefore be it

RESOLVED, That the ACEP Bylaws, Article IV – Membership, Section 2.1 Regular Members, paragraph 4, be amended to read:

"Regular members who have retired from medical practice for any reason**, or those working less than 280 hours annually,** shall be assigned to retired status."

Background

This Bylaws amendment would allow members who work less than 280 hours annually to qualify for retired status and pay retired dues.

The Membership Committee conducted a comprehensive review of the various classes of membership this past year and eligibility for retired status was of specific interest. The number of retired members continues to rise and we need to ensure ACEP's policies and procedures reflect the needs of the membership now and in the future.

The dues rate for retired members is set at 1/3 of the regular member dues rate. Many chapters have matched the dues discount for retired members for membership retention, but some have not. These veteran members have significant experience and much to offer the College from continued membership; however, they are often constrained by the cost of continuing membership in ACEP and their constituent state chapters.

The committee discussed the current prohibition of any working hours to be eligible for the retired dues rate as well as the potential to develop a semi-retired category to offer a pathway from full time practice to retirement. After several lengthy discussions, the committee determined that adding an additional category of semi-retired is an unnecessary step. There was consensus that the retired definition should be expanded to include a small number of working hours. This will allow our most senior members to continue to participate in limited ways to support the specialty while receiving the dues discount that may be necessary to maintain membership on a more limited income.

While there is the potential for some fiscal impact if members move from the regular member dues rate to retired dues rate, there is a stronger belief that these individuals will remain involved members longer if they are able to continue to work limited hours and receive a dues discount that concedes their changing financial situation without a full-time salary.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Increase total membership and retain graduating residents.

Fiscal Impact

Reduced dues revenue when members move from the regular member dues rate to retired dues rate.

Prior Council Action

Resolution 9(10) Life, Disabled, and Retired Members – Bylaws Amendment referred to the Board of Directors.

Resolution 18(08) Retaining Retired and Disabled Members adopted. Directed ACEP to study the feasibility of a no cost retired membership category or reducing the cost of life membership as a means of retaining retired members.

Amended Resolution 25(05) Combining Life and Retired Membership Categories adopted. Combined the life and retired membership categories.

Amended Resolution 3(02) Chapter Membership for Retired Members adopted. Allowed retired members who move to another state after retirement to continue their chapter affiliation in the chapter of prior professional practice/residence.

Amended Substitute Resolution 5(00) Retired Membership adopted. Called for the creation of a new category of membership for retired members.

Resolution 9(98) Life Membership not adopted. Called for the redefinition of Life Member to include physicians who are retired from practice.

Prior Board Action

June 2021, approved the recommendation from the Membership Committee to submit a Bylaws resolution to the 2021 Council to establish a maximum number of 280 working hours annually for eligibility for the retired dues rate.

June 2011, approved taking no further action on Referred Resolution 9(10) Life, Disabled, and Retired Members and assigned an objective to the Membership Committee to revise the classes of membership.

June 2011, determined to not submit a resolution to the 2011 Council regarding

June 2010, approved the definition of "retired from active medical practice" as "one no longer engaged in the practice of clinical emergency medicine as evidenced by non-renewal of their medical license or less than 1/3 of their income comes from activities associated with being employed as a physician." Also approved an updated policy and benefits for retired members.

June 2009, approved changing the dues structure for future Life members to eliminate the discount for dues and receive a 15% discount for *Scientific Assembly* registration fees effective July 1, 2009.

Resolution 18(08) Retaining Retired and Disabled Members adopted.

Amended Resolution 25(05) Combining Life and Retired Membership Categories adopted.

Amended Resolution 3(02) Chapter Membership for Retired Members adopted.

Amended Substitute Resolution 5(00) Retired Membership adopted.

September 2000, established dues for the proposed retired category of membership at 33.33% of active dues.

June 2000, approved the Membership Committee's recommendation for a retired category of membership and to submit a resolution to the 2000 Council. Also directed the committee to propose reduced dues rate for the Board to consider in anticipation that the Council would adopt the resolution.

October 1998, assigned an objective to the Membership Committee regarding retired membership that included directives to recommend a new status or revisions to a current status and to recommend a dues rate and options for retired member.

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

Jana Nelson
Senior Vice President, Communications

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 12(21)

SUBMITTED BY: Sara Chakel, MD, FACEP; Michael McCrea, MD, FACEP; Scott Pasichow, MD, MPH; Paul Pomeroy, MD, FACEP; Todd Slesinger, MD, FACEP, FCCM, FCCP; James Thompson, MD, FACEP; Larisa Traill, MD, FACEP; Nicole Veitinger, DO, FACEP

SUBJECT: Permitting Bylaws Amendments on the Unanimous Consent Agenda

PURPOSE: Amends the Council Standing Rules to allow Bylaws amendments to be included on the Unanimous Consent Agenda with the proviso that the change will become effective after the 2021 Council meeting.

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

WHEREAS, The ACEP Council Standing Rules (CSR) provide for the use of the "Unanimous Consent Agenda" (UCA) to facilitate the efficiency of the Council; and

WHEREAS, A UCA is for "matters that are routine or expected to be noncontroversial and on which there are likely to be no questions or discussion.[1]"; and

WHEREAS, The CSR prohibit any College Bylaws amendment resolution to be included on the unanimous consent agenda[2]; and

WHEREAS, Any resolution may be extracted from the unanimous consent agenda by a single councillor; and

WHEREAS, Any Bylaws amendment extracted from the unanimous consent agenda will still require a two-thirds vote of credentialled councillors for adoption; and

WHEREAS, Resolutions that amend the CSR do not require Board of Director ratification and become effective immediately; therefore be it

RESOLVED, That the ACEP Council Standing Rules "Unanimous Consent Agenda" section, paragraph two, be amended to read as follows with the proviso that the change will become effective after the 2021 Council meeting:

"All resolutions assigned to a Reference Committee~~, except for Bylaws resolutions,~~ shall be placed on a Unanimous Consent Agenda."

Background

The resolution amends the Council Standing Rules to allow Bylaws resolutions to be included on the Unanimous Consent Agenda for disposition by the Council with the proviso that the change will become effective after the 2021 Council meeting.

[1] Sturgis, Alice. The Standard Code of Parliamentary Procedure, 4th Edition (p. 116). 2001.
[2] "All resolutions assigned to a Reference Committee, except for Bylaws resolutions, shall be placed on a Unanimous Consent Agenda." ACEP Council Standing Rules, Oct 2020.

Last year, the Council adopted a Council Standing Rules amendment to allow all resolutions except Bylaws resolutions to be included on the Unanimous Consent Agenda for disposition by the Council, with the proviso that the changes become effective after the 2020 Council meeting. The resolution further codified that recommendations for amendment or substitution of the resolution will also be included on the Unanimous Consent Agenda.

Bylaws resolutions have previously not been included on the Unanimous Consent Agenda since such amendments require a 2/3 vote for adoption. However, the threshold for adoption, whether a majority vote or a 2/3 vote, is irrelevant since it is the Unanimous Consent Agenda and a request for extraction of any resolution is allowed by any credentialed councillor at the beginning of the Reference Committee report. If a Bylaws amendment is removed from the Unanimous Consent Agenda, the 2/3 vote for adoption would still apply.

ACEP Strategic Plan Reference

None

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

Resolution 17(20) Unanimous Consent Agenda adopted. Amended the Council Standing Rules to include all resolutions, except Bylaws resolutions, on a Unanimous Consent Agenda for disposition by the Council, with the proviso that the changes become effective after the 2020 Council meeting. The resolution further codified that recommendations for amendment or substitution of the resolution will also be included on the Unanimous Consent Agenda.

Resolution 14(17) Unanimous Consent not adopted. This resolution intended to amend the Council Standing Rules 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.

Resolution 3(16) Unanimous Consent not adopted. The resolution intended to amend the Council Standing Rules to require the requestor for extraction to provide up to a one-minute summary of the reason for extraction and, after reading the summary of the testimony from the Reference Committee report, a one-third affirmative vote of the councillors present and voting would be required 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. The resolution 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 – the Board does not take action on Council Standing Rules resolutions.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 13(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: ACEP President-Elect Selected Directly by Members

PURPOSE: Change the process for election of the president-elect by allowing any member of the College to seek election for president-elect, that the election be determined by a majority vote of the physician members of the College, and that if a majority vote is not achieved that a runoff of the top two candidates from the initial election would be held within 24 hours to 7 days of the initial vote to determine the president-elect.

FISCAL IMPACT: Unbudgeted costs to obtain and program voting software or for ACEP to develop its own proprietary voting system.

WHEREAS, It is important to have the membership of the American College of Emergency Physicians, engaged in emergency medicine and have significant influence over the direction of the College; and

WHEREAS, It serves the College well to have its membership engaged and have the perception that ACEP serves its membership and the members are ultimately who control the College; and

WHEREAS, The current arrangement of ACEP is such that members do not vote directly for candidates for the Board of Directors or the President of ACEP; and

WHEREAS, The president serves for only one year, has oversight by the Board of Directors to prevent potentially harmful actions to the College or its members should it were a concern; and

WHEREAS, Some perceive a closed system for leadership in the College i.e., the president-elect being elected by the Council as opposed to the membership; and

WHEREAS, While it is possible for someone to be nominated for president-elect from the floor and not the typical existing Board member; and

WHEREAS, The annual election of the figurehead and single individual identifiable by the public to represent the individual emergency physician, it seems most logical for the individual emergency physician members of the College to directly vote for and elect the president-elect; and

WHEREAS, The president-elect candidates rarely if ever, speak directly to the membership to inform them of what his/her intention and goals are if elected president-elect ("campaign"), but instead campaign to the councillors; and

WHEREAS, The Election process of the ACEP president-elect has not always been in its current form; and

WHEREAS, Given technology and the ability to have remote electronic voting, it is much easier now to allow members to vote and tabulate their vote prior to the Council meeting; therefore be it

RESOLVED, That any member of the College in good standing is eligible to seek election for president-elect of the College; and be it further

RESOLVED, That the ACEP president-elect be determined by a vote directly by the individual emergency

physician members of the College with the majority winner becoming the president-elect; and be it further

RESOLVED, Should a non-majority vote for the president-elect by the membership not be achieved in the initial election, a runoff of the top two candidates from the initial election would be held within 24 hours to 7 days of the initial vote to determine the ultimate winner.

Background

This resolution seeks to change the way the president-elect of the College is elected by allowing any member of the College to be eligible to seek election for president-elect, that the election be determined by a majority vote of the physician members of the College, and that if a majority vote is not achieved that a runoff of the top two candidates from the initial election would be held within 24 hours to 7 days of the initial vote to determine the president-elect.

Election of the president-elect of the College is stipulated in the ACEP Bylaws:

- Article VIII – Council, Section 2 – Powers of the Council, paragraph one, second sentence: "…the Council shall have the right to amend the College Bylaws and College Manual, amend or restate or repeal the College Articles of Incorporation, and to elect the Council officers, the president-elect, and the members of the Board of Directors." Paragraph 2: "…voting rights…are vested exclusively in members currently serving as councillors and are specifically denied to all other members."
- Article VIII – Council, Section 7 – Nominating Committee: "A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker."
- Article X – Officers/Executive Director, Section 2 – Election of Officers, second sentence: "The president-elect shall be elected each year and the speaker and vice speaker elected every other year by a majority vote of the councillors present and voting at the annual meeting."
- Article X – Officers/Executive Director, Section 8 – President-Elect: "Any member of the Board of Directors excluding the president, president-elect, and immediate past president shall be eligible for election to the position of president-elect by the Council." Fourth sentence: "The president-elect shall be elected by a majority vote of the councillors present and voting at the annual meeting of the Council."

The Council Standing Rules address campaign rules and election procedures. The "Election Procedures" section states: "Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot. There shall be no write-in voting." The "Election Procedures" section further delineates how the elections will be conducted and the process for subsequent votes when a majority vote is not achieved.

Additionally, the Council Standing Rules, "Nominating Committee" section, states:

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

Since this resolution would allow for any member of the College in good standing to be eligible to seek election as the president-elect, the role of the Nominating Committee is eliminated regarding candidates for president-elect.

The Council began electing the president-elect in 2005. Prior to 2005, the president-elect was elected by the Board of Directors from among members of the Board of Directors. The Bylaws language governing the election of officers of the Board of Directors, including the president-elect, had been in place since the 1972 revision of the Constitution and Bylaws. In 1990, a proxy vote of the membership was held to codify the existing governance structure and operation establishing councillors with exclusive voting rights to both amend the Bylaws and elect the Board of Directors. This

vote effectively delegated the individual voting rights of members to councillors for those specific purposes.

In 1995, the Council considered a resolution for the Bylaws Committee to develop the necessary Bylaws amendments for election of the president-elect, vice president, and secretary-treasurer by the membership and that the Bylaws amendments be submitted to the 1996 Council. The resolution was not adopted.

As proposed, this resolution would allow any member of the College in good standing to seek election for president-elect. However, the ACEP Bylaws also delineate the eligibility of certain members to hold office:

- Article IV – Membership, Section 2.1 – Regular Members, paragraph 6: "Regular members, with the exception of those in inactive status, may hold office, may serve on the Council, and may vote in committees on which they serve. Regular members in inactive status shall not be eligible to hold office, to serve on the Council, or serve on committees."
- Article IV – Membership, Section 2.3 – Candidate Members, paragraph 2 (second sentence):"At the national level, candidate members shall not be entitled to hold office, but physician members may serve on the Council." The last sentence of paragraph 3: "Candidate members in inactive status shall not be eligible to hold office, serve on the Council, or serve on committees."
- Article IV – Membership, Section 2.4 – International Members, paragraph 4 (first sentence): "International members may not hold office and may not serve on the Council."

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Unbudgeted costs to obtain and program voting software or for ACEP to develop its own proprietary voting system.

Prior Council Action

Amended Resolution 12(04) Election of President-Elect by the Council – Council Standing Rules Amendment adopted. Amended sections of the Council Standing Rules to allow for election of the president-elect by the Council.

Amended Resolution 11(04) Election of the President-Elect by the Council – Bylaws Amendment adopted. Proposed changes to the Bylaws to allow for election of the president-elect by the Council.

Resolution 3(03) Election of President-Elect by the Council not adopted. The resolution proposed to amend the Bylaws and Council Standing Rules to allow for direct election of the president-elect by the Council.

Substitute Resolution 6(02) Election of President-Elect by the Council referred to the Steering Committee. The Steering Committee prepared a resolution for submission to the 2003 Council.

Resolution 34(95) Officer Elections not adopted. The resolution directed the Bylaws Committee to develop Bylaws amendments for direct elections by the membership for the positions of president-elect, vice president, and secretary-treasurer for discussion at the 1996 Council meeting.

Resolution 17(95) Election of the President-Elect not adopted. The resolution proposed to transfer the power to directly elect the president-elect from the Board of Directors to the Council.

Amended Resolution 30(94) Officer Elections adopted. It directed the Bylaws Committee to develop the necessary additions and deletions to the Bylaws to directly elect the president-elect by the membership and that the resultant Bylaws amendment be discussed at the 1995 Council meeting.

Amended Resolution 16(94) Board Eligibility for Officer Positions – President-Elect Option A adopted. The resolution defined that a director is eligible for election to the position of president-elect if he or she has at least one year remaining on the Board as an elected director. Resolutions were also adopted at the 1994 Council meeting requiring that the vice president and secretary treasurer also have at least one year remaining on the Board as an elected director.

1972 revision of the Bylaws approved.

Prior Board Action

Amended Resolution 11(04) Election of the President-Elect by the Council – Bylaws Amendment adopted. Proposed changes to the Bylaws to allow for direct election of the president-elect by the Council.

Amended Resolution 30(94) Officer Elections adopted.

Amended Resolution 16(94) Board Eligibility for Officer Positions – President-Elect Option A adopted.

1990 action following proxy vote to amend the Bylaws establishing councillors with exclusive voting rights to both amend the Bylaws and elect the Board of Directors.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 14(21)

SUBMITTED BY: Young Physicians Section

SUBJECT: Establishing a Young Physician Position on the ACEP Nominating Committee

PURPOSE: Directs the Steering Committee to submit a Bylaws amendment to the Council in 2022 to create a young physician position on the Nominating Committee.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Young physician leaders in ACEP have expressed interest in increased opportunities for leadership and professional development within the College; and

WHEREAS, Participation as a member of the ACEP Nominating Committee provides valuable mentoring and leadership opportunities not gained through other College activities; and

WHEREAS, Several young physician members of ACEP have significant experience in the College including participation on committees, sections, and the Council; and

WHEREAS, Young physician participation in the Nominating Committee ensures representation of our College's largest membership demographic and section[1]; and

WHEREAS, The greatest attrition of ACEP membership has been in those under 40 years of age, during the early years of practice when clinical and financial obligations can overwhelm the call to leadership in organized medicine; and

WHEREAS, The fiscal impact of adding a young physician member to the Nominating Committee is negligible and would be far outweighed by potential retention of young physician members of ACEP; therefore be it

RESOLVED, That the Council Steering Committee submit a Bylaws amendment to the Council in 2022 to support the establishment of a young physician position on the Nominating Committee.

Reference

1. ACEP Annual Report, 2018

Background

This resolution directs the Steering Committee to submit a Bylaws amendment to the Council in 2022 to create a young physician position on the Nominating Committee.

The ACEP Bylaws Article VIII – Council, Section 7 – Nominating Committee, defines the composition of the Nominating Committee:

> "A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members and the president shall appoint the president-elect plus

> two additional Board members. A member of the College cannot concurrently accept nomination to the Board of Directors and Council Office. Nominations will also be accepted from the floor."

The Council Standing Rules, "Nominating Committee" section, provides additional guidance about the role of the Nominating Committee:

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

The definition of a young physician within ACEP is typically someone less than 40 years of age or in the first 10 years of regular ACEP membership, although membership in ACEP's Young Physicians Section is not restricted to any specific time frame or in any respect to age. The current Bylaws language allow for a young physician to be appointed by the Council speaker to serve on the Nominating Committee and young physician members have served on the committee in the past.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

None

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 15(21)

SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section

SUBJECT: Member Determined Council Representation

PURPOSE: Assign a task force or a committee to consider an alternative method of determining councillor allocation (with specific considerations) and that a report be provided to the Board no later than June 2, 2022 (at least one month before the resolution submission deadline for the 2022 Council meeting).

FISCAL IMPACT: Budgeted committee/task force and staff resources. Unbudgeted resources of $20,000-$30,000 if an in-person committee/task force meeting is held.

WHEREAS, The current system of representation is determined by the location of the member i.e., state in which they are registered; and

WHEREAS, Many within the College have various interests that may be more important to them than to others; and

WHEREAS, The College (ACEP) wants to best represent what the membership wants the College to represent; and

WHEREAS, Each member essentially gets "one vote" that is counted towards the state that the member is from, without any consideration of other interests that may be more important to the individual member; and

WHEREAS, There are common sense ways to better represent the will of the membership; therefore be it

RESOLVED, That a task force or committee be appointed to consider an alternative method of determining representation of the membership with specific consideration given to addressing the following:

1. Council composition to be determined by the allocation of credits or points that each individual emergency physician members in good standing of the College will be allotted equally.
2. Each and every full member in good standing who pays full membership dues will be assigned five (5) points or credits that the individual emergency physician is free to assign in whatever breakdown the member wishes towards his/her state chapter, another state chapter, a particular section, or any combination the member wishes to assign the points/credits.
3. Council representation will be determined by the total number of votes/points that were assigned by all paying emergency physician members, i.e., total number of Council positions available (councillors) will be divided into the total number of points to determine how many available councillors will be assigned to each specific chapter, section, etc.
4. Consider maintaining a minimum number of councillor positions i.e., one (1) could be assigned to each state and each section with a minimum of 100 paying members, with the remaining councillor positions assigned according to the pro-rated number of credits/points that the individual emergency physicians assigned.
5. Consider a hybrid that gives preference as seen fit; and be it further

RESOLVED, That a task force or committee assigned to review alternative methods of determining representation of the members in the Council conclude its investigation, research, and suggestions and report back to

the Board with sufficient time for the Board to report the information to the Council at least one month before the resolution submission deadline for the 2022 Council meeting.

Background

This resolution requests that a committee or task force be assigned to consider an alternative method of determining councillor allocation by: 1) allocation of credits or points that each member will be allotted; 2) each member in good standing that pays full membership dues will be given five points or credits that each member can assign to their home chapter, another chapter, a section, or any combination the member desires to assign the points/credits; 3) Council representation will be determined by the total number of votes/points that were assigned by all paying emergency physician members, i.e., total number of Council positions available (councillors) will be divided into the total number of points to determine how many available councillors will be assigned to each specific chapter, section, etc.; 4) consider maintaining a minimum number of councillor positions i.e., one could be assigned to each state and each section with a minimum of 100 paying members, with the remaining councillor positions assigned according to the pro-rated number of credits/points that the individual emergency physicians assigned; and 5) consider a hybrid that gives preference as seen fit. The resolution further requests that a report be provided to the Board no later than June 2, 2022 (at least one month before the resolution submission deadline for the 2022 Council meeting).

The ACEP Bylaws, Article VIII – Council, Section 1 – Composition of the Council, states:

> "Each chartered chapter shall have a minimum of one councillor as representative of all of the members of such chartered chapter. There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the membership rolls of the College on December 31 of the preceding year."

That section of the Bylaws also specifies that EMRA is entitled to 8 councillors; ACOEP, AACEM, CORD, SAEM, and sections of membership are entitled to one councillor each.

The Council and the Board of Directors adopted Amended Resolution 13(18) Growth of the ACEP Council. The resolution directed the Council officers to appoint a task force of councillors to study the growth of the Council and determine whether to submit a Bylaws amendment to the 2019 Council addressing the size of the Council and the relative allocation of councillors. The task force provided their report to the Council Steering Committee in May 2019. The Steering Committee recommended that the report and the options developed by the task serve as the topic of the Town Hall Meeting during the 2019 Council meeting. The Town Hall meeting focused on the Growth of the Council and five scenarios were presented for consideration by the Council:

1. no changes to the current councillor allocation method as delineated in the Bylaws;
2. capping the maximum number of councillors at 35;
3. two councillors per chapter and additional councillors for each 200 members
4. one councillor per chapter with one additional councillor for each 200 members; and
5. each chapter allocated two councillors and additional councillors based on their percentage of total ACEP members and removing section councillors.

The majority response from the Council was to take no action to change the current councillor allocation method as delineated in the Bylaws.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted committee/task force and staff resources. Unbudgeted resources of $20,000-$30,000 if an in-person

committee/task force meeting is held.

Prior Council Action

Amended Resolution 13(18) Growth of the ACEP Council adopted. Directed the Council officers to appoint a task force of councillors to study the growth of the Council and determine whether to submit a Bylaws amendment to the 2019 Council addressing the size of the Council and the relative allocation of councillors.

Prior Board Action

Amended Resolution 13(18) Growth of the ACEP Council adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 16(21)

SUBMITTED BY: John C. Moorhead, MD, FACEP
Christopher Strear, MD, FACEP

SUBJECT: ACEP Group Membership

PURPOSE: Provide individual members a 20% discount each year their group maintains 100% membership and that chapters be encouraged to match this discount on chapter dues.

FISCAL IMPACT: Unknown at this time.

WHEREAS, ACEP Group membership is recognized as '100 per cent club' if all group members are ACEP members; and

WHEREAS, "100 % Club" groups are recognized at ACEP meetings and in publications; and

WHEREAS, Benefits to groups who meet criteria for "100 % Club" include 25% discount for membership dues for new members and $25 'ACEP bucks' that can be used for ACEP educational products for existing members; and

WHEREAS, All emergency physicians receive benefits from ACEP advocacy efforts; and

WHEREAS, ACEP's goals should include 100% membership for all emergency physicians; therefore be it

RESOLVED, That ACEP group membership policy be revised to provide individual members a 20% discount on annual ACEP membership dues for every year that the group maintains 100% membership in ACEP beginning in 2022; and be it further

RESOLVED, That ACEP state chapters be encouraged to provide annual state chapter individual dues discount for members of groups who maintain 100% ACEP membership.

Background

This resolution asks ACEP to revise the group membership policy to provide individual members a 20% discount on annual dues every year that the group maintains 100% membership and that chapters be encouraged to provide chapter dues discounts for members of groups that maintain 100% membership.

Promotion of group master billings and ACEP's group recognition program began in 2006. In addition to the efficiency of group billing, which reduced administrative costs to groups, involvement in the 100% Club also included recognition in ACEP publications and online as well as a plaque acknowledging this distinction. Additionally, the application fee of $30 was waived for each new member added to the 100% Club. A $250 rebate was given for groups with 5 or more physicians registered to attend the same ACEP educational meeting.

In 2007, the Membership Committee suggested a discount program for all groups. Because the data regarding group employees was incomplete at that time, a fiscal analysis could not be completed. As an alternative, a 10% discount for new members was suggested by the Membership Committee and considered by the Finance Committee. It was agreed

that using only new members would have a positive fiscal impact. The recommended discount program was considered but ultimately not adopted because ACEP lacked the software needed to efficiently implement the discounts. At the time, the billing process and procedures would have required significant revision and required significant investment to implement. Using a variable discount added to the complexity of combined billing of both national and chapter dues making it a daunting task.

The Council and the Board of Directors adopted Resolution 16(08) Dues Discount for Groups Participating in the "100% Club." The Board approved the group membership benefit program in April 2009 and implementation began in July 2009. The current group discount program includes:

- $25 coupon for each of individual physician to use on any ACEP meeting or product.
- 15% discount with 15 or more physicians registered to attend the annual conference.
- 15% discount on all job postings and ad products on EM Career Central (ACEP and EMRA's online job board).
- Waiver of the $30 ACEP application fee for each ACEP member that is added to the physician employment group.

As of 2020, ACEP launched a group billing portal that has streamlined the group billing process. This portal has increased efficiency in group billing significantly and it allows bi-directional communication between ACEP and groups as well as simplified payment processing. Currently, there are:

TOTAL # OF ACEP GROUPS	1,897
# GROUPS 100% Club	137
# GROUP BILLING	144
# INDIVIDUAL MEMBERS	4,754

While national ACEP can encourage chapters to provide individual dues discount for members of groups who maintain 100% ACEP membership, the decision is ultimately determined by each chapter. There would need to be consistency applied across all chapters to launch this type of discounted rates in an effective manner. Variable discount rates selected by various chapters can create implementation problems.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Objective B – Increase total membership and retain graduating residents.
  - Tactic 1 – Grow total ACEP membership by expanding on the following membership categories:
    A. Recruitment and retention of Regular Members
       i. Increase retention of graduating members
       ii. Increase retention of early career physicians at 2nd, 3rd, and 4th year post residency
       iii. Increase business development strategies to increase group membership participation
    B. Test multiple membership models to determine potential path for ACEP's future structure.

Fiscal Impact

The actual fiscal impact cannot be calculated as groups move in and out of group billing and participation in the 100% Club.

Prior Council Action

Resolution 16(08) Dues Discount for Groups Participating in the "100% Club" adopted. The resolution directed ACEP to provide a dues discount for members of the 100% Club.

Amended Substitute Resolution 55(05) Recognition of Group Participation in ACEP adopted. The resolution directed that a recognition program be developed for groups with 100% participation of eligible members.

Prior Board Action

April 2009, approved the group membership benefit program. Implementation began in July 2009.

Resolution 16(08) Dues Discount for Groups Participating in the "100% Club" adopted.

April 2007, supported the Membership Committee's member recruitment recommendations that included a continued promotional plan with an ultimate goal of 50% participation by groups.

January 2006, approved the Membership Committee recommendation to implement and promote a comprehensive master billing and recognition program to emergency physician groups.

Amended Substitute Resolution 55(05) Recognition of Group Participation in ACEP adopted.

Background Information Prepared by: Jana Nelson
Senior Vice President, Communications

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 17(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Fair Emergency Physician Employment Contract Template

PURPOSE: Develop sample contracts for employees and independent contractors to ensure members are effective and educated self-advocates when considering potential employment opportunities.

FISCAL IMPACT: Budgeted committee or task force and staff resources. Additional unbudgeted resources to implement the resolution as written, which could likely include the need to add a part-time legal department staff member to work with members and outside counsel to revise, review, and develop the contract templates and manage the creation of a database. Potential cost is a minimum of $25,000.

WHEREAS, All, or almost every emergency physician must contract with an employer, contract management group, hospital or other entity for employment; and

WHEREAS, Many emergency physicians, particularly residents who are still in their training have little legal or contractual training or experience relative to the entity they will be contracting with; and

WHEREAS, Emergency physicians do not fully understand or have vast experience with contract negotiations to understand the many factors and variables that are associated with a contract; and

WHEREAS, Many emergency physicians often make an error or assume that a contract is not negotiable; and

WHEREAS, Many emergency physicians are told that the contract that they are presented with is a “standard contract” and make the mistake or assume that the contract must be fair if others agree to it; and

WHEREAS, The party that represents the entity that the emergency physician is to contract with does not often clearly explain the many points that are negotiable; and

WHEREAS, The reality is that most every contract is negotiable; and

WHEREAS, The emergency physician often does not fully understand market forces and often undervalues the market value of his or her services; and

WHEREAS, It would behoove ACEP to provide a service or a template of a “favorable” contract for an emergency physician that could be of significant value to its members and serve as a template or guidance to the emergency physician to better understand the many factors involved in a negotiation that have value and not to simply allow a contract management group, hospital or other employer to take advantage of the emergency physician; and

WHEREAS, Many emergency physicians may view such a template as a very valuable service and alone could help the emergency physician avoid agreeing to a contract that they will regret and may save or make the emergency physicians enough money to pay for ACEP membership many times over; and

WHEREAS, Even if the emergency physician did not get each of the items, the emergency physician would at least be aware of the variables and likely could negotiate the variables to achieve other items of value that the emergency physician might not have otherwise gotten; and

WHEREAS, Even if the emergency physician chooses to sign the "standard contract" that the contract management group, physician group or hospital offers, the emergency physician would at least be aware of the items that could be negotiated and would not be worse off by having the knowledge and the choice to accept them, negotiate for more, or walk away; and

WHEREAS, Other professional organizations have "standard contracts" available for their members and the public to use in a contract negotiation; and

WHEREAS, Many of these templates are available at no cost online; and

WHEREAS, It is understood that ACEP would provide this sample favorable emergency physician template only for informational purposes at no charge to its members, would not be giving legal advice, not offering to represent the emergency physician in contractual negotiations, or having any sort of contractual or other relationship because of producing such a template; therefore be it

RESOLVED, ACEP develop a sample employment and independent contract template specific that is fair to emergency physicians and specifically points out numerous items that can and should be part of the negotiation, understanding that when an emergency physician is asked to give up a right or agree to something that favors the employer, it is reasonable to expect or negotiate something favorable to the emergency physician in return, including but not limited to the following items:

1. Compensation and how it is determined with base or minimum amount
2. Other compensation that the employer may generate directly or indirectly as a result of emergency physician services and how much of that the emergency physician is entitled to
3. Incentives, what ones, how they are determined, who determines them, by what measure/metrics, is the data available to both parties to review, etc.
4. Percentage of gross billing or collection, how is it determined, who collects data, how accessible is this data by the emergency physician, etc.
5. Deductions that are often taken from income and how much may be reasonable i.e. medical malpractice, scheduling, etc.
6. Equitable scheduling of shifts and a reasonable differential pay or incentives for accepting less favorable shift distribution
7. Equal treatment as all members of the medical staff at the facility the emergency physician will work i.e. employer will not agree that emergency physicians have less rights than other members of the same medical staff, etc.
8. Emergency physician's right and final say to determine whether or not to settle a claim without trial
9. Specific language as to the transparency of the operations of the group/company that the emergency physician will be joining/working with/for and what power i.e. vote percentage the emergency physician will have and when
10. Severance pay to the emergency physician should the employer contract to hire and then withdraw the contract; terminate the physician; or there is separation of the parties (emergency physician and the group)
11. Non-compete clauses or specific language that there are no non-compete clauses (NCC). If there is a non-compete clause, is it only to prevent taking over a staffing contract? What is the duration of the NCC? Is the NCC only at the same facility, same town or city? What is the geographic distance of the NCC? Is there a buy out of the NCC? How much does the employer compensate the emergency physician to agree to a non-compete clause?
12. Whether the emergency physician is required to supervise, oversee, or collaborate with non-physicians and what control the emergency physician has to select who they work with, what control they have over quality measures, assurance, and enforcement including termination of the non-physician? How much additional compensation does the emergency physician receive for this service of oversight? How is it calculated? Who measures it? How accessible is the data?
13. The emergency physician should be aware of and should consider negotiating/demanding in their particular circumstances
14. Clear language requiring the employer to provide billing information that is complete, clear and transparent to

the emergency physician regarding that emergency physician's billing on a regular i.e. monthly, quarterly, semi-annual basis, without the emergency physician having to request it and not allowing the employer to require the emergency physician to have to ask for the information

15. Other topics and points that are deemed appropriate; and be it further

RESOLVED, That the ACEP Board of Directors expeditiously appoint a task force or committee to identify many factors to include in a sample employment document that is fair to emergency physicians that identifies as many items that can be separately negotiated, and provide favorable and unfavorable examples of each negotiating item, and to have such task force or committee submit their final recommendations to the Board within six (6) months and for ACEP to have a final document produced and out for viewing by the membership as soon as possible but no later than before the 2022 Council meeting begins.

Background

This resolution asks the College to appoint a task force to create template employment and independent contractor agreements that would include, at a minimum, sample provisions addressing fifteen potential employment and compensation concerns.

In 1994, the Board approved a resolution calling for the College to provide members with practical and comprehensive resources to assist them in negotiating contracts that meet their needs. Since that time, ACEP has created and updated several resources seeking to accomplish this goal, with additional educational materials being planned in 2021-22. Based on contract guidelines developed by the Medical-Legal Committee for EMRA, ACEP recently created a contract checklist for members to utilize when reviewing an employment contract.

Staff is currently working with member volunteers to update many of the contract resources found on our website such as policy statements, model contracts, and articles on fairness and due process considerations.

In March 2021, a promotional campaign was launched reminding ACEP members of resources available through Mines & Associates, a vendor that provides members financial and legal support. For $15 annually, ACEP members can schedule an unlimited number of 30-minute in-person consultations for each individual legal matter. Members can also take advantage of a 25% discount on select legal services within the Mines & Associates legal network if additional support is required.

On May 6, 2021, the Young Physicians Section hosted a webinar, "Standard Contract Precautions," that was promoted in advance and now resides on ACEP's Career Resources page and is referenced in career-related communications.

Staff is reviewing and updating existing resources (Indemnification Clauses, Fairness and Due Process, and more) found at acep.org/contracts. We are currently working to curate external resources and create new resources to expand member's understanding of contract nuances.

Because contract needs are individualized, plans are underway for a contract clause library based on many of the recommended subjects in this resolution. This online library will be categorized by topic and will provide favorable clauses for consideration.

There are also plans underway to recruit member volunteers to participate in a peer-to-peer mentoring program addressing common issues that arise in contract negotiations. We will host several virtual training opportunities with experts in employment law as well as organize webinars with veteran emergency physicians who will answer member questions and discuss real life examples, both successes and pitfalls, of their own contract negotiation wins and losses.

ACEP Strategic Plan Reference
Goal 2 – Enhance Membership Value and Member Engagement

- Objective A – Improve the practice environment and member well-being.

- Tactic 1 – Enhance and promote availability of a clearinghouse of materials, resources, and courses on professional liability and litigation stress.

Fiscal Impact

Budgeted committee or task force and staff resources. Additional unbudgeted resources to implement the resolution as written, which could likely include the need to add a part-time legal department staff member to work with members and outside counsel to revise, review, and develop the contract templates and manage the creation of a database. Potential cost is a minimum of $25,000.

Prior Council Action

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) adopt a policy prohibiting members from denying another emergency physician the right to due process regarding their medical staff privileges and prohibits members from holding management positions at entities that deny an emergency physician this right; 2) revise the policy statement "Emergency Physician Rights and Responsibilities;" 3) adopt a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians

Amended Resolution 49(19) Protecting Emergency Physician Compensation During Contract Transitions adopted. Directed ACEP to adopt a new policy statement addressing continuity of fair compensation including monetary compensation as well as uninterrupted provision of benefits and malpractice coverage during times of contract transitions.

Amended Resolution 17(19) Pay Transparency adopted. Directed ACEP to develop a policy statement in favor of physician salary and benefit package equity and transparency.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted. Directed ACEP to develop model language for emergency physician employment contracts addressing termination for any emergency physician subjected to adverse action related to involvement in quality/performance improvement, patient safety, or other medical staff activities, and specifying due process for physicians subjected to such adverse action.

Resolution 29(11) Due Process for Emergency Physicians adopted. Directed ACEP to review and update the policy statement "Emergency Physician Contractual Relationships" regarding due process and distribute the updated policy to other organizations and request that it be distributed to their membership and to other entities deemed appropriate by the Board of Directors.

Resolution 15(02) Promotion of College Policies on Contracting and Compensation not adopted. Requested that ACEP review the policy statement "Promotion of College Policies on Contracting and Compensation" for potential revisions, realign the policy statement "Promotion of College Policies on Contracting and Compensation" with other clearly stated College policy or rescind it entirely, and provide a report to the 2003 Council.

Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted. Directed ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and to continue to promote the adoption of the principles outlined in the "Emergency Physician Rights and Responsibilities" policy statement by the various emergency medicine contract management groups, the American Hospital Association and other pertinent organizations.

Resolution 12(01) Coercive Contracting not adopted. Called for the College to discourage any contracting practice that may be illegal, unethical, or any practice that may circumvent fair and equitable negotiations, explore the legal issues surrounding coercive contracting and, if appropriate, request an OIG opinion on contracts that force emergency physicians to accept less than fair market value reimbursement from third party payers in exchange for the right to retain their contract.

Substitute Resolution 10(01) Commercial Sponsorships adopted. Directed the Board to continue initiatives to develop and implement policies on self-disclosure of compliance by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings with ACEP physicians' rights policies, including: "Emergency Physicians Rights and Responsibilities," "Emergency Physician Contractual Relationships," "Agreements Restricting the Practice of Emergency Medicine," and "Compensation Arrangements for Emergency Physicians."

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.

Resolution 59(95) Due Process for Emergency Physicians referred to the Board of Directors. The resolution called for the College to support, and incorporate into educational and advocacy efforts, promotion of the concepts of due process in all employment arrangements for emergency physicians, that any emergency physician being terminated has the right to receive the reasons for such termination and to formally respond to those reasons prior to the effective date of the termination.

Amended Resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clauses and 54(94) Due Process. The amended resolution directed the College to study the issue of peer review and due process exclusion clauses in emergency physician contracts.

Amended Resolution 49(94) Information on Contract Issues adopted. Directed ACEP to continue to make efforts to provide members with current and comprehensive information to assist them in negotiating contracts.

Prior Board Action

June 2021, approved developing and distributing a questionnaire to all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products in which they are asked to voluntarily provide information about their organizations.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised June 2018, October 2012, January 2006, March 1999, August 1993 with current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" revised April 2015, April 2002, June 1997. Reaffirmed October 2008, April 1992; originally approved June 1988.

October 2020, approved the policy statement "Emergency Physician Compensation Transparency."

February 2020, approved the policy statement "Protecting Emergency Physician Compensation During Contract Transitions."

July 2019, reviewed the updated information paper "Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships;" revised June 1997, originally reviewed July 1996.

Amended Resolution 49(19) Protecting Emergency Physician Compensation During Contract Transitions adopted.

Amended Resolution 17(19) Pay Transparency adopted.

July 2018, reviewed the Policy Resource and Education Paper (PREP) "Emergency Physician Contractual Relationships." The PREP is an adjunct to the policy statement "Emergency Physician Contractual Relationships."

May 2018, reviewed the information paper "Emergency Department Physician Group Staffing Contract Transition."

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

April 2016, reviewed the information paper "Indemnification Clauses in Emergency Medicine Contracts."

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted.

Resolution 29(11) Due Process for Emergency Physicians adopted.

Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted.

Substitute Resolution 10(01) Commercial Sponsorships adopted.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Group adopted.

Amended Resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clauses and 54(94) Due Process.

Amended Resolution 49(94) Information on Contract Issues adopted.

Background Information Prepared by: Jana Nelson
Senior Vice President, Communications

Leslie Moore, JD
Senior Vice President, General Counsel

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 18(21)

SUBMITTED BY: Howard K. Mell, MD, MPH, FACEP
Phillip Luke LeBas, MD, FACEP

SUBJECT: Change to ACEP Conflict of Interest Statement

PURPOSE: 1) Revise ACEP's Conflict of Interest (COI) disclosure form to include all immediate family members, intimate partners, and non-adopted children of a current spouse; 2) provide the COI forms to all members and staff working on the project, committee, or task force and be included in the materials for that project, committee, or task force; 3) revise the COI disclosure form to include a question to indicate whether the person completing the form is related to a non-physician provider (e.g., nurse practitioner or physician assistant) and if that person formerly or currently works in an ED or urgent care facility; and 4) all candidates for election by the Council, including anyone running from the floor, complete the COI form and copies of the forms be included in the election materials and available to all councillors

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, ACEP policy requires "key leaders" of the College and staff of the College to complete a Conflict of Interest (COI) form; and

WHEREAS, Current ACEP policy calls for:

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

a. Positions of leadership in other organizations, chapters, commissions, groups, coalitions, agencies, and entities – e.g., board of directors, committees, spokesperson role. Include a brief description of the nature and purposes of the organization or entity.
b. Positions of employment, including the nature of the business of the employer, the position held, and a description of the daily responsibilities of the employment.
c. Direct financial interest (other than a less than 1% interest in a publicly traded company) or positions of responsibility in any entity:
    i. From which ACEP obtains substantial amounts of goods or services;
    ii. That provides services that substantially compete with ACEP; and
    iii. That provides goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company).
d. Industry-sponsored research support within the preceding twenty-four (24) months.
e. Speaking fees from non-academic entities during the preceding twenty-four (24) months.
f. The receipt of any unusual gifts or favors from an outside entity or person, or the expectation that a future gift or favor will be received in return for a specific action, position, or viewpoint taken in regard to ACEP or its products.
g. Any other interest the Key Leader believes may create a conflict with the fiduciary duty to ACEP or that may create the appearance of a conflict of interest.; and

WHEREAS, The current ACEP policy states:

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

a. The individual;

b. A member of that individual's immediate family; or
c. Any party, group, or organization to which the individual has allegiance that can cause ACEP to be legally or otherwise vulnerable to criticism, embarrassment or litigation."; and

WHEREAS, The role and use of non-physician providers (e.g., nurse practitioners or physician assistants – term used as it remains the legal term in most states) in the emergency department is a subject of frequent debate and the questions of their role permeates many projects within the College; and

WHEREAS, Some individuals may be blinded to their own biases, especially when it comes to the influence exerted by immediate family members or intimate partners; therefore be it

RESOLVED, That the ACEP Conflict of Interest form include all immediate family members or intimate partners in situations of same sex couples not recognized by local law as well as non-adopted children of a current spouse; and be it further

RESOLVED, That the ACEP Conflict of Interest forms be provided to all members and relevant staff and be included in the introductory materials for the project, committee, or task force; and be it further

RESOLVED, That a question be added to the College's Conflict of Interest form to indicate if the person completing the form is related to a non-physician provider and if that non-physician provider formerly or currently works in an emergency department or urgent care; and be it further

RESOLVED, That every candidate for the College President, Board of Directors, or Council Officer positions, including those running from the floor, complete the ACEP Conflict of Interest (COI) form and copies of those COI statements be included in election materials and available to all councillors.

Background

This resolution seeks to revise ACEP's Conflict of Interest (COI) disclosure form to include all immediate family members, intimate partners, and non-adopted children of a current spouse; provide the COI forms to all members and staff working on the project, committee, or task force and be included in the materials for the project, committee, or task force; revise the COI disclosure form to include a question to indicate whether the person completing the form is related to a non-physician provider (e.g., nurse practitioner or physician assistant) and if that person formerly or currently works in an ED or urgent care facility; and that all candidates for election by the Council, including anyone running from the floor, complete the COI form and copies of the forms be included in the election materials and available to all councillors.

ACEP's "Conflict of Interest" policy statement was first adopted in 1996 and it has undergone multiple revisions since that time. The policy statement is also informed by external standards such as the Council of Medical Specialty Societies' (CMSS) "Code for Interactions with Companies" and the Accreditation Council for Continuing Medical Education's (ACCME) "Standards for Integrity and Independence in Accredited Continuing Education."

ACEP adopted the CMSS "Code for Interactions with Companies" in 2010. The purpose of the Code is to guide Medical Specialty Societies in the development of policies and procedures that safeguard the independence of their programs, policies, and advocacy positions. Because Societies can vary in their activities and corporate structures, each Society that chooses to sign on to the Code is encouraged to adopt policies and procedures that are tailored to meet its individual organizational needs. Collectively, adopting this Code helps to ensure that a Society's interactions with Companies will be for the benefit of patients and members and for the improvement of care in their respective specialty fields.

ACEP must adhere to the ACCME "Standards for Integrity and Independence in Accredited Continuing Education" as an accredited provider of continuing medical education (CME). The Standards cover a variety of issues, including preventing commercial bias and marketing in accredited CME and identifying, mitigating, and disclosing relevant financial relationships.

"Key leaders," as defined in the "Conflict of Interest" policy statement, are "Officers, Directors, Committee Chairs and Members, Section Chairs, Task Force Chairs, *Annals* Editor, and the Executive Director." The policy requires key leaders to sign an annual conflict of interest disclosure form. ACEP also requires all task force members to complete the disclosure form. The disclosure form is the same for all key leaders, except that the heading on the form is updated for each type of key leader (e.g., Board members, committee chairs, etc.). The COI forms are maintained in each key leader's membership record and they are required to submit updated disclosure forms any time throughout the year as necessary to continuously keep the information current. The questions on the disclosure form can be modified at any time to include additional questions that may be needed at any time such as those requested in this resolution.

The COI disclosure forms are available to any committee or task force member and staff. The forms can be provided to all committee and task force members with any materials distributed for that project, committee, or task force.

All candidates seeking election as president-elect, Board member, or Council officer, including those running from the floor, must complete a Candidate Data Sheet and a Candidate Disclosure Form.

The Candidate Data Sheet requests candidates to provide the following information:

- current and past professional position(s)
- education (including internships and residency information), medical degree, and year received
- specialty certifications and dates certified and recertified
- membership in professional societies
- national ACEP and chapter activities
- practice profile
- description of current emergency medicine practice (e.g., type of employment, type of facility, single or multi-hospital group, etc.) including title and position
- expert witness experience.

The Candidate Disclosure Form requests candidates to provide the following information:

- employer, position held, type of organization
- Board of Directors positions held (current and past) including the name of the organization, address, type of organization, and duration on the Board

The Candidate Disclosure Form also requests the following information:

- I hereby state that I or members of my immediate family have the following affiliations and/or interests that might possibly contribute to a conflict of interest. Full disclosure of doubtful situations is provided to permit an impartial and objective determination. (answer none or if yes describe)
- Describe any outside relationships that you hold with regard to any person or entity from which ACEP obtains goods and services, or which provides services that compete with ACEP where such relationship involves: a) holding a position of responsibility; b) an equity interest (other than a less than 1% interest in a publicly traded company); or c) any gifts, favors, gratuities, lodging, dining, or entertainment valued at more than $100.
- Describe any financial interests or positions of responsibility in entities providing goods or services in support of the practice of emergency medicine (e.g., physician practice management company, billing company, physician placement company, book publisher, medical supply company, malpractice insurance company), other than owning less than a 1% interest in a publicly traded company.
- Describe any other interest that may create a conflict with the fiduciary duty to the membership of ACEP or that may create the appearance of a conflict of interest.
- Do you believe that any of your positions, ownership interests, or activities, whether listed above or otherwise, would constitute a conflict of interest with ACEP?

The information requested on the Candidate Disclosure Form is essentially the same as what is requested on the COI disclosure form. Additionally, the CVs of all candidates are provided to the Council. Upon election, all new Board members and Council officers are required to submit the COI form.

Information on each of this year's candidates is provided in the PDF compendium of Council meeting materials and

will also be emailed separately to the Council.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 8(12) Conflict of Interest Disclosure. Added a new section to the Council Standing Rules on conflict of interest disclosure.

Resolution 23(03) Conflict of Interest for ACEP Leaders not adopted. The resolution sought to have all members serving on committees, in the Council, and Board members disclose any leadership positions with potential conflict by written notification to the Council speaker and Board president.

Substitute Resolution 23(97) Conflict of Interest adopted. The resolution directed that the Council support the Conflict of Interest policy as approved by the ACEP Board of Directors and that the Council commend the Board of Directors for its rapid and decisive action in establishing this policy.

Resolution 42(95) Executive Officer Business Interests referred to the Board of Directors. Called for ACEP's top ten executives to not have any financial arrangement and/or direct affiliation with any corporate or private organization that profits financially from the field of emergency medicine.

Resolution 40(95) NEMPAC Officer Business Interests not adopted. Called for NEMPAC officers members to report and publish annually in *ACEP News* any personal business investments in emergency medicine related companies. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Resolution 39(95) Board Member Business Interests not adopted. Called for ACEP Board members to disclose and publish annually in *ACEP News* any personal business investments in emergency medicine related companies. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Resolution 38(95) Conflict of Interest Disclosure Statement not adopted. Called for ACEP to add a fourth category to the Conflict of Interest disclosure form regarding personal or family material interest in any outside concern that profits financially from the clinical practice of emergency medicine. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Substitute Resolution 37(95) Disclosure Prior to Board Elections adopted in lieu of resolutions 37, 38, 39, and 40. The substitute resolution directed ACEP to amend the Conflict of Interest form by adding specific language about known financial interest in any business or organization that profits financially from the practice of emergency medicine.

Substitute Resolution 59(94) adopted. Board officer candidates to disclose financial interests prior to election.

Substitute Resolution 31(90) Elected Officer Activities adopted. Directed the Board to examine the current endorsement and conflict of interest policies to assure they adequately address potential conflicts and review recommended revisions with the Council Steering Committee.

Prior Board Action

April 2010, adopted the Council of Medical Specialty Societies' "Code for Interactions with Companies."

January 2017, approved the revised policy statement "Conflict of Interest;" revised and approved June 2011, June

2008; reaffirmed October 2001; revised and approved September 1997; originally approved January 1996.

Substitute Resolution 23(97) Conflict of Interest adopted.

Substitute Resolution 37(95) Disclosure Prior to Board Elections adopted.

Substitute Resolution 31(90) Elected Officer Activities adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 19(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Clear and Complete Conflict of Interest Disclosure at the Council Meeting

PURPOSE: 1) Requests a requirement that all councillors, alternate councillors, and anyone else with speaking rights on the Council floor or otherwise complete a conflict of interest disclosure form; 2) implement a system, i.e., electronic wristband, that can be scanned and will display pertinent elements of the conflict of interest disclosure form.

FISCAL IMPACT: Budgeted staff resources to collect conflict of interest forms. Unbudgeted and unknown costs to obtain a system to scan wristbands or other devices, program the system, and upload data. Additional unknown costs to employ the technology in the Council meeting and Reference Committee hearing rooms.

WHEREAS, It is important to have constructive discussions at the Council meeting; and

WHEREAS, It is important to disclose conflict of interests before speaking so it is clear and apparent to others if they perceive the speaker to have a conflict of interest or bias on the subject matter being discussed; and

WHEREAS, The conflict of interests are based on the "honor system' for the speaker to determine if a conflict exists or not and to disclose it to the Council before stating the speaker's opinion on the topic being discussed or debated; and

WHEREAS, Many in the College have biases and conflicts that they themselves may not fully appreciate that others may find important to be aware of; and

WHEREAS, Many in the College and Council may be significantly influenced by, or have a financial incentive to argue i.e. they are employed by or hold a compensated leadership position, and may have a personal or financial incentive to make a particular argument; and

WHEREAS, Many who may have a conflict of interest, or a perceived conflict of interest may not even realize it themselves; and

WHEREAS, An officer of a contract management group has spoken on the Council floor during a discussion of private equity involvement without disclosing that speaker's leadership position with a contract management group owned by private equity; and

WHEREAS, Candidates for office within ACEP have run for office and help leadership positions without clearly communicating and all Councilor and ACEP members being made aware of the potential influence or perceived conflict of interest that might exist; and

WHEREAS, ACEP has been viewed in the past as being too influenced by contract management groups or private equity, and

WHEREAS, It is important for the integrity of the Council and ACEP, and the debate being made to have clear and full disclosures to allow for the entire Council to reasonably determine for themselves if the speaker has a bias or conflict regarding the topic being discussed or debated; and

WHEREAS, The advancements of technology has allowed us to do things today that were impossible or much more difficult or expensive to do before; therefore be it

RESOLVED, That all councillors, alternate councillors, and anyone else who may speak during Council on the Council floor or otherwise complete a disclosure form prior to the Council meeting with specific questions regarding potential conflicts that may be of importance to the Council at large to be aware; and be it further

RESOLVED, That the College implement a system i.e., electronic wristband that can be scanned when person approaches any microphone, that will display on the large screens in the room where Council is taking place that will reveal pertinent elements of the disclosure form that the speaker completed prior to Council i.e., employer, position with employer, percentage of clinical time vs. non-clinical time, other sources of revenue, etc., without disclosing specific amounts or data that the Council would find too invasive.

Background

This resolution requests that all councillors, alternate councillors, and anyone else with speaking rights on the Council floor or otherwise complete a conflict of interest disclosure form prior to the Council meeting and that ACEP implement a system, i.e., electronic wristband, that can be scanned and will display pertinent elements of the conflict of interest disclosure form regarding employer, position with employer, percentage of clinical time vs. non-clinical time, other sources of revenue, etc.

ACEP's "Conflict of Interest" policy statement was first adopted in 1996 and it has undergone multiple revisions since that time. The policy statement is also informed by external standards such as the Council of Medical Specialty Societies' (CMSS) "Code for Interactions with Companies" and the Accreditation Council for Continuing Medical Education's (ACCME) "Standards for Integrity and Independence in Accredited Continuing Education."

ACEP adopted the CMSS "Code for Interactions with Companies" in 2010. The purpose of the Code is to guide Medical Specialty Societies in the development of policies and procedures that safeguard the independence of their programs, policies, and advocacy positions. Because Societies can vary in their activities and corporate structures, each Society that chooses to sign on to the Code is encouraged to adopt policies and procedures that are tailored to meet its individual organizational needs. Collectively, adopting this Code helps to ensure that a Society's interactions with Companies will be for the benefit of patients and members and for the improvement of care in their respective specialty fields.

ACEP must adhere to the ACCME "Standards for Integrity and Independence in Accredited Continuing Education" as an accredited provider of continuing medical education (CME). The Standards cover a variety of issues, including preventing commercial bias and marketing in accredited CME and identifying, mitigating, and disclosing relevant financial relationships.

ACEP's current Conflict of Interest" policy statement requires "Key Leaders" to complete Conflict of Interest (COI) disclosure forms. "Key leaders" are defined as "Officers, Directors, Committee Chairs and Members, Section Chairs, Task Force Chairs, *Annals* Editor, and the Executive Director."

Councillors, alternate councillors, and others that have speaking rights as defined in the Council Standing Rules do not complete COI disclosure forms unless they meet the definition of a Key Leader. Per the Council Standing Rules, those with speaking rights include councillors, members of the Board of Directors, past presidents, past speakers, and past chairs of the Board as well as alternate councillors not currently seated and other individuals authorized by the presiding officer to speak at a designated time. Reference Committee meetings are open to all members of the College, its committees, and invited guests (which may include non-members, such as representatives from other organizations) and anyone may speak on any resolution under consideration upon recognition by the Reference Committee chair.

The Council Standing Rules, "Conflict of Interest Disclosure" section states:

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

Guidelines and compliance procedures would need to be developed to implement a system as described in the resolution.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

Fiscal Impact

Budgeted staff resources to collect conflict of interest forms. Unbudgeted and unknown costs to obtain a system to scan wristbands or other devices, program the system, and upload data. Additional unknown costs to employ the technology in the Council meeting and Reference Committee hearing rooms.

Prior Council Action

Amended Resolution 8(12) Conflict of Interest Disclosure. Added a new section to the Council Standing Rules on conflict of interest disclosure.

Resolution 23(03) Conflict of Interest for ACEP Leaders not adopted. The resolution sought to have all members serving on committees, in the Council, and Board members disclose any leadership positions with potential conflict by written notification to the Council speaker and Board president.

Substitute Resolution 23(97) Conflict of Interest adopted. The resolution directed that the Council support the Conflict of Interest policy as approved by the ACEP Board of Directors and that the Council commend the Board of Directors for its rapid and decisive action in establishing this policy.

Resolution 42(95) Executive Officer Business Interests referred to the Board of Directors. Called for ACEP's top ten executives to not have any financial arrangement and/or direct affiliation with any corporate or private organization that profits financially from the field of emergency medicine.

Resolution 40(95) NEMPAC Officer Business Interests not adopted. Called for NEMPAC officers members to report and publish annually in *ACEP News* any personal business investments in emergency medicine related companies. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Resolution 39(95) Board Member Business Interests not adopted. Called for ACEP Board members to disclose and publish annually in *ACEP News* any personal business investments in emergency medicine related companies. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Resolution 38(95) Conflict of Interest Disclosure Statement not adopted. Called for ACEP to add a fourth category to the Conflict of Interest disclosure form regarding personal or family material interest in any outside concern that profits financially from the clinical practice of emergency medicine. Substitute Resolution 37(95) was adopted in lieu of this resolution.

Substitute Resolution 37(95) Disclosure Prior to Board Elections adopted in lieu of resolutions 37, 38, 39, and 40. The substitute resolution directed ACEP to amend the Conflict of Interest form by adding specific language about known financial interest in any business or organization that profits financially from the practice of emergency medicine.

Substitute Resolution 59(94) adopted. Board officer candidates to disclose financial interests prior to election.

Substitute Resolution 31(90) Elected Officer Activities adopted. Directed the Board to examine the current endorsement and conflict of interest policies to assure they adequately address potential conflicts and review recommended revisions with the Council Steering Committee.

Prior Board Action

April 2010, adopted the Council of Medical Specialty Societies' "Code for Interactions with Companies."

January 2017, approved the revised policy statement "Conflict of Interest;" revised and approved June 2011, June 2008; reaffirmed October 2001; revised and approved September 1997; originally approved January 1996.

Substitute Resolution 23(97) Conflict of Interest adopted.

Substitute Resolution 37(95) Disclosure Prior to Board Elections adopted.

Substitute Resolution 31(90) Elected Officer Activities adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 20(21)

SUBMITTED BY: Howard Mell, MD, MPH, FACEP
Taylor Nichols, MD

SUBJECT: Creation of the Social Emergency Medicine Association

PURPOSE: Create a new 501c(3) non-profit organization called the "Social Emergency Medicine Association" under the umbrella of ACEP and develop the governing documents by the Council meeting in 2022.

FISCAL IMPACT: Establishing the entity costs – $7,000 – $13,500; one-time start-up costs – $22,000; ongoing annual costs $152,000; annual audit and tax services – $10,000. Additional undetermined direct and indirect costs.

WHEREAS, There are a number of issues of a nature commonly referred to as "social emergency medicine" issues that directly affect the daily practice of all emergency physicians; and

WHEREAS, The Andrew Levitt Center for Social Emergency Medicine describes the field as "Today's emergency departments can be viewed as the crucibles of social experimentation. As we modify American social structure, providing or withdrawing this or that benefit or element of the social safety net, the results are manifest in the emergency department. Most obviously, the decline of private health insurance has led to increased use of the ED as a provider of primary care. But in so many ways, perhaps more so than any other discipline in medicine, emergency medicine is enmeshed in the mores and practices of its immediate community, as well as the larger social and regulatory milieu."; and

WHEREAS, Each year any number of increasingly complex and nuanced issues in social emergency medicine (e.g., the presence of law enforcement body worn cameras in the emergency department or the effect of race on pain control in the ED) have been brought before the Council for action; and

WHEREAS, The Council has limited time to educate themselves on and debate these complex issues resulting in difficulties prioritizing the expenditure of increasingly very limited resources on such issues; and

WHEREAS, The creation of the Emergency Medicine Foundation (EMF) has allowed for the Council to no longer be the focal point of debate about funding emergency medicine research or prioritizing specific research objectives; and

WHEREAS, The creation of the National Emergency Medicine Political Action Committee (NEMPAC) has largely kept questions of direct political action for or against specific candidates off the Council floor; therefore be it

RESOLVED, That ACEP create a 501c(3) non-profit fund to be called the "Social Emergency Medicine Association" (SEMA) as a daughter organization in the same fashion as the Emergency Medicine Foundation and the National Emergency Medicine Political Action Committee for the purpose of funding, prioritizing, and administering efforts in social emergency medicine; and be it further

RESOLVED, That the ACEP Board of Directors and staff create the Social Emergency Medicine Association, including its rules and bylaws, by the Council meeting in 2022.

Background

This resolution calls for the establishment of a separate tax-exempt entity that could raise money through member donations and corporate and foundation support to fund work on unique social emergency medicine issues. ACEP works with two entities with close affiliation to help the College carry out related work: the Emergency Medicine Foundation (EMF) and the National Emergency Medicine Political Action Committee (NEMPAC).

The Social Emergency Medicine section was established in 2017 with a vision to incorporate social context into the structure and practice of emergency care. The section has 329 active member and is focused on:

- promoting the incorporation of patients' social context into routine emergency care.
- serving as a central organizing point for emergency providers interested in the interplay of the emergency care system and social forces affecting both patients and communities.
- fostering high-quality research and translate this research into best practices for the application of social determinants of health at the bedside and beyond.
- disseminating emergency department (ED) interventions that improve population health through emergency care informed by community needs, with a focus on EDs that see underserved patients.
- proposing, evaluating, and critiquing health policies that affect the social determinants of health of our communities, especially as they pertain to marginalized and vulnerable populations that frequently present to EDs for their care.

NEMPAC was established more than 40 years ago. It started with a small group of ACEP advocates who raised $10,000 (each one contributed $1,000) and has grown to $1 million + per year. NEMPAC is not a separately incorporated entity; rather it is a separate segregated fund, connected with and dependent on administrative funding from ACEP and operates with Articles of Association approved both by ACEP Board of Directors and the NEMPAC Board of Trustees. The purpose of NEMPAC is to provide the opportunity for individuals interested in the future of emergency medicine to contribute to the support of worthy candidates for federal offices who believe, and have demonstrated their beliefs, in the principles to which emergency medicine is dedicated. To further these purposes, NEMPAC is empowered to solicit, directly or indirectly, and accept voluntary personal contributions, and to make expenditures in connection with the attempt to influence the selection, nomination, or election of any individual to any elective federal office. Under Federal election law governed by the Federal Election Commission, NEMPAC may only solicit active ACEP members and cannot go outside of the membership for support. NEMPAC is the fourth largest physician specialty PAC and for the past several years has outraised and outspent the AMA. More information about NEMPAC can be found here.

The Emergency Medicine Foundation (EMF) was founded in 1972 by leaders of the American College of Emergency Physicians (ACEP) and is a 501(c)3 tax exempt nonprofit organization. EMF's mission is to develop career emergency medicine researchers, improve patient care, and provide the basis for effective health policy. To date, EMF has awarded more than $17 million in research grants to advance emergency medicine science and health policy. Donations are received primarily from ACEP members who are solicited annually through the ACEP dues statement. ACEP and EMF, while separate organizations, have common goals and interest in furthering and promoting emergency medicine education and research. The parties operate under a shared services agreement in which ACEP provides EMF certain resources, including an annual $200,000 donation, in kind personnel, office space, and equipment. EMF commitment's to ACEP is to work within the agreement and continue to advance the mission of emergency medicine research. EMF has awarded a $50,000 COVID-19 research grant "Social Determinants of Health and COVID-19 Infection in North Carolina: A Geospatial and Qualitative Analysis." Additionally, EMF has approved funding of $50,000 each for two health disparities grants during the FY 21-22 grant cycle: EMF Health Disparities Grant and the EMF/ENAF Health Disparities Grant.

Establishing a separate legally incorporated entity would require legal and financial resources. In addition, staff support would need to be established to support the fundraising work and any grant making work. Consideration would need to be given to the Board composition up for this new entity as well as the criteria and process to be used for awarding funding to support social emergency medicine issues. Fundraising and communication coordination

would be needed between this new entity, EMF, and NEMPAC to avoid confusing or diverting donors from ACEP's already existing allied entities as well as ongoing financial support for ACEP.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care.

- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
- Objective I – Play a defining role in addressing health care equity in emergency medicine.

Fiscal Impact

Establishing the Entity Costs – $7,000 – $13,500

- Drafting articles of incorporation, bylaws, organizational minutes, and state filing fees = $3,000 – $5,000
- Filing 1023 application with the IRS = $2,500 – $5,000
- Logo/name registration with the USPTO = $1,500 – 3,500

One Time Start Up Costs – $22,000

- Set up Great Plains financial database – $3,000
- Donor database annual fee – $4,500
- Finance Department (staff labor and benefits expense) = $6,500 = 80 hours of work
  - establish bank account
  - establish merchant account (credit card payments)
  - assist IT with Great Plains database set up – GL account set up, AP check printing, AR module, etc.
- Technology Services – $7,000 – $8,000 = 80 hours of work
  - create website
  - create online donation interface with new merchant account and donor database

Ongoing Annual Costs – $152,000

- $37,000 (salary and benefits) for executive director role – 20% of existing staff person's time to manage the governance/Board meetings, set strategy, etc.
- $4,000 – Technology Services staff (salary and benefits) 160 hours per year to update the website, etc.
- $50,000 – 25% of grants manager salary and benefits to write grants/fundraise, etc.
- $35,000 – A combination of 35% of staff time from Member Care and Marketing to answer questions about donations, etc. and to create marketing emails, etc.
- $26,000 – Staff labor and benefit expense for 30% of Finance FTE to prepare monthly financials, reconcile the bank accounts, assist with budget preparation, IRS 1099 annual filings, AP payment processing, deposit checks, etc.

**as support and programs grow annual operating cost would increase as staff time needed to support the work would increase.*

Annual Audit and Tax Services – $10,000

- Annual Financial Audit – $7,000
- IRS 990 Preparation Assistance and Filing – $3,000

Undetermined Direct and Indirect Cost Considerations:

- Annual costs do not include additional personnel required to undertake funded programs and/or ongoing activities, including donor relations.
- No projections can be made at this time about the feasibility or sustainability of individual donations or organizational grants, nor about the extent to which these would simply redirect funds currently received by ACEP, NEMPAC, or EMF.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Bobby Heard, MBA, CAE
Chief Operating Officer

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 21(21)

SUBMITTED BY: Ramon W. Johnson, MD, FACEP
Nicholas Jouriles, MD, FACEP
Marcus Wooten, MD
Yvette Calderon, MD, FACEP
Diversity, Inclusion, & Health Equity Section

SUBJECT: Diversity, Equity, and Inclusion

PURPOSE: 1) Convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion and create a road map to promote diversity, equity, and inclusion: 2) embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP; and 3) provide a report to the 2022 Council regarding the outcome of the summit.

FISCAL IMPACT: Budgeted task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 – $30,000 for an in- person meeting depending on the size of the group.

WHEREAS, ACEP members serve a diversified public; and

WHEREAS, ACEP champions and promotes health equity and racial justice to reduce health disparities and build structural competency within emergency medicine; and

WHEREAS, ACEP hopes to contribute to a diverse emergency medicine workforce; and

WHEREAS, The AMA has a center for health equity and which has created a strategic plan to address health equity; and

WHEREAS, Achieving optimally equitable solutions requires disruption and dismantling of existing norms, collective advocacy, and action across multiple sectors and disciplines; therefore be it

RESOLVED, That ACEP convene a summit meeting inviting the societies of emergency medicine to align efforts to address diversity, equity, and inclusion within the next year; and be it further

RESOLVED, That ACEP embed diversity, equity, and inclusion into its strategic plan and the internal and external work of ACEP; and be it further

RESOLVED, That ACEP report back to the 2022 Council meeting the outcome of the summit and have a road map created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

Background

This resolution asks ACEP to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion and create a road map to promote diversity, equity, and inclusion: embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP; and provide a report to the 2022 Council regarding the outcome of the summit.

The ACEP Board of Directors have embarked on an extensive strategic planning process to help guide the future

direction of the College. During this process ACEP has been working to create a roadmap for developing a new strategic plan for the College and is engaging key stakeholders throughout this process. Ensuring diversity, inclusion and equity is part of that process has been very deliberate. Representatives from the Diversity, Inclusion & Health Equity (DIHE) Section participated with the Board for the first strategic planning retreat meeting held in July in Washington DC and will also be part of the second retreat meeting scheduled for September. The DIHE Section has also been invited to provide representatives to participate on some of the eight strategic issues action teams. As the process moves forward, diversity, inclusion and equity will be an important consideration in all aspects of the new strategic plan.

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

ACEP's policy statement "Cultural Awareness and Emergency Care Policy Statement" supports that "cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP's position that resources should be made available to emergency departments and emergency physicians to assure they properly respond to the needs of all patients regardless of background. This is important to the subject of implicit bias, as cultural awareness helps combat negative assumptions and associations.

ACEP hosted a Diversity Summit on Thursday, April 14, 2016, at the ACEP Headquarters. The summit was highlighted in an ACEP Now article in June 2016. There were two visions for ACEP: establishing emergency medicine as the nucleus of a new acute care continuum and fostering generational, racial, and gender diversity within the specialty. ACEP utilized the services of a diversity consultant to help facilitate this summit.

The primary objectives for this summit were:

- Provide environmental data important to the specialty of emergency medicine.
- Create a safe space to share stories, create dialogue, new ideas, and awareness.
- Capture results and identify areas of focus that will influence diversity and inclusion for ACEP.

In June 2016, a Diversity & Inclusion Task Force was created. The primary objectives of the task force were:

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

Following on the work of the task force, ACEP's Diversity, Inclusion, & Health Equity Section was formed.

ACEP is supporting the Society for Academic Emergency Medicine's SAEM22 Consensus Conference on "Diversity, Equity and Inclusion. The conference, as described by SAEM: "The overarching goal of this Consensus Conference is to stimulate researchers and educators in our specialty to generate a research agenda around the role of racism in modern healthcare and medical education that results in disparate outcomes for our patients. The themes of the conference have been informed by national experts both within and outside our specialty and include: Education and Training; Leadership; Research, and Social Determinants of Health. The specific objectives are to: 1) Identify best practices, clarify knowledge gaps and prioritize research questions; 2) Bring together key stakeholders with varied backgrounds to develop collaborative research networks; and 3) Disseminate findings of the consensus conference through peer-reviewed publications, national meetings, policy briefs, and other venues."

ACEP and the Council of Residency Directors in Emergency Medicine (CORD) are participating in a collaboration between the Accreditation Council for Graduate Medical Education (ACGME) and the Council of Medical Specialty

Societies (CMSS) called "Equity Matters." The program, as described by CMSS: "Equity Matters is an Accreditation ACGME initiative that supplies a framework for continuous learning and process improvement in the areas of diversity, equity, and inclusion (DEI) and anti-racism practices. The purpose of this initiative is to achieve health equity through increasing physician workforce diversity, and by creating clinical learning environments that are safe, inclusive, and equitable." ACEP's participation in the program will run through December 2022 and will culminate in capstone project.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Objective G – Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine.
  - Tactic 3 – Work with organizations such as SAEM's Academy for Diversity and Inclusion in Emergency Medicine to advance diversity in emergency medicine.

Fiscal Impact

Budgeted task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 – $30,000 for an in- person meeting depending on the size of the group.

Prior Council Action

None

Prior Board Action

The Board of Directors approves the Strategic Plan annually.

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; originally approved April 2008 with the current title replacing "Cultural Competence and Emergency Care" approved October 2001.

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

April 2017, approved the revised Strategic Plan objective "Promote/facilitate diversity and inclusion and cultural sensitivity within emergency medicine."

April 2016, approved adding the objective "Promote and facilitate diversity and cultural sensitivity with ACEP" to ACEP's Strategic Plan.

Background Information Prepared by: Riane Gay, MPA, CAE
Director, Corporate Development

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 22(21)

SUBMITTED BY: New York Chapter

SUBJECT: Expanding Diversity and Inclusion in Educational Programs

PURPOSE: Survey ACEP speakers and educational presenters and report on speaker/educator demographics and set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

FISCAL IMPACT: Budgeted staff resources for development and analysis of survey and results, data entry into CRM for data collected. Potential unbudgeted costs for temporary staff assistance.

WHEREAS, ACEP is committed to increasing diversity and inclusion in its membership; and

WHEREAS, There is benefit in understanding the collective perspectives and diverse set of experiences to adequately address disparities in healthcare and healthcare outcomes; and

WHEREAS, ACEP educational programs are a significant source of training and continuing education for the Emergency Medicine community; and

WHEREAS, Differences in care and diagnosis related to age, gender, identity, race, culture, sexual orientation, physical disability/limitation, ethnicity and social status are classically understudied and taught; and

WHEREAS, The ACEP Leadership Diversity Task Force has already been assigned to look at the nominating processes and pipeline programs within the Council component bodies; therefore be it

RESOLVED, That ACEP survey its speakers and educational presenters and report on speaker/educator demographics; and be it further

RESOLVED, That ACEP set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

Background

This resolution requests ACEP to survey speakers and educational presenters and report on speaker/educator demographics and set guidelines for including material pertaining to diversity, inclusion, and/or healthcare disparities related to educational content being presented.

The Education Committee has an ongoing objective to increase diversity in the faculty for ACEP educational meetings and programs and ensure educational products include diversity and inclusion throughout offerings and include topics such as implicit bias or microaggressions in clinical care and practice management.

The Educational Meetings Subcommittee that plans the annual *Sceintific Assembly* meeting has an ongoing strategy to increase diversity among speakers at ACEP meetings as one of many factors considered when selecting speakers. They subcommittee also continues to identify content that specifically addresses diversity, equity, and inclusion (DEI) within its objectives and strives to include at least five courses on the topic. The committee continues to foster DEI through the composition of the committee and its leadership and through the engagement of a diverse set of faculty

with strong representation from racial and ethnic populations that are underrepresented in the medical profession.

Staff encounters challenges in gathering this information about faculty since our membership data does not include ethnicity. A decision was made to identify a minimum number of required fields to complete an online form to ensure a streamlined experience for member registration and renewals. While this has improved the user experience, it has created a void in the critical demographic information that ACEP needs. Attempts have been made for members to update their records with minimal results. Therefore, staff must use manual processes to identify speaker/educator ethnicity for the purposes of gauging diversity in our educational programs and seeking new content experts that are underrepresented.

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted staff resources for development and analysis of survey and results, data entry into CRM for data collected. Potential unbudgeted costs for temporary staff assistance.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Debbie Smithey, CMP, CAE
Educational Meetings Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 23(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Media Marketing of Value of Emergency Medicine Board Certification

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

FISCAL IMPACT: Budgeted resources. A public awareness campaign is currently in progress.

WHEREAS, There has been significant threats to the practice of emergency medicine and the safety of emergency physicians and patients, including balanced billing, creep of practice by non-physicians, lack of equal rights of emergency physicians as compared to others on medical staffs; and

WHEREAS, Many in the public do not understand or appreciate the difference between an emergency physician and a doctor in the emergency room, or a nurse practitioner, physician assistant or a physician associate;

WHEREAS, Insurers are continually trying to lessen reimbursement or substitute lesser trained or qualified persons, deny payment for emergency services and act in ways that threaten the safety and security of patients and the public safety net; and

WHEREAS, Contract management groups regularly hire non-emergency physicians instead of emergency physicians because of lower costs, or pay non-emergency physicians the same as emergency physicians in spite of less training and lack of residency training or board certification in emergency medicine; and

WHEREAS, Hospitals do not require or exert significant pressure on contract groups to hire emergency physicians, choosing lower costs, or higher profits, over better emergency training or better patient care; and

WHEREAS, If the public was aware of the difference in training, knowledge and ability of emergency physicians as compared to non-board certified physicians and non-physicians, they may be outraged or demand emergency physicians to staff emergency departments; and

WHEREAS, With more education of the public, the public will appreciate the difference in education and training, and appreciate the value of having emergency physicians provide emergency care to them; and

WHEREAS, Many of the issues facing emergency medicine and the patients we serve would likely be better served by having public support of emergency physicians and facilities requiring emergency physicians be used; therefore be it

RESOLVED, That ACEP focus more on marketing to and educating the public on the value of emergency physicians focusing on the differences in education and training that emergency physicians go through compared to non-emergency physicians; and be it further

RESOLVED, That ACEP focus more resources on a local, state, and national level campaign of marketing to the public through TV, radio, newspaper, social media, and public service announcements.

Background

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

This resolution is similar to Amended Resolution 18(19) Promoting Emergency Medicine Physicians and builds on ACEP's "Value of Emergency Medicine" campaign that is currently underway. ACEP is refining the campaign to specifically address the difference in training, knowledge, and ability of emergency physicians as compared to non-board-certified physicians and non-physicians. In August 2021, ACEP launched the findings of a public opinion poll that was conducted with Morning Consult. The results demonstrate that emergency physicians are extremely valued by their communities, but many people have difficulty identifying who leads their care while they are in the emergency department. In addition to a proactive earned media push, ACEP will be infusing this data into our campaign messaging and materials. As part of the campaign, ACEP is currently working with a professional agency to develop engaging digital collateral (e.g., videos, animated gifs, social cards, infographics). ACEP is also in the process of hiring an external public relations firm to help execute and amplify the campaign.

ACEP has a repository of public relations materials on the ACEP website that demonstrates the value of emergency medicine.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
- Objective H – Position ACEP as a leader in emergency preparedness and response.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective C – Provide robust communications and educational offerings via the website and novel delivery methods.
- Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.

Fiscal Impact

Budgeted resources.

Prior Council Action

Amended Resolution 18(19) Promoting Emergency Medicine Physicians adopted. Directed ACEP to create a public awareness campaign to highlight the unique skill set, knowledge base, and value of those that meet the ACEP definition of an emergency physician and partner with the American Medical Association and other national medical specialty societies on a campaign to promote the unique skill set, knowledge base, and value of residency trained and board certified physicians.

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

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

Prior Board Action

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

Amended Resolution 18(19) Promoting Emergency Medicine Physicians adopted.

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

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

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

Background Information Prepared by: Maggie McGillick
Public Relations Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 24(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: More Focused College

PURPOSE: 1) Coordinate with, work with, or allow other groups or entities that hold common values and interests, to advocate for some issues important to members of the College to conserve resources to use for higher priority issues; 2) lessen the number of initiatives ACEP chooses to promote or pursue as a means of focusing on fewer initiatives it can do very well; and 3) choose initiatives that affect the highest percentage of ACEP members, are the greatest threat to emergency medicine profession, ACEP members and patients, and are the least divisive to ACEP members.

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

WHEREAS, There are over 30,000 members of our College from all states, with many very diverse interests, but all, or the majority of all, having some common interests; and

WHEREAS, The College has tried to address more and more of the interests of its members, even those that may not be held by a supermajority of its members; and

WHEREAS, When one tries to do too many things with limited resources, often the effectiveness is diminished and many of the issues pursued are not done well; and

WHEREAS, There are other organizations and entities that may have similar interests and goals as our College and it may be worthwhile to always consider working or coordinating with them in order to achieve common goals and do so using fewer resources; and

WHEREAS, The College has pursued some topics that are strongly supported by some of its members, but strongly opposed to by other members of the College, creating a divisiveness amongst its members; and

WHEREAS, Too much divisiveness amongst members of the College is detrimental to the College and its members; and

WHEREAS, The topics that divide us do not have to be pursued by the College and can be pursued in other organizations or groups; and

WHEREAS, The College and its members must be especially united due to the increased threat to our profession, our specialty and the health and safety of the public and our patients; therefore be it

RESOLVED, That the College give consideration to coordinating or working with, or allowing other groups or entities that hold common values and interests to advocate for some issues important to members of the College, to conserve resources to use for higher priority issues facing the membership and the College; and be it further

RESOLVED, That the College lessen the number of initiatives it chooses to promote or pursue, but instead focus on fewer initiates and do them very well; and be it further

RESOLVED, That the College choose the few initiatives that affect the highest percentage of its membership, is the greatest threat to our profession, our members, and patients, and is of the least divisiveness to our members.

Background

This resolution calls for the College to consider coordinating with, working with, or allowing other groups or entities that hold common values and interests to advocate for some issues important to members of the College, in order to conserve resources to use for higher priority issues. Further, it asks the College to lessen the number of initiatives it chooses to promote or pursue, as a means of focusing on fewer initiatives it can do very well. Finally, it asks the College choose initiatives that affect the highest percentage of its membership, are the greatest threat to the emergency medicine profession, ACEP members and patients, and are the least divisive to ACEP members.

ACEP often collaborates with other groups or entities in advocating for issues important to the College and its members. In some cases, the decision to collaborate conserves staff and direct resources; at other times, collaboration can serve to strengthen ACEP's voice. Maintaining such relationships with those who hold common values and interests is an active part of the work of ACEP staff and leadership. When opportunities for collaboration are either brought to ACEP or are identified by ACEP, staff and leadership assess not only the merits of the opportunity from the lens of value to the membership and the organization, but also the extent to which ACEP and the potential partners has the needed expertise and resources to be successful. The current process is conducted in a manner consistent with this resolution.

The work of balancing the quality and quantity of initiatives undertaken by ACEP is similarly the focus of ACEP staff, the Board, and other volunteers. The vetting of each year's budget proposal by the Finance Committee and the Board works as an important checks and balance to ensure initiatives are meeting their intended goals with the appropriate use of limited resources. Finding the way to lessen the number of initiatives it chooses to pursue is a common challenge for non-profit professional organizations, and the reason why many non-profits are rethinking how they do business and compete. Over the past year, and under the direction of the Executive Director, ACEP has begun using a tool called the MacMillan Matrix to conduct an assessment of programs. This competitive assessment tool, developed by Ian MacMillan of the Wharton School of Business, is designed specifically to help non-profits assess how well their programs "fit" and are a good strategic investment for their organization.

The operating assumptions are:

- There are more opportunities to respond to member/customer needs, wants, and expectations than there are resources to meet those expectations.
- In light of limited resources, the organization generally should not directly duplicate the services of other organizations.
- Focus is important. Providing mediocre or low-quality programs in many areas is inferior to delivering higher quality programs in a more focused (limited) way.

The assessment is conducted by rating programs, products, and initiatives on:

- Overall fit within the organization's mission.
- High or low appeal to members, customers, partners, or volunteers.
- Strong or weak operational capacity (money, expertise, track record).
- Low or high alternative coverage by others who deliver a similar program to similar constituents.

Program scores are placed into a matrix that guides what changes in direction are needed. Currently, staff have conducted two rounds of reviews (50% of programs), with the goal of completing the remaining 50% by the end of the calendar year. The results will be shared with the Board, Finance Committee, and key stakeholders and used to reframe ACEP's operating and strategic plan for the coming years.

These program assessment scores will be informed by the recently completed ACEP 2021 Needs Assessment Survey. A survey of this kind is fielded to members and non-members every few years and is designed to help ACEP assess the needs of emergency physicians, obtain needed feedback to improve the programs, services, and materials we offer, and to learn about the workforce landscape and job satisfaction.

Further, the ACEP Board and staff have begun a formal process of building a new strategic plan to guide the next three to five years. The six-month process is being guided by Daniel Stone, a highly experienced facilitator of strategic planning, and involves ACEP leaders, members, and staff to ensure the final product both sets a big and bold vision and will also ensure the College focuses on what it can do best and what is needed by individual emergency physicians now and in the future. A draft of a new strategic plan will be shared with members, chapters, and councillors during ACEP21. Stakeholder feedback will be incorporated into the final action plan that will launch in 2022.

ACEP Strategic Plan Reference

Broadly, this work is integral with all aspects of ACEP's strategic plan

Fiscal Impact

Budgeted staff resources.

Prior Council Action

None

Prior Board Action

June 2021, approved funds in the FY 2021-22 budget to revise the strategic plan.

The Board approves the Strategic Plan each year.

Background Information Prepared by: Susan Sedory, MA, CAE
Executive Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Meeting
Reference Committee Members

Reference Committee B – Advocacy & Public Policy
Resolutions 25-41

Ashley Booth-Norse, MD, FACEP (FL), Chair
Erik Blutinger, MD, MSc, (NY)
Paul Kozak, MD, FACEP (AZ)
Catherine Marco, MD, FACEP (OH)
Howard K. Mell, MD, CPE, FACEP (IL)
Thomas J. Sugarman, MD, FACEP (CA)

Jeff Davis
Ryan McBride, MPP

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 25(21)

SUBMITTED BY: John Moorhead, MD, FACEP
Christopher Strear, MD, FACEP

SUBJECT: ACEP Report Card

PURPOSE: Undertake a new state chapter survey with questions similar to previous Report Card studies, publish distribute the results of the survey in a National Report Card 2022, and provide assistance and resources for chapter activities to improve access and quality of emergency care in their state.

FISCAL IMPACT: Unbudgeted national and chapter staff resources to develop the survey, collect and analyze data, develop and employ grading methodology, and publicize results at the national and state level. Costs for using an outside contractor(s) to perform many of the tasks, without conducting the additional primary and secondary research performed in the first three Report Cards, could exceed $150,000.

WHEREAS, ACEP National Report Cards published in 2010 and again in 2014 provided a comparison (including national ranking) among states in areas of emergency care including Public Health/Injury Prevention, Access to Emergency Care, Quality of Emergency Care, Medical Liability Environment, and Disaster Preparedness. These data provided assistance to many state chapters' advocacy efforts; and

WHEREAS, State chapters were able to leverage these reports and media attention to focus on areas of reform, including the establishment of state task forces and recommendations for policy changes; therefore be it

RESOLVED, That ACEP undertake a new state chapter survey with questions similar to previous Report Card studies but edited to reflect current emergency medicine practice issues in 2021; and be it further

RESOLVED, That ACEP publish and widely distribute the results of a state chapter survey in a National Report Card 2022 and provide assistance and resources for chapter activities to improve access and quality of emergency care in their state.

Background

The resolution calls for ACEP to undertake a new state chapter survey with questions similar to previous Report Card studies but edited to reflect current emergency medicine practice issues in 2021, and to publish and widely distribute the results of the survey in a National Report Card 2022, and provide assistance and resources for chapter activities to improve access and quality of emergency care in their state.

In 2006, ACEP released its first "National Report Card on the State of Emergency Medicine," grading each state on its support for emergency medicine in four categories: 1) Access to Emergency Care; 2) Quality and Patient Safety; 3) Public Health and Injury Prevention; and 4) Medical Liability Environment. The 2009 Report Card expanded on the number of metrics analyzed in each of those four categories and added Disaster Preparedness as a fifth category. It contained 116 overall indicators across the five categories. In 2014, the College released its third Report Card "America's Emergency Care Environment: A State-By-State Report Card", utilizing the same categories as the 2009 version.

The 2014 Report Card included 136 measures across the five categories. As with the previous Report Cards, a research consultant was retained to conduct research to collect, analyze, and compare 50-state data. Data sources

included the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the National Highway Traffic Safety Administration, the Department of Health and Human Services, the Department of Labor, the National Practitioner Data Bank, the American Medical Association, the American Hospital Association, the National Conference of State Legislatures, the National Association of Insurance Commissioners and many more. Two surveys were also developed and sent to health officials in each state. More details on the 2014 Report Card can be found at www.emreportcard.org.

The Report Cards, which were heavily supported and promoted by extensive ACEP media relations efforts at the national and state levels, resulted in widespread coverage by major national and local news outlets, with more than 2,000 news stories across the country in 2014. Chapters were engaged in the development of the reports and were equipped and mobilized to utilize Report Card results to bolster their state advocacy efforts on priority issues. Dozens of printed copies of the report were sent to each chapter for distribution to state policymakers. Many chapters utilized the Report Card to engage state leaders in discussions of key state policy deficiencies and some chapters cited the Report Card as being a key contributor to state legislative and other successes in their state, including the passage of liability reform protections for emergency physicians, trauma system funding, and creation of new emergency medicine residency programs.

A survey of chapters taken a few months after the release of the 2014 Report Card showed that 28 chapters reported using the Report Card in a state advocacy effort, while 12 indicated that they had not. When asked how valuable they thought the Report Card was to their chapter, 10 indicated very valuable, 23 answered somewhat valuable, and 7 indicated not valuable.

Development of each Report Card was a two-to-three-year project with total costs of each exceeding $400,000, including the cost of a research consultant, public relations support, printing, travel, and staff labor. Some outside funding was obtained for the 2009 Report Card. The Wellpoint Foundation provided $250,000 and the Robert Wood Johnson Foundation provided $50,000 to support data collection, public relations, and distribution efforts for the Report Card. No outside funds were secured for the 2006 or the 2014 Report Cards.

The resolution calls for a chapter survey with questions similar to previous Report Cards, which would apparently not entail the utilization or expense of an outside consultant to conduct the research, analysis, and state grading that occurred with previous Report Cards. Such an approach may glean useful results but without efforts to conduct additional primary and secondary research, such as what was performed with the first three Report Cards, may pose challenges in obtaining a sufficient range of standardized data in each state from all chapters to make results comparable either to previous Report Cards or to other states. The validity of the data may be questioned if an outside consultant is not used.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system
- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.
- Objective G – Pursue meaningful medical liability reform and other initiatives at the state and federal levels.
- Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Unbudgeted national and chapter staff resources to develop the survey, collect and analyze data, develop and employ grading methodology, and publicize results at the national and state level. Costs for using an outside contractor(s) to perform many of the tasks, without conducting the additional primary and secondary research performed in the first three Report Cards, could exceed $150,000.

Prior Council Action

Amended Resolution 24(14) Future Funding for ACEP Report Cards on the Emergency Care Environment adopted. Directed the Board of Directors to continue to identify potential private, public, foundational, and other funding sources to support future creation and dissemination of the ACEP National Report Card and that a report of the investigation be provided to the 2015 Council.

Prior Board Action

June 2015, reviewed the report on Amended Resolution 24(14) and approved it for distribution to the 2015 Council.

October 2014, Amended Resolution 24(14) Future Funding for ACEP Report Cards on the Emergency Care Environment adopted.

Approved funding in the annual budget for the 2006, 2009, and 2014 Report Cards.

Background Information Prepared by: Craig Price, CAE
Senior Director, Practice Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 26(21)

SUBMITTED BY: Ohio Chapter ACEP
Pennsylvania College of Emergency Physicians

SUBJECT: Advocacy for Syringe Services Programs and Fentanyl Test Strips

PURPOSE: 1) Support federal funding of syringe services programs (SSPs); 2) develop advocacy materials to assist and encourage chapters to advocate for local/state laws permitting SSPs to reduce risks associated with injection drug use in addition to naloxone and educational material; and 3) update harm reduction materials for members regarding risks of fentanyl analogues and use and limitations of fentanyl test strips.

FISCAL IMPACT: Budgeted committee and staff resources. Additional financial impact depends on the extent of associated costs of developing and updating materials and making resources available to members and chapters.

WHEREAS, Overdose deaths continue to surge in the United States with recent data published by the Centers for Disease Control and Prevention (CDC) showing a 30% increase from October 2019 to October 2021; and

WHEREAS, Injection drug use represents a significant proportion of overdose deaths and morbidity associated with substance use; and

WHEREAS, Illicit, non-pharmaceutical synthetic opioids including fentanyl and its analogues account for the largest proportion of overdose deaths; and

WHEREAS, Illicit fentanyl has been increasingly identified in pill form pressed to resemble prescription opioids or benzodiazepines; and

WHEREAS, Illicit fentanyl and its analogues have been found to either adulterate or be mistaken for other substances such as cocaine; and

WHEREAS, Infectious complications of injection drug use such as HIV, Hepatitis C, and severe bacterial infections are a significant source of morbidity, mortality, as well as healthcare utilization and cost; and

WHEREAS, People who inject drugs represent 7% of new HIV cases in the U.S.[2]; and

WHEREAS, Newly reported cases of hepatitis C rose 133% from 2012 to 2019 with injection drug use identified as the most common contributing risk factor[3]; and

WHEREAS, The ACEP Council has previously passed a resolution to endorse and support syringe services programs as well as investing in educating its members on harm reduction techniques and the importance of emergency departments (EDs) to partner with local Syringe Services Programs (SSPs) to advance the care of people who inject drugs[4]; and

WHEREAS, The ACEP Council has previously passed a resolution calling for the development of guidelines for harm reduction strategies with health providers, local officials, and insurers for safely transitioning patients with substance use disorders to sustainable long-term treatment programs from the ED while providing educational resources to ED providers for improving direct referral of patients with substance use disorder (SUD) to treatment[5]; and

WHEREAS, Members of the ACEP Public Health and Injury Prevention Committee developed a report which was reviewed by the ACEP Board of Directors in June, 2019, entitled "After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use, An Information Paper" concluding that "Emergency Physicians can help lead and effect change by providing testimony about the human suffering, economic burden, and the demand placed on the healthcare system by IDU; and

WHEREAS, Emergency physicians who have studied or witnessed the positive effects of these interventions in the communities they serve can provide supportive arguments for expansion of harm reduction; and

WHEREAS, Unfortunately, policy papers and research studies have not been enough to facilitate SSP and SIF implementation; and

WHEREAS, It is therefore incumbent on clinicians, particularly emergency physicians who treat the complications of IDU daily, to advance public health advocacy efforts on behalf of harm reduction for PWID and the communities supporting them[6]; and

WHEREAS, ACEP has developed a smart phrase to promote the utilization of harm reduction services including SSPs but not fentanyl test strips[7]; and

WHEREAS, AMA supports community implementation of syringe services programs, encouraging state medical organizations to advocate for expanded availability of syringe services programs, and advocating for local, state, and federal legislation to ensure accessibility[8]; and

WHEREAS, Fentanyl test strips have been shown to alter behaviors leading to less risky drug use[9]; and

WHEREAS, SSPs are associated with a 50% decline in HIV and Hepatitis C transmission among injection drug users[10]; and

WHEREAS, SSPs were associated with more than $240 million in health care savings in one city (Philadelphia, PA) over a 10 year time period[11]; and

WHEREAS, While the federal government will provide funding for SSPs, multiple barriers exist to accessing that funding and those funds are not permitted to be used for purchasing syringes or needles[12]; and

WHEREAS, The CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) announced on April 7, 2021, that federal funding could be used to purchase fentanyl test strips[13]; and

WHEREAS, SSPs and fentanyl test strips remain illegal under many local and state drug paraphernalia laws throughout much of the United States; and

WHEREAS, ACEP and its members should continue to employ all available means to engage and refer patients with substance use disorders to evidence-based treatment programs, but also recognize that not all patients with substance use disorders and risky drug use will be ready to enter treatment so should be educated on strategies to minimize injury and death associated with ongoing drug use; and

WHEREAS, Emergency physicians have an obligation to advocate for evidence-based interventions that will benefit the health of our patients; therefore be it

RESOLVED, That ACEP support federal funding of syringe services programs; and be it further

RESOLVED, That ACEP develop advocacy materials to assist and encourage chapters to advocate for state and local laws permitting syringe services programs intended to reduce the risk of harm associated with injection drug use in addition to naloxone and educational material; and be it further

RESOLVED, That ACEP update harm reduction materials and resources available to its members to include informing patients of the risks of fentanyl analogues and other potentially harmful admixtures and the utilization and limitations of fentanyl test strips to better inform decision-making when using drugs.

References

1. Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov). Accessed 6/10/2021
2. U.S. Statistics | HIV.gov. Accessed 6/10/2021
3. Figure 3.1 of 2019 Viral Hepatitis Surveillance report | CDC. Accessed 6/10/2021
4. Resolution 52(17): Support for Harm Reduction and Syringe Services Programs
5. Resolution 21(16): Best Practices for Harm Reduction Strategies
6. after-the-ed-visit---the-role-of-harm-reduc-progs-in-mitigating-the-harms-assoc-with-inj-drug-use.pdf (acep.org) Accessed 6/10/2021
7. Injection Drug Use Smart Phrase. ACEP // Injection Drug Use Accessed 6/11/2021
8. H-95.958 Syringe and Needle Exchange Programs | AMA (ama-assn.org) Accessed 6/10/2021
9. Peiper NC, Clarke SD, Vincent LB, Ciccarone D, Kral AH, Zibbell JE. Fentanyl test strips as an opioid overdose prevention strategy: Findings from a syringe services program in the Southeastern United States. Int J Drug Policy. 2019 Jan;63:122-128. doi: 10.1016/j.drugpo.2018.08.007. Epub 2018 Oct 3. PMID: 30292493.
10. Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C, Jordan A, Degenhardt L, Hope V, Hutchinson S, Maher L, Palmateer N, Taylor A, Bruneau J, Hickman M. Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. Cochrane Database Syst Rev. 2017 Sep 18;9(9):CD012021. doi: 10.1002/14651858.CD012021.pub2. PMID: 28922449; PMCID: PMC5621373.
11. Ruiz MS, O'Rourke A, Allen ST, Holtgrave DR, Metzger D, Benitez J, Brady KA, Chaulk CP, Wen LS. Using Interrupted Time Series Analysis to Measure the Impact of Legalized Syringe Exchange on HIV Diagnoses in Baltimore and Philadelphia. J Acquir Immune Defic Syndr. 2019 Dec 1;82 Suppl 2(2):S148-S154. doi: 10.1097/QAI.0000000000002176. Erratum in: J Acquir Immune Defic Syndr. 2020 Feb 1;83(2):e12. PMID: 31658203; PMCID: PMC6820712.
12. Determination of Need for Syringe Services Programs | CDC Accessed 6/11/2021
13. Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips | CDC Online Newsroom | CDC Accessed 6/10/2021

Background

The resolution calls for ACEP to support federal funding for syringe services programs and to develop advocacy materials to assist and encourage chapters to advocate for state and local laws permitting syringe services programs intended to reduce the risk of harm associated with injection drug use. It also calls for the College to update harm reduction materials and resources available to its members to include informing patients of the risks of fentanyl analogues and other potentially harmful admixtures and the utilization and limitations of fentanyl test strips to better inform decision-making when using drugs.

The use 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. In 2020, the Centers for Disease Control and Prevention (CDC) reported more than 93,000 opioid deaths, the highest number on record and a nearly 30 percent increase from 2019. This increase was driven primarily by illicitly manufactured fentanyl and synthetic opioids, and also thought to be exacerbated by the COVID-19 pandemic. An additional effect of the opioid crisis is a significant increase in the infectious diseases often associated with injection drug use, including acute hepatitis C virus (HCV), HIV, and other bloodborne infections. The CDC noted that over from 2010-2016, HCV cases more than tripled.

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. The CDC Fact Sheet on SSPs states that these programs are an effective public health intervention, associated with a 50% decrease in HIV and HCV incidence. They also help serve to connect individuals to other health services, such as HCV or HIV testing and treatment as well as medication-assisted treatment (MAT) for opioid use disorder. Some SSPs also educate people who inject drugs with education and training on how to recognize, respond to, and reverse a drug overdose through the use of naloxone, with some SSPs even providing kits containing naloxone to help prevent overdose deaths. Federal funding for states and local communities is available under limited circumstances to support certain components of SSPs.

With regard to fentanyl test strips, these strips are used to identify the presence of fentanyl and many known fentanyl analogues in a sample of an illicit drug, whether injectable drugs, powders, or pills. The test strips typically take only one or two minutes to determine if a drug has been mixed or cut with fentanyl or an analogue. As the resolution notes, fentanyl test strips do have limitations and may not be able to detect certain fentanyl-like substances such as carfentanil, sufentanil, alfentanil, benzylfentanyl, benzoylfentanyl, U47700, U49900, or other substances the test strips are not able to find. Federal, state, and local governmental entities and other organizations are also adopting and promoting the use of fentanyl test strips as part of overdose prevention efforts. As of April 7, 2021, the CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) announced federal grants for the purchase of fentanyl test strips. Other examples include local governments like Arlington County, VA recently adding fentanyl test strips to emergency release kits (which include treatment resources, toiletries, a public transportation card, and NARCAN nasal spray) provided to individuals being released from incarceration.

The Council and the Board adopted Resolution 21(16) Best Practices for Harm Reduction Strategies, which 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. The Emergency Medicine Practice and the Public Health & Injury Prevention Committee developed alcohol screening and brief intervention in the ED resources and opioid resources. The Pain Management & Addiction Medicine Section continues to develop resources on pain management and addiction medicine. ACEP has developed the E-QUAL Network Opioid Initiative, which includes toolkits, webinar series, podcasts, and other resources.

A year later, the Council and the Board adopted Resolution 52(17) Support for Harm Reduction and Syringe Services Programs. The resolution directed the College to endorse SSPs for those who inject drugs, promote the access of SSPs to people who inject drugs, and to invest in educating members on harm reduction techniques and the importance of Emergency Departments to partner with local SSPs to advance the care of people who inject drugs. The Public Health & Injury Prevention Committee developed the information paper "After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use."

ACEP supports other related harm reduction strategies related to IV drug use as well. In 2017, the Council and the Board adopted Amended Resolution 31(17) Development and Study of Supervised Injection Facilities that directed the College support the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision and endorse Supervised Injection Facilities (SIFs) as an effective public health intervention in areas and communities heavily impacted by IV drug use. SIFs include an additional layer of services beyond those provided by SSPs, providing people who inject drugs to do so in a safe environment under direct supervision of a medical professional. In communities that have established SIFs, these facilities have also shown promising results in reducing drug overdoses, deaths, and preventable illnesses like HIV, Hepatitis C, and soft tissue infections.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Fiscal Impact

Budgeted committee and staff resources. Additional financial impact depends on the extent of associated costs of developing and updating materials and making resources available to members and chapters.

Prior Council Action

Resolution 52(17) Support for Harm Reduction and Syringe Services Programs adopted. Directed the College to 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.

Amended Resolution 31(17) Development and Study of Supervised Injection Facilities adopted. Directed the College to work with the AMA in supporting the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision and endorse Supervised Injection Facilities as an effective public health intervention in areas and communities heavily impacted by IV drug use.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to appropriate potential treatment resources after receiving medical care from the ED.

Prior Board Action

June 2019, reviewed the information paper "After the Emergency Department Visit: The Role of Harm Reduction Programs in Mitigating the Harms Associated with Injection Drug Use."

Resolution 52(17) Support for Harm Reduction and Syringe Services Programs adopted.

Amended Resolution 31(17) Development and Study of Supervised Injection Facilities adopted.

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: Ryan McBride, MPP
Senior Congressional Lobbyist

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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(21)

SUBMITTED BY:
Kathleen Cowling, DO, MS, MBA, FACEP
Larry Bedard, MD, FACEP
Gregory Gafni-Pappas, DO, FACEP
Cai Glushak, MD, FACEP
Michael Gratson, MD, MHSA, FACEP
James Maloy, MD
Jacob Manteuffel, MD, FACEP
James Mitchiner, MD, MPH, FACEP
Charles Pattavina, MD, FACEP
Megan Ranney, MD, MPH, FACEP
Rachel Solnick, MD, MSc
Robert Solomon, MD, FACEP
Peter Viccellio, MD, FACEP
Bradford Walters, MD, FACEP

SUBJECT: Conditional Support for Medicare-for-All

PURPOSE: 1) Provide conditional support for Medicare-for-All, conditioned on the ability of such a program to provide universal access, foster competition, preserve patient choice, promote physician autonomy, and recognize the essential value of emergency medicine; and 2) explore opportunities to partner with other like-minded organizations that favor the Medicare-for-All approach.

FISCAL IMPACT: Budgeted committee and staff resources. Potential additional unbudgeted costs associated with working with like-minded partners or coalitions depending on the scope.

WHEREAS, The primary business objective of a for-profit health insurer is to make a profit, which directly leads to decreased or denied reimbursement for legitimate emergency care; and

WHEREAS, The 2010 Affordable Care Act (ACA) created a complex and inefficient bureaucracy that works through private insurers with high administrative overhead, and even prior to COVID-19 left 28 million Americans uninsured and another 44 million underinsured, causing them to receive care at an advanced stage of disease or to forego care altogether[1]; and

WHEREAS, Tying insurance to employment creates an undue burden on both employees and businesses alike; and

WHEREAS, Medicare-for-All is based on *expanding* and *improving* the current non-profit Medicare program, in a way that would both provide more services and cover more Americans; and

WHEREAS, There is no truth to the belief that Medicare-for-All implies physician reimbursement at current Medicare fee-for-service rates[2]; and

WHEREAS, There is no truth to the memes that Medicare-for-All is "socialized medicine"; that it is "government-controlled health care"; or that it will block health care competition, diminish quality, forestall medical innovation, or inhibit patient choice of provider; and

WHEREAS, Polls have consistently demonstrated majority support for Medicare-for-All or single-payer insurance by the general public[3,4,5,6] and among clinicians[7]; and

WHEREAS, The ACEP Council adopted Resolution 15 in 1999, stipulating that ACEP "develop a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured," a stipulation that has yet to be consummated; and

WHEREAS, ACEP's Health Care Financing Task Force, created in 2017 to study alternative financing

models that foster competition and preserve patient choice, did not provide any actionable conclusions; therefore, be it

RESOLVED, That ACEP provide conditional support for Medicare-for-All, conditioned on the ability of such a program to provide universal access, foster competition, preserve patient choice, promote physician autonomy, and recognize the essential value of emergency medicine; and be it further

RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations that favor the Medicare-for-All approach to providing universal health care to all Americans.

References

[1]Collins SR, Bhupal HK, Doty MM. Health insurance coverage eight years after the ACA: fewer uninsured Americans and shorter coverage gaps, but more underinsured (Commonwealth Fund, February 2019), at: https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca.
[2]117th Congress (2021-2022), U.S. House of Representatives, H.R. 1976 ("Medicare for All Act of 2021"), introduced March 17, 2021, Sec. 612(b)(1), p. 74 of 131, at: BILLS-117hr1976ih.pdf (congress.gov)
[3]KFF Health Tracking Poll. Public opinion on single-payer, national health plans, and expanding access to Medicare coverage (slide file; published May 27, 2020), at: http://files.kff.org/attachment/SP_5.21.20
[4]Poll: 69 percent of voters support Medicare for All. *The Hill.* Published April 24, 2020, at: https://thehill.com/hilltv/what-americas-thinking/494602-poll-69-percent-of-voters-support-medicare-for-all
[5]Murad Y. As coronavirus surges, 'Medicare for All' support hits 9-month high. *Morning Consult/Politico* poll (February 21-23, 2020 and March 27-29, 2020; published April 1, 2020), at: https://morningconsult.com/2020/04/01/medicare-for-all-coronavirus-pandemic/
[6]Galvin G. About 7 in 10 voters favor a public health insurance option. Medicare for All remains polarizing. *Morning Consult/Politico* poll (March 19-22, 2021; published March 24, 2021), at: https://morningconsult.com/2021/03/24/medicare-for-all-public-option-polling/
[7]Serafini M. Why clinicians support single-payer – and who will win and lose. *NEJM Catalyst*. Published on January 17, 2018, at: https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0278

Background

The resolution asks ACEP to provide conditional support for Medicare-for-All, conditioned on the ability of such a program to provide universal access, foster competition, preserve patient choice, promote physician autonomy, and recognize the essential value of emergency medicine. The resolution also asks ACEP to explore opportunities to partner with other like-minded organizations that favor a Medicare-for-All approach to providing universal health care to all Americans.

Public support for Medicare-for-All often varies depending on the details provided in polling questions and surveys. A 2016 poll conducted by Kaiser Family Foundation (KFF) found significant variation in support among Democratic voters for various proposals, including Medicare-for-All (53% very positive), guaranteed universal health coverage (44% very positive), single-payer health insurance (21% very positive), and socialized medicine (22% very positive). However, those variations appear to have diminished within the past few years – according to a 2019 Morning Consult poll, a majority of voters support either Medicare-for-all (53%) or single-payer (51%). Regardless, as the Morning Consult notes, while the terms are often used interchangeably, "there are differences between the two: Single-payer is a sweeping term for a system in which the costs of essential care for all residents are covered by one public system, while a "Medicare for all" program could be single-payer but does not necessarily have to be." Most recently, a 2021 Morning Consult Poll of registered voters found that 55% of voters support Medicare-for-All (unchanged from previous results in March 2020). However, Medicare-for-All is significantly more politically polarizing, with 62% of Republican voters outright opposing the proposal. The same poll also found that support for a public option had increased from 63% to 68%, a steady upward trend over the past several years from both Republican and Democrat voters.

The resolution references the Health Care Financing Task Force (HCFTF) established by Amended Resolution 19(16) to study alternative health care financing models delivered its report in Fall 2018. The report notes:

> Although the HCFTF cannot recommend a financing system at this time, a majority of the HCFTF agree that there are elements of [single payer] systems that strongly adhere to the '9 Principles' outlined. Therefore, if ACEP were to advocate for significant health care financing reform in the future, HCFTF members would want some elements of varied SP models to be considered and included in an ACEP-endorsed model.

The task force determined that ACEP should continue to advocate for and propose meaningful ideas for health care financing reform, but at the current time, no one system – single payer, two-tier, or the current health care system – could be espoused over another. The HCFTF concluded "ACEP shall focus on securing access to coverage for our patients and their families for, acute unscheduled care services in any health care financing model, including single payer."

The United States currently operates under a multi-payer system. Individuals and businesses pay taxes to the government, in the form of payroll taxes and income taxes, as well as paying premiums to private insurers. The government then reimburses health care providers who deliver care through one of the public programs, such as Medicare, Medicaid, CHIP, or military health care (TRICARE or VA/CHAMPVA). For those who are privately insured, health care providers seek reimbursement from the respective insurance company. Presently, there are dozens of private health insurance companies and thousands of private health insurance plans offered through state and federal insurance exchanges, public programs, and in the private marketplace. According to the CDC's National Health Interview Survey Early Release Program for January-June 2020, among adults 18-64 years of age who had health insurance in 2020, 67.9% were covered by private insurance, 20.8% were covered by public insurance, and 13.4% of adults 18-64 were uninsured (about 30 million Americans). Some observers have also noted that these figures may not reflect the potential impact of COVID-19 with respect to individuals losing their jobs and their employer-sponsored insurance coverage, so these numbers could shift as new data become available.

Among the more prominent Medicare-for-All legislative proposals put forward in Congress, a bill (S. 1129) introduced by Senator Bernie Sanders (D-VT) in the 116th Congress would establish a single-payer national health insurance program through a phased-in process, essentially replacing all private coverage (with narrow exceptions), including employer-sponsored coverage, state insurance exchanges, as well as Medicaid. To briefly summarize an expansive bill: Medicare would be expanded to provide comprehensive coverage, including dental, vision, hearing, and all prescription drug benefits, as well as home- and community-based long-term care services, mental health and substance use disorder treatment, and reproductive and maternity care. Beneficiaries would be subject to no cost sharing requirements (deductibles, copays, coinsurance, etc.) except for some prescription drugs and biologics (but with a $200 annual cap on out of pocket expenses per individual, adjusted for inflation) as well as some long-term care services.

In the case of single-payer financing, individuals and businesses would pay taxes to the government. The government would then reimburse health service providers directly for care delivered through a national health insurance program. Although the collection of funds and the process of reimbursement are conducted by one entity, the delivery of care would be through both public and private sources.

In another example, under the terms of the single-payer system proposed by Physicians for a National Health Program (published in the Journal of the American Medical Association in 2003), all residents of the U.S. would be enrolled and all medically necessary care would be covered. Obviously, the question of what is considered medically necessary could be contentious, especially given the recent developments in the State of Washington.

Financing the proposal would be achieved using existing sources of government funding (for public programs) and supplemented with new taxes. According to PNHP, businesses and individuals would pay more taxes, but those taxes would be offset because there would no longer be health insurance premiums.

Hospitals would receive a global budget for operating expenses every month. Medications and supplies would be purchased by the federal government according to a national formulary and using its bulk purchasing power to negotiate the lowest prices for medications and supplies. Physicians would have three reimbursement options: (1) fee-for-service (with a simplified, binding fee schedule); (2) salaried positions in facilities that receive global budget payments (i.e. hospitals); or (3) salaried positions within group practices or HMOs receiving capitation payments.

Two of the more common economic arguments in favor of single-payer are administrative simplification and the ability to control costs. According to a 2003 New England Journal of Medicine study, the U.S. spends more than $294 billion annually on administrative costs, which represents 31% of health expenditures in this country.

However, not all administrative costs are harmful or inappropriate, thus diminishing the amount of savings generated by administrative simplification. Furthermore, these savings would only be generated one time.

With regard to cost control, the U.S. has a fragmented, non-centrally coordinated system where different payers operate by different rules. Some argue that these variances have curtailed efforts to implement effective, systemic cost control measures, such as global budgeting (lump-sum monthly payments for all care provided); price controls; supply controls; reimbursement caps; and overall expenditure targets. Centrally administered plans, such as single-payer, provide policy makers who wish to institute cost controls with a substantial tool for obtaining that objective. Although, implementing that option would be largely dependent on public opinion. Additionally, if cost containment measures are too aggressive, it can lead to an underfunded system with significant wait times for elective procedures, insufficient resources, and diminished research and development.

Some argue that the biggest disadvantage to a single-payer system is the threat of underfunding by the government (due to fiscal or policy determinations). A single-payer system is particularly reliant upon a government that is committed to high funding levels to ensure quality of care is not diminished. As the Medicare and Medicaid Trust Funds rapidly approach projected insolvency, questions arise about the federal government's ability to sufficiently provide benefits even under our current system. Another acknowledged disadvantage is that the transition from the current U.S. system to single-payer would be very difficult and disruptive. The ACEP HCFTF also notes several potential tradeoffs with regard to implementing a single-payer system. These include: "restricted availability and lengthy wait times for certain elective procedures, as well as the potential for capitation that could limit reimbursement for providers." Finally, it has been suggested that Americans would have to be willing to accept other certain sacrifices under a single-payer system, such as accepting less choice in their coverage options and a willingness to accept more government control, oversight, and regulations through a single-payer system.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted staff time and resources. Potential additional costs associated with working with like-minded partners or coalitions.

Prior Council Action

Resolution 32(20) Loss of Health Insurance Due to COVID-19 not adopted. The resolution requested ACEP to support adoption of Medicare-for-All as an alternative to employment-based insurance (with conditions) and explore opportunities to partner with other like-minded organizations favoring a Medicare-for-All approach

Resolution 37(19) Single-Payer Health Insurance not adopted. The resolution asked for ACEP to support the adoption of a single-payer health insurance program and explore opportunities to partner with other organizations that favor the single-payer approach to providing universal health care to all Americans.

October 2018, the Health Care Financing Task Force report served as the foundation for the 2018 Council Town Hall Meeting.

Amended Resolution 19(16) Health Care Financing Task Force adopted. Directed ACEP to establish a Health Care Financing Task Force to study alternative health care financing models, including single-payer, and provide a report to the 2017 Council.

Substitute Resolution 31(14) Financing Health Insurance adopted. Directed ACEP to create a Health Care Financing Task Force to study alternative financing models that foster competition and preserve choice for patients and that the task force report to the 2015 ACEP Council regarding its investigation.

Resolution 20(12) Single Payer Universal Health Insurance not adopted. The resolution supported the adoption of single payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Resolution 26(11) Single-Payer Universal Health Insurance not adopted. The resolution supported the adoption of single-payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Substitute Resolution 21(10) Medicare-for-All Health Insurance referred to the Board. The original resolution Supported the adoption of Medicare for everyone and work with organizations that favor this approach to providing health insurance for all Americans. The substitute resolution directed the Board to appoint a task force to investigate alternative models of healthcare financing.

Resolution 18(09) Single-Payer Health Insurance not adopted. Directed ACEP to support the adoption of single payer health insurance and work with organizations that favor the single-payer approach.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted. Directed ACEP to support the adoption of single-payer health insurance and work with organizations that favor the single-payer approach. A substitute resolution was adopted, although the title of the resolution was not changed. The substitute resolution directed the Board of Directors to derive a list of essential components to be included in any new healthcare system and create a white paper.

Resolution 21(07) Single-Payer Health insurance referred to the Board of Directors. The resolution asked the College to support the adoption of single-payer health insurance and to work with organizations that favor the single-payer approach.

Resolution 34(05) Single-Payer Health Insurance referred to the Board of Directors. The resolution called for ACEP to explore opportunities toward a single-payer approach for health insurance.

Resolution 11(00) Funding the Mandate referred to the Board. The resolution called for the College to work with chapters to obtain funding for uncompensated services provided by emergency physicians and to assist chapters to sponsor legislation to provide funding, as well as use funds such as tobacco settlement monies and tax subsidies. Further, the College should work with HCFA to encourage health plans contracted with Medicare and Medicaid to reimburse EMTALA mandated care and create a task force to explore alternative funding sources including establishing regional case rates and a public utility model.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted. Directed the College to develop a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; make a long-term commitment to work with federal, state, and private agencies to resolve the problem; and provide a progress report at the 2000 Council meeting. This resolution was linked to Resolution 12(99). A health policy report, “Emergency Medicine and the Debate Over the Uninsured: A Report from the Task Force on Health Care and the Uninsured” was developed and included in the published proceedings of ACEP’s educational conference “National Congress for Preserving America’s Healthcare Safety Net.” The report included several principles developed by the task force, including the urgent need to expand health insurance coverage.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted. It called for ACEP to continue working with the AMA and other leaders on developing and implementing an educational program, on the issue of the medically uninsured and underinsured.

Substitute Resolution 17(98) Responsibilities of On-call Physicians adopted. It called for a study on the ramifications of on-call physicians and EMTALA including reimbursement issues.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted. The resolution asked for swift action to identify any adverse effects on public health, safety, and access to emergency services resulting from the Act that could result in making many persons covered by Medicaid ineligible, thus increasing the number of uninsured, and to seek immediate government action if any of these are jeopardized.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. The resolution called for the increase of federal taxes on handguns and ammunition to support increased coverage for the uninsured.

Amended Resolution 38(94) Single-Payer System adopted. The resolution asked the Board to facilitate debate and discussion within ACEP about the merits to emergency physicians and patients regarding a single-payer system, all payer system, and other reform options and report back to the Steering Committee.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted. The resolution directed ACEP to develop a policy statement outlining a national health care reform plan that addressed access to care for all, cost containment mechanisms, basic benefits package, health care insurance for all, freedom of choice by consumers, patient responsibility, quality improvement and ethical standards, education and research, and malpractice reform.

Prior Board Action

September 2018, accepted the final report from the Health Care Financing Task Force. The report was distributed to the Council.

Amended Resolution 19(16) Health Care Financing Task Force adopted.

June 2015, reaffirmed the policy statement, "Universal Health Care Coverage;" reaffirmed August 2009; originally approved December 1999.

Substitute Resolution 31(14) Single Payer Health Insurance adopted.

April 2014, approved the revised policy statement "Health Care Cost Assignments by Taxes," replacing the policy statement "Health Promotion Revenues ("Sin Taxes"); reaffirmed October 2006; revised and approved July 2000; originally approved in 1993.

April 2012, the Board reviewed a report regarding policies and regulations that were in process since enactment of the Affordable Care Act. ACEP submitted comment letters on a wide range of issues and held multiple meetings with department and agency officials over various provisions of the Act (accountable care organizations, the Physicians Quality Reporting System, information technology, workforce challenges etc.). The Board determined that no further action was needed on the resolution.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted.

January 2008, discussed whether ACEP should have a more defined position on health care reform, including universal health care coverage. There was consensus that system reform and health care coverage were ACEP's primary goals in the health care debate.

August 2007, agreed with the assessment of the Federal Government Affairs Committee that support of reform principles and involvement in discussions regarding health care reform constitute sound approach to health care reform and thus took no action on Resolution 34(05).

January 2006, endorsed the "Principles of Reform of the U.S. Health Care System" developed by eleven physicians' organizations, including ACEP.

June 2005 discussed whether ACEP should take the lead in advocating for fundamental changes in public financing of health care to provide universal coverage of basic benefits.

Resolution 11(00) Funding the Mandate was assigned to the EMS Committee, Reimbursement Committee, Federal Government Affairs Committee, and the State Legislative/Regulatory Committee. ACEP addressed the resolution through ongoing legislative and regulatory activities, both nationally and at the state level.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted.

Substitute Resolution 17(98) Responsibilities of On Call Physicians adopted.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted.

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

Amended Resolution 38(94) Single-Payer System adopted.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

Background Information Prepared by: Ryan McBride, MPP

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 28(21)

SUBMITTED BY: Paul Kivela, MD, FACEP
California Chapter
Delaware Chapter
Florida College of Emergency Physicians
Maryland Chapter

SUBJECT: Consumer Awareness Through Classification of Emergency Departments

PURPOSE: 1) Create a system to classify EDs by 5 types; 2) work with a variety of groups to promote this classification and the criteria so it is widely known and understood by the public and the media; 3) promote any and all EDs that meet the standard at no or minimal charge and assist all members to document these standards; 4) work with a wide range of organizations to create an enforcement agency to ensure such classifications are accurate and up-to-date; 5) report on this process on an annual basis to the Council and ACEP membership.

FISCAL IMPACT: Unbudgeted expenses of $20,000 – $30,000 for in-person stakeholder meeting/task force depending on the size of the group. A public media campaign could cost $100,000. Potential loss of income from ACEP's ED Accreditation program (non-dues revenue) $500,000 + per year.

WHEREAS, Patients cannot decide and often do not know who will provide them care in the emergency department and patients seeking emergency care should ideally be entitled to physician-delivered or physician-led medical care, and ideally a specially-trained emergency physician; and

WHEREAS, There are varying standards as to whom provides care in emergency departments and patients are often not aware of the varying degrees of training and experience among physicians and non-physician providers; and

WHEREAS, Patients and communities deserve to have transparent information on the credentials of the professionals providing them care in an emergency department and clear knowledge if they are going to be cared by an emergency physician, other physician, or non-physician; and

WHEREAS, ABMS has determined that specific standards should be in place for each specialty and determined in emergency medicine specialty that should be defined by ABEM and AOBEM; and

WHEREAS, ABEM and AOBEM standards are such that EM physicians require both graduation from an undergraduate and approved medical school usually consisting of 3-4 years of additional emergency medicine specialty specific training;-and

WHEREAS, Medical schools require nearly 10,000 hours of generalized training and EM residency requires an additional nearly 10,000 hours of emergency medicine specialty specific training; and

WHEREAS, Supplemental non-physician training programs such as "bootcamp" programs or post-graduate "residency" programs may provide valuable education and training, they are not commensurate with the standards required by ABEM/AOBEM for the practice of Emergency Medicine;

WHEREAS, One of the fundamental issues core to physician specialization is that training matters;

WHEREAS, ACEP is studying creating its own accreditation of emergency departments, this proposed

resolution may stand alone and also serve to direct the College; therefore be it

RESOLVED, That:

1. ACEP advocate with professional, consumer, other health organizations and all other interested parties to classify emergency departments as follows

   Type A: All patients will be seen and evaluated exclusively by either:
   a. an ABEM or AOBEM certified emergency physician; or
   b. a physician recently graduated from a Residency Review Committee approved emergency medicine residency; or
   c. an emergency medicine resident in a Residency Review Committee approved emergency medicine residency under the onsite supervision of an ABEM or AOBEM certified emergency physician faculty member; or
   d. an emergency physician (who has been practicing emergency medicine greater than 20 years and has greater than 20,000 hours of emergency medicine experience) who is a member in good standing with an emergency medicine professional organization that has a method to enforce ethical behavior of its members including documentation of meeting these practice standards.

   Type B: All patients will have their care provided by the same criteria as Type A or by a physician assistant (PA) or nurse practitioner (NP) overseen by a ABEM or AOBEM certified or emergency medicine residency trained and/or can request and be seen by an emergency medicine residency trained or emergency physician (who has been practicing greater than 20 years and has greater than 20,000 hours of experience.)

   Type C: Patients may be seen by a PA or NP with supervision (either onsite or by telemedicine) by an ABEM or AOBEM certified, or by an emergency physician (who has been practicing greater than 20 years and has greater than 20,000 hours of emergency medicine experience) or patients may be seen by a MD or DO that does not meet the above criteria.

   Type D: Patients may be seen by a PA or NP (with 10,000 hours of emergency medicine experience) and without any direct or indirect supervision by an ABEM or AOBEM certified, approved emergency medicine residency trained, or emergency physician (who has been practicing greater than 20 years and has greater than 20,000 hours of emergency medicine experience).

   Type E: None of above criteria have been met.

2. ACEP will work with other likeminded medical professional, hospital organizations, and consumer groups to make available the classification and criteria so that it is widely known to the public and media.
3. ACEP will work to promote at no or minimal charge any and all emergency departments that meet the standards and assist all members to document these standards.
4. ACEP will work with other likeminded medical professional, hospital organizations, consumer groups, and governmental organizations to create an enforcement agency to ensure classifications are accurate and up to date.
5. ACEP will provide a report on this process and developments to the Council and ACEP membership on an annual basis.

Background

This resolution calls for ACEP to create a system by which hospital emergency departments (EDs) are classified by the criteria stated in the resolution. It calls for ACEP to advocate with a very wide variety of groups to create such a classification including professional organizations, consumer groups, and other health organizations; work with these groups to promote this classification and the criteria that define that so that it is widely known and understood by the public and the media; promote any and all EDs that meet the standard at no or minimal charge and assist all members in documenting these standards; work with a wide range of organizations to create an enforcement agency that would

ensure that such classifications are accurate and up-to-date; and report on this process and developments annually to the Council and the membership..

Accreditation of hospitals is limited to four organizations, The Joint Commission (TJC), Healthcare Facilities Accreditation Program, DNV GL Healthcare, and the Center for Improvement in Healthcare Quality.[1] Accreditation is required for participation in CMS and MC/MA reimbursement. TJC, the largest accreditation group, created a classification of EDs in the early 1970s but abandoned them in the early 1980s because they were poorly understood by the public. It was also difficult to enforce, "irrelevant," and they believed it was too complicated and blunted investment in increasing resources for emergency departments. TJC has no interest in reopening such a classification system. (Personal communication with TJC staff).

The Australasian College of Emergency Medicine proposed a similar system for Australia in 1997.[2] After 10 years of advocacy work, a new commission was established in 2017 to investigate the feasibility of such a system and to begin to classify possible criteria of inclusion.[3,4] It now appears to have been repurposed to create a reimbursement system rather than a classification of ED capabilities.

In June, 2021 ACEP President Mark Rosenberg, DO, FACEP, created the ED Accreditation Task Force to establish the feasibility of an accreditation program and create criteria for such a program. The task force is chaired by Adrian Tyndall, MD, FACEP, currently Dean at Morehouse School of Medicine, and the Board Liaison is Arvind Venkat, MD, FACEP. The task force is composed of emergency physicians from across the U.S., several of them in administrative jobs, including a CEO, and with expertise in reimbursement. The task force is charged with creating a system that will ensure that "a patient's zip code does not dictate the emergency care they receive." The task force is also charged with providing a final report, with recommended criteria and a business plan, to the Board by June 2022. If approved by the Board, ACEP is committed to have the accreditation program established, marketed, and enrolling EDs no later than by the end of 2022.

The task force has already discussed using accreditation to promote the policies of the College including the emergency physician as the leader of every emergency care team. ACEP's policies do not support the independent practice of NPs and PAs and this would be incorporated into the criteria for accreditation.

The task force will provide a written update to the Board of Directors and the Council Officers at each Board meeting during its deliberation. ACEP has had great success with its hospital-based geriatric ED accreditation program (GEDA) and, despite the pandemic, is seeing growing interest in the hospital-based program for pain and addiction accreditation (PACED). There are many anecdotal examples of facilities that make significant changes to meet the criteria for accreditation. More importantly, accreditation standards can be changed over time, and, as every teaching hospital knows, losing accreditation or even receiving a citation is taken very seriously. Accreditation is important to the C-Suite, which is why there are such representatives on the task force. Ideally, accreditation would be tied to payment/reimbursement. Most importantly, we have seen accreditation to be important for market share (larger hospitals and systems), and for small hospitals who wish to attract/retain patients from the community. It also provides a non-dues revenue source for the College.

This resolution calls for a proscribed classification system, which would remove the need for the task force and remove accreditation as an option. The resolution also calls on ACEP to establish a way to classify all 5,000 EDs in the U.S., an enforcement system that would likely require on-site investigation, and then a public campaign to inform the public of the multiple types of EDs. Even after the current EDs are classified, it would still be difficult to ensure public understanding what level of care they require for a given incident. There are a myriad of public websites and insurance campaigns that attempt to educate the public on identifying an emergency.

More importantly, this resolution calls for ACEP to help the public differentiate between departments staffed by emergency physicians and those staff by NPs/PAs. The literature suggests that the general public does not understand the difference between NPs/PAs and physicians, and at least in primary care, some prefer to see an NP/PA over a physician.[5] Despite the existence of trauma centers for several decades, the literature suggests that the public lacks awareness of the system, other than that they exist.[6]

Finally, using the classifications proposed in the resolution, it can be anticipated that the Type C, D, E facilities will be largely in rural America. About 30% of EDs have an annual volume of less than 10,000 visits or about 25 visits per day.[7] Patients who live in rural areas do not have a choice in emergency care as the next nearest facility may be many miles away.[8] In one national study 19% of Americans live more than 10 miles from their nearest hospital, while 24% live between 5 and 10 miles.[9] Using any classification of a stroke center as a surrogate for Type A, B facilities, 33% of the population live > 60 minutes from the nearest facility.[10]

Background References

[1]Healthcare Facilities Accreditation Program, DNV GL Healthcare and the Center for Improvement in Healthcare Quality.
[2]Australasian College for Emergency Medicine. Statement on the Delineation of Emergency Departments. November 2012.
[3]Health Policy Analysis 2014, Investigative review of classification systems for emergency care – Final report, Independent Hospital Pricing Authority, Sydney.
[4]Australasian College for Emergency Medicine. Australasian Emergency Care Classification. 2016.
[5]Leach B, Gradison M, Morgan P, et al. Patient preference in primary care provider type. *Healthc (Amst)*. 2018;6(1):13-6.
[6]Champion HR, Mabee MS, Meredith JW. The state of US trauma systems: public perceptions versus reality--implications for US response to terrorism and mass casualty events. *J Am Coll Surg*. 2006;203(6):951-61.
[7]Camargo C, Freess D, Marco CA, et al. Future of Emergency Medicine – People. 2020.
[8]Pew Research Center. How far Americans live from the closest hospital differs by community type. December 2018.
[9]Mullen MT, Wiebe DJ, Bowman A, et al. Disparities in accessibility of certified primary stroke centers. *Stroke*. 2014;45(11):3381-8.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
  - Tactic 1 – Advocate for ACEP's principles for healthcare reform in current and future legislation that supports the practice of emergency physicians
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
  - Tactic 3 – Promote emergency medicine to the general public using communication tools such as health and safety press releases, social media, ACEP's consumer website EmergencyPhysicians.org, or other marketing campaigns.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.
  - Tactic 9 – Explore expansion of ACEP accreditation programs.

Fiscal Impact

Unbudgeted expenses of $20,000 - $30,000 for in-person stakeholder meeting/task force depending on the size of the group. A public media campaign could cost $100,000. Potential loss of income from ACEP's ED Accreditation program (non-dues revenue) $500,000 + per year.

Prior Council Action

Amended Resolution 20(08) Emergency Department Categorization Task Force adopted. Directed ACEP to convene a task force to explore the feasibility of sponsoring a national emergency center categorization program.

Resolution 15(98) Certifying Emergency Departments adopted. Directed the Board to appoint a task force to study the advisability of regionalization of care, developing a strategy to consolidate certifying agencies, and consider development of an ACEP certifying agency to replace as many other certifying agencies as possible.

Substitute Resolution 24(87) Levels of Staffing for Hospital Emergency Departments adopted. Directed ACEP to develop criteria within the next year to categorize the emergency services capabilities of healthcare facilities, include the qualification of emergency physicians, and continue to participate with the Joint Commission on Accreditation of

Healthcare Organizations in developing categorization criteria for emergency services accreditation standards.

Prior Board Action

October 2009, accepted for information the ED Categorization Task Force report. The report was distributed to the 2009 Council.

Amended Resolution 20(08) Emergency Department Categorization Task Force adopted.

Resolution 15(98) Certifying Emergency Departments adopted. A task force was appointed to further study the issues and potentially collaborate with SAEM. The task force report was distributed to the 2000 Council.

September 1997, sunsetted the policy statement "Categorization of Emergency Services;" previously reaffirmed June 1992 and originally approved April 1984.

January 1996, elected not to pursue ACEP certification of EDs but to continue to influence JCAHO and NCQA on emergency services certification issues.

April 1994, rescinded the policy statement "Health Care Facility Definitions;" previously approved June 1985.

Substitute Resolution Adopted 24(87) Levels of Staffing for Hospital Emergency Departments adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 29(21)

SUBMITTED BY: Florida College of Emergency Physicians
Illinois College of Emergency Physicians
Minnesota Chapter
Missouri College of Emergency Physicians

SUBJECT: Downcoding

PURPOSE: 1) Develop strategies to assist chapters in identifying if downcoding is occurring in their state; 2) develop model legislative language to include downcoding in existing prudent layperson statutes; 3) work with CMS and private insurers to prevent downcoding practices in Medicaid programs; and 4) work with chapters on model legislative language requiring transparency by insurers making changes to or requiring additional information for a claim.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The Prudent Layperson Standard guarantees patients the right to receive treatment in the emergency department if they feel they have a medical emergency; and

WHEREAS, Emergency providers have an unfunded mandate to provide a medical screening exam and evaluate for an emergency condition under the Emergency Medical and Labor Act (EMTALA); and

WHEREAS, Determining whether an emergent condition exists and stabilizing it as required by EMTALA requires a thorough evaluation that may include multiple diagnostics and treatment modalities; and

WHEREAS, The presenting, or chief complaint, is inadequate to determine if a patient has a medical emergency and does not consistently correlate with a non-emergent final diagnosis; and

WHEREAS, according to the Federal Register Final Rule, 2016, the final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis; and

WHEREAS, The Prudent Layperson Standard requires health insurance companies to cover a patient's emergency department (ED) evaluation based on the patient's symptoms and not their final diagnosis; and

WHEREAS, Insurance companies are arbitrarily downcoding ED charts based on a final diagnosis without reviewing the medical record or presenting symptoms or chief complaint; and

WHEREAS, Insurance companies are using both arbitrary diagnosis lists and tools developed for non-billing and coding purposes to downcode ED charts; therefore be it

RESOLVED, That ACEP develop strategies to assist chapters in identifying if downcoding is occurring in their state; and be it further

RESOLVED, That ACEP develop specific model legislative language to include downcoding in existing prudent layperson statutes; and be it further.

RESOLVED, That ACEP work with the Centers for Medicare & Medicaid Services and private insurers to prevent the practice of downcoding in state Medicaid programs and by private insurers; and be it further

RESOLVED, That ACEP work with chapters to develop specific model legislative language to require transparency when insurance companies make changes to or require additional information for a claim.

Background

The resolution calls upon the College to develop model legislative language to include downcoding restrictions in existing prudent layperson statutes, work with CMS and private insurers to prevent downcoding practices, and work with chapters on model legislative language requiring transparency by insurers making changes to or requiring additional information for a claim.

The State of Maryland enacted the first prudent layperson law in 1993, and the federal government followed suit for Medicaid Managed Care and Medicaid recipients in the Balanced Budget Act of 1997. The scope of the laws applying the standard has expanded with its inclusion in the laws of 48 states, the District of Colombia, and the 2010 federal ACA Bill of Rights. However, both commercial insurers and government programs have persisted in efforts to reduce payments for emergency care that they deem non-emergent based on diagnosis.

ACEP has repeatedly reached out to Centers for Medicare & Medicaid Services (CMS) on the issue of downcoding, attempting to point out that downcoding is a violation of the prudent layperson standard (PLP). Most recently, ACEP has talked to CMS staff implementing the *No Surprises Act*. After an initial conversation, on June 14, 2021, ACEP and Emergency Department Practice Management Association (EDPMA) wrote a letter to CMS staff detailing this issue. The letter conveyed that both the Obama and Trump Administrations clearly stated that the PLP standard prevents plans from modifying payment (downcoding) of emergency claims based on diagnosis. The letter further explains that there are clear documentation standards and guidelines that dictate what level of service should be included on the claim. The letter also included a list of private payor and Medicaid policies that violate the PLP. This information will be reiterated in the key points of a letter in official response to the Interim Final Rules implementing the *No Surprises Act*.

ACEP developed a toolkit in 2018 for third-party stakeholders to begin an ACEP-led outreach to all impacted groups to ensure a coordinated approach and encourage information sharing and a unified message. Congressional and state legislative activity has focused on identifying legislative champions to lead various efforts, such as Congressional pressure on the third-party payers that violate PLP in their state, Congressional pressure on the insurance commissioner within their state to limit enforcement, Congressional outreach to HHS or CCIIO to encourage their action, and a Hill briefing (featuring a panel of emergency physician(s), a consumer representative, and an impacted patient). The toolkit and Congressional pressure in 2018 led to the publication by Senator McCaskill (D-MO) of the report, “Coverage Denied: Anthem BCBS’ Emergency Room Initiative,” which included data ACEP had compiled and shared with the Senator’s office.

ACEP provided data on specific retroactive denials collected from various emergency physician groups to several federal agencies to supplement any investigative work on PLP denials they might have had underway. ACEP continues to advocate for PLP strengthening in federal law as part of our surprise billing advocacy. Finally, ACEP has written letters to CMS and had calls with and sent letters to several states to address various issues with state Medicaid agencies and/or managed care plans’ downcoding or retroactively denying claims.

ACEP is working with chapters to identify champions in the state legislatures and/or governors’ offices who might have influence with insurance commissioners, develop op-eds in key markets to influence state lawmakers, and encourage impacted constituents to write to their legislators. Favorable legislation passed in Missouri in 2019 and in Maine in 2020. Model legislation drafted by EDPMA/ACEP to prevent down coding was recently introduced in the California Assembly.

ACEP will continue to explore legal options to prevent third-party payers from enforcing policies that violate PLP, including possible injunctions. ACEP filed suit against Anthem Blue Cross Blue Shield of Georgia in July 2018. On October 22, 2020, the 11th Circuit Court ruled in favor of the appeal filed by ACEP and the Medical Association of Georgia. The case was remanded back to the Northern District Court in Georgia. The wording of the opinion is strongly supportive of ACEP’s position.

In June 2021, the Board of Directors approved an RFP to commission an independent study on the financial influence of health insurers on emergency physicians, with a focus on Emergency Medical Treatment and Labor Act (EMTALA)-related mandates and associated reimbursement issues affecting emergency physicians.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted. The resolution directed ACEP to commission an independent study on the financial influence exerted by health insurers to leverage EMTALA mandates and withhold appropriate reimbursement and work with other allied organizations to better understand their impact on physician delivery of emergency care.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted. Directed ACEP to develop and enact strategies (including state and federal legislative solutions) to prevent payors from arbitrarily downcoding charts and work to develop and enact policy at the state and federal level that prevents payors from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Resolution 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.

Prior Board Action

June 2021, approved and RFP to commission an independent study on the financial influence of health insurers on emergency physicians, with a focus on Emergency Medical Treatment and Labor Act (EMTALA)-related mandates and associated reimbursement issues affecting emergency physicians.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted.

October 2020, approved the revised policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved April 2014, June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

February 2020, approved prudent layperson model state legislation stipulating that "the health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway."

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

February 2018, reaffirmed the policy statement "Assignment of Benefits;" reaffirmed April 2012; originally approved April 2006.

July 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients.

January 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25).

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

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.

Resolution 43(97) Prudent Layperson Legislation adopted.

Background Information Prepared by: Harry J. Monroe, Jr.
State Legislation Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 30(21)

SUBMITTED BY: Douglas P Brosnan, MD, JD, FACEP
Bing S Pao, MD, FACEP
Thomas J. Sugarman, MD, FACEP
California Chapter
Michigan College of Emergency Physicians
Missouri Chapter

SUBJECT: Unfair Health Plan Payment Policies

PURPOSE: 1) Develop model legislation and advocate for enactment at both the state and federal levels, prohibiting health plans from implementing new payment policies during the term of a provider's contracts unless the new policy is required by new laws or regulations; 2) advocate at the American Medical Association to pass legislation prohibiting health plan contracts from requiring adherence to new health plan payment policies unless the new policy is required by new laws or regulations.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Health plans have been increasingly introducing new payment policies to reduce or deny emergency provider payments; and

WHEREAS, These payment policies include downcoding, bundling charges, unreasonable timely filing requirements, payment reductions for physician extenders and ancillary care services, and non-emergent denials; and

WHEREAS, In-network providers are required to follow the policies during the term of the contract in order to stay in-network; and

WHEREAS, Emergency physicians are compelled to agree to the policies unless the provider terminates the contract with the health plan; and

WHEREAS, Health plans will often unilaterally implement the payment policies even if the provider is out-of-network; therefore be it

RESOLVED, That ACEP develop model legislation and advocate for enactment at both the state and federal levels, prohibiting health plans from implementing new payment policies during the term of a provider's contracts unless the new policy is required by new laws or regulations; or the provider consents in writing to the specific policy change prior to its being implemented; and be it further

RESOLVED, That ACEP advocate at the American Medical Association to promote legislation prohibiting health plan contracts from requiring adherence to new health plan payment policies unless the new policy is required by new laws or regulations.

Background

This resolution calls for the College to develop model legislation and advocate for enactment at both the state and federal levels, prohibiting health plans from implementing new payment policies during the term of a provider's contracts, unless the new policy is required by new laws or regulations, as well as to advocate at the American

Medical Association to pass legislation prohibiting health plan contracts from requiring adherence to new health plan payment policies unless the new policy is required by new laws or regulations.

ACEP has increasingly seen insurers change the payment terms of a contract during the agreed upon term of the existing contract. While most contracts contain provisions to modify or terminate a contract within certain parameters and length of notice, changes that enact unfavorable payment policies leave the emergency physician with the unfortunate option of either terminating the contract and being out of network or accepting less favorable payment policy. Health plans have been known to use this tactic to force groups to either be out-of-network to take advantage of balance billing prohibitions or other state language, which create administrative hassles, delay in obtaining payment, and sometimes unfavorable publicity in the community and with lawmakers.

Health plans have been increasingly introducing new payment policies to unfairly deny or unreasonably reduce payment to emergency physicians. These payment policies include, but are not limited to, downcoding, bundling, unreasonable timely filing requirements, payment reductions or denials for separate billable procedures, unconventional payment reductions for ancillary care clinicians, non-emergent denials, and unreasonable usual and customary payments. In most cases, in-network emergency physicians are required to abide by the health plan policies, but insurers often unilaterally apply the same policies to out-of-network emergency physicians. Emergency physicians are often compelled to agree to new policies during the term of a contract to stay in-network.

ACEP advocacy has produced some tangible results in response to unfair health plan payment policies. Forming coalitions with state ACEP chapters and medical societies has been a key ingredient for success. Involving government regulators has caused payers to respond to complaints and at least delay implementation. Some advocacy successes against unfair health plan payment policies include:

1. delayed implementation of United Health Care's evaluation and management coding policy;
2. reversing Medicaid downcoding policies in Kansas and Illinois;
3. improvements to Anthem's problematic policy denying coverage for what it deemed nonemergent in several States; and
4. suspension of Centene's (Managed Health Services [MHS], Indiana) downcoding policy and reduced payment policy for claims billed with a modifier-25. A Centene subsidiary (HealthNet) suspended a similar modifier-25 policy in California.

Legislation has been an effective tool to curb unfair health plan payment practices. Most states have statutes that waive authorization requirements and provide prudent layperson protection for coverage of emergency services. States often require timely payments for emergency clinician claims and an appeal process for denied claims. Some states mandate assignment of benefits for emergency services. Many of these laws have successfully achieved the intended purpose. It is not clear if legislation that was designed to reduce non-emergent denials or downcoding has been effective. Maine passed legislation that would require utilization review by a board-certified emergency physician to prevent non-emergent denials and downcoding. There are reports that downcoding continues to occur in Maine, but it is unknown if the frequency decreased following passage of the bill. Missouri requires a review of the medical records by a board-certified physician before denying payment based on the absence of an emergency medical condition. However, an analysis by one emergency physician group in Missouri found the frequency of downcoding did not decrease after passage of the bill. Model legislation drafted by EDPMA/ACEP to prevent downcoding was recently introduced in the California Assembly. A separate bill that was introduced in the California Senate would shift the responsibility of collecting the patient cost share to the health plans. Oklahoma recently introduced a bill that would require the policyholder to agree to any changes to a policy benefit, including removal of a patient's physician from his or her network contract, at any time the policy is in force. The impact of some of these legislative efforts is still unknown. Passing legislation to prevent the implementation of harmful health plan payment policies during the term of a contract could be another effective method to prevent underpayment of claims.

ACEP has lobbied extensively on unfair health plan payment polices for the past few years, but not specifically to midterm changes in existing contracts. ACEP could submit a resolution to the AMA House of Delegates calling for advocacy on this issue.

The AMA does have current policy that calls for a mechanism to address grievances and supports advocacy on behalf of patients, 11.2.3 Contracts to Deliver Health Care Services, which was last modified in 2017:
E-11.2.3 11.2.3 Contracts to Deliver Health Care Services| AMA (ama-assn.org)

A second AMA policy on Physician Negotiations says that physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations and that physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting, H-383.997 Hospital Based Physician Contacting:
H-383.997 Hospital-Based Physician Contracting | AMA (ama-assn.org)

A third AMA policy urges CMS to ban "no cause" terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract with a MA plan, H-285.902 Ban on Medicare Advantage "No Cause" Network Terminations:
H-285.902 Ban on Medicare Advantage "No Cause" Network Terminations | AMA (ama-assn.org)

Finally, an AMA policy requiring managed care organizations to provide due process to physicians in all adverse selective contracting decisions, H-285.981 Fair Market Practices:
H-285.981 Fair Market Practices | AMA (ama-assn.org)

ACEP has several policy statements that address this resolution::

1. Compensation Arrangements for Emergency Physicians
2. Fair Payment for Emergency Department Services
3. Emergency Physician Compensation Transparency
4. Emergency Physician Rights and Responsibilities
5. Protecting Emergency Physician Compensation During Contract Transitions

ACEP's Policy Resource and Education Paper (PREP) "Emergency Physician Contractual Relationships" states that "contracting parties should be ethically bound to honor the terms of any contractual agreement to which it's a party and to relate to one another in an ethical manner." The PREP is an adjunct to the ACEP's policy statement "Emergency Physician Contractual Relationships."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
  - Strategy 2 – Collaborate with the AMA, state medical societies, and other medical organizations on payment and practice sustainability issues such as out-of-network reimbursement and balance billing issues, including advocacy with entities such as FAIR Health, NCOIL, NAIC, and PFC, as appropriate.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine first two resolveds adopted and last three resolveds referred to the Board of Directors.

Resolution 15(02) Promotion of College Policies on Contracting and Compensation not adopted. Requested the Board of Directors to review the policy statement " Promotion of College Policies on Contracting and Compensation" and

Resolution 14(02) Emergency Physician Rights and Self-Disclosure not adopted. The resolution would have required any exhibitor, advertiser, grant provider, and sponsor who employs emergency physicians as medical care providers to disclose their level of compliance with College policies on compensation and contractual relationships. Amended

Resolution 14(01) Fair and Equitable EM Practice Environments adopted. Directed ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and to continue to promote the adoption of the principles outlined in the "Emergency Physician Rights and Responsibilities" policy statement by the various emergency medicine contract management groups, the American Hospital Association, and other pertinent organizations.

Resolution 12(01) Coercive Contracting not adopted. Directed ACEP to discourage any contracting practice that may be illegal, unethical, or any practice that may circumvent fair and equitable negotiations and to explore legal issues surrounding coercive contracting and if appropriate request an OIG opinion on contracts that force emergency physicians to accept less than fair market value reimbursement from third party payers in exchange for the right to retain their contract.

Substitute Resolution 10(01) Commercial Sponsorships adopted. Directed the Board to continue initiatives to develop and implement policies on self-disclosure of compliance by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings with ACEP physicians' rights policies, including: "Emergency Physicians Rights and Responsibilities," " Emergency Physician Contractual Relationships," " Agreements Restricting the Practice of Emergency Medicine," and " Compensation Arrangements for Emergency Physicians"

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 74(95) Support Part B of the Health Care Quality Improvement Act not adopted. There were concerns about anti-kickback statutes and the need to recognize where it occurs between both hospitals and contracting entities and management companies and physicians.

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted. Called for ACEP to reaffirm its value statement that "the best interests of the patient are served when emergency physicians practice in a fair, equitable, and supportive environment," and its accompanying objective that "fair and equitable compensation for emergency physicians will be established through fair business practices and be available for all emergency services rendered."

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.

Substitute Resolution 9(93) Contractual Relationships adopted. Called for ACEP to support fair and equitable contractual business arrangements and promote these relationships through a public relations campaign and the development of a policy statement on fair and equitable contractual relationships. Substitute Resolution 18(85) Fairness adopted. Directed the development of a position statement on contractual relationships between emergency physicians and contracting/employing entities that addresses emergency physicians' rights to fair and equitable treatment.

Substitute Resolution 18(85) Fairness adopted. Directed the development of a position statement on contractual relationships between emergency physicians and contracting/employing entities that addresses emergency physicians' rights to fair and equitable treatment.

Prior Board Action

June 2021, approved filing the report of the EDPMA/ACEP Unfair Health Plan Payment Policy Task Force and utilizing the recommendations contained in the report as options for future implementation to address unfair health plan payment policies.

April 2021, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" revised and approved April 2015, April 2002 and June 1997; reaffirmed October 2008 and April 1982; originally approved June 1988.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised and approved October 2015, April 2008, July 2001; originally approved September 2000.

Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine first two resolveds adopted. Directed ACEP to revise the policy statement "Emergency Physician Rights and Responsibilities" with specific language.

October 2020, approved the policy statement "Emergency Physician Compensation Transparency."

February 2020, approved the policy statement "Protecting Emergency Physician Compensation During Contract Transitions."

July 2018, reviewed the Policy Resource & Education Paper (PREP) " Emergency Physician Contractual Relationships" as an adjunct to the policy statement " Emergency Physician Contractual Relationships."

June 2018, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved Octobe4 2012, January 2006, March 1999, and August 1993 with the current title. Originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

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

Amended Resolution 14(01) Fair and Equitable Emergency Medicine Practice Environments adopted.

Substitute Resolution 10(01) Commercial Sponsorships adopted.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. June 1997 reviewed the information paper " Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships."

Substitute Resolution 56(94) Exploitation of Emergency Physicians adopted. Amended Resolution 49(94) Information on Contract Issues adopted.

Amended Resolution 49(94) Information on Contract Issues adopted.

Substitute Resolution 9(93) Contractual Relationships adopted. A Contracts Task Force was appointed as a result of this resolution.

Substitute Resolution 18(85) Fairness adopted.

Background Information Prepared by: David McKenzie, CAE
Reimbursement Director

Harry Monroe
State Legislative & Regulatory Affairs Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 31(21)

SUBMITTED BY: Olga Gokova, MD, FACEP
Rebecca Parker, MD, FACEP
Amish Shah, MD, FACEP
Arizona College of Emergency Physicians

SUBJECT: Employment-Retaliation, Whistleblower, Wrongful Termination

PURPOSE: Submit a resolution at the June 2022 AMA House of Delegates Annual Meeting promoting Arizona House Bill 2622 (2021) and promote the legislation to chapters through mechanisms such as the State Legislative/ Regulatory Committee and other membership outreach.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, "Doctors often hesitate to speak out because of the prospect of losing their jobs. A 2013 study of emergency physicians found that nearly 20% reported a possible or real threat to their employment if they expressed concerns about quality of care."[1]; and

WHEREAS, Emergency physicians have been retaliated against numerous times for raising concerns regarding patient safety, harassment, and/or fraud and these physicians have been affected mentally and financially as results of such retaliation and job loss and many report worsening anxiety, depression, financial hardships, family trouble and need to relocate; and

WHEREAS, The interests of patients are best served when emergency physicians practice in a stable, fair, equitable, and supportive environment and quality patient care is best promoted within a framework of fair and appropriate contractual relationships among various involved parties. [Emergency Physician Contractual Relationships Policy Resource and Education Paper (PREP)][2]; and

WHEREAS, "The COVID-19 pandemic put to the test physicians' ability to speak publicly about troublesome issues and in the first few weeks, healthcare facilities were struggling to obtain personal protective equipment (PPE) and to create policies that would keep patients and caregivers safe."[1,6]; and

WHEREAS, According to AAEM "Both the JCAHO and the Health Care Quality Assurance Act of 1986 require hospitals to give physicians appropriate due process before taking an adverse action on their privileges… There are also a number of state and federal laws which protect employees from discrimination or retribution for "whistle-blowing." These protections may be weakened or inapplicable if the physician is an independent contractor."[3]; and

WHEREAS, ACEP has a policy statement on due process: "Emergency physicians are entitled to due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges or their ability to see patients. Emergency physicians' medical and/or clinical staff privileges should not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law."[4]; and

WHEREAS, Arizona House Bill 2622 (2021) as signed into law has the following provisions:

1. Prohibits a third-party contractor of a health care institution from taking retaliatory action against a health professional.
2. Makes the period of time before there is a rebuttable presumption six months.

3. Defines third-party contractor as an entity that contracts with a health care institution to provide health care services in the health care institution by contracting or hiring health professionals.
4. Makes technical and conforming changes.[5]; therefore be it

RESOLVED, That ACEP submit a resolution to the June 2022 AMA House of Delegates Annual Meeting promoting Arizona house bill 2622 (2021) as signed into law as model state and national legislation to protect emergency physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or government, which also includes independent and third-party contractors providing patient services at said facilities; and be it further

RESOLVED, That ACEP promote Arizona house bill 2622 (2021) to chapters through mechanisms such as the State Legislative/Regulatory Committee and other membership outreach.

References

1. https://www.medscape.com/viewarticle/950074
2. https://www.acep.org/globalassets/new-pdfs/preps/emergency-physician-contractual-relationships---prep.pdf
3. https://www.aaemrsa.org/get-involved/residents/key-contract-issues
4. https://www.acep.org/patient-care/policy-statements/emergency-physician-rights-and-responsibilities/
5. https://www.azleg.gov/legtext/55leg/1R/bills/HB2622P.pdf
6. https://verdictsearch.com/verdict/hospitals-firing-of-doctor-was-retaliation-plaintiff-alleged/
https://www.reliasmedia.com/articles/146234-enforcement-action-likely-if-hospital-retaliates-against-ed-staff
https://www.npr.org/sections/health-shots/2020/05/29/865042307/an-er-doctor-lost-his-job-after-criticizing-his-hospital-on-covid-19-now-hes-sui

Background

This resolution calls for ACEP to submit a resolution at the June 2022 AMA House of Delegates Annual Meeting promoting Arizona House Bill 2622 (2021) as signed into law as model state and national legislation to protect emergency physicians from corporate, workplace, and/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of work (licensed health care institution) or government, which also includes independent and third-party contractors providing patient services at said facilities. It also directs ACEP to promote the legislation to chapters through mechanisms such as the State Legislative/Regulatory Committee and other membership outreach.

Whistleblower protection laws applying to health care workers vary widely in their degree and scope. At the federal level, the Occupational Safety and Health Administration, "Section 11(c) of the Occupational Safety and Health Act of 1970 (OSH Act) prohibits employers from retaliating against employees for exercising a variety of rights guaranteed under the OSH Act, such as filing a safety or health complaint with OSHA, raising a health and safety concern with their employers, participating in an OSHA inspection, or reporting a work-related injury or illness." In April 2020, OSHA issued a news release reminding employers that they cannot retaliate against employees reporting unsafe conditions during the pandemic, and the agency specifically included an anti-retaliation provision in its COVID-19 Emergency Temporary Standard issued this year.

While many states provide some level of whistleblower protection for healthcare workers, this year Arizona notably expanded its law related to protections for those working in health care institutions through House Bill 2622, to specifically extend requirements to apply to workers of third-party contractors of a health care institution. The previous law just covered the health care institution itself. Under the revised statute, health care institutions and third parties (those that contract to provide health care services to health care institutions by contracting or hiring health professionals) are precluded from taking retaliatory action against health care professionals who report an activity, policy or practice that the health professional reasonably believes violates professional standards of practice or is against the law and poses a substantial risk to the health, safety or welfare of a patient. If the institution or third party fail to address the initial report, the health care professionals are similarly protected from retaliation if they subsequently report the activity to an accrediting body or governmental entity. The bill also extended the length of time for a "rebuttable presumption" that any termination or other adverse action would be considered a retaliatory action from 180 days after the report is made by the health professional to six months.

ACEP policy supports protection of emergency physicians from retaliation for speaking out about conditions that could negatively impact patient care. The policy statement "Emergency Physician Rights and Responsibilities" states in part that "Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment." The policy statement "Safer Working Conditions for Emergency Department Staff" contains a provision under the section "Leadership promotion of a culture of safety and open reporting of safety concerns" that includes "Protections and support for physicians who raise or report safety concerns." Further, ACEP's policy statement "Supporting Political Advocacy in the Emergency Department" states that "Physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests."

During the pandemic, ACEP has expressed strong opposition to retaliation against physicians for speaking out against policies and practices that created unsafe working conditions. On March 30, 2020, ACEP issued a press release entitled "ACEP Strongly Supports Emergency Physicians who Advocate for Safer Working Conditions Amidst Pandemic." In July 2020, then ACEP President William Jaquis, MD, FACEP, and ACEP staff met with officials from the Occupational Safety and Health Administration (OSHA). During the meeting, ACEP shared de-identified stories from emergency physicians who have been penalized by their hospitals for wearing their own PPE or for speaking out publicly about PPE shortages or other issues. The College strongly urged OSHA to revise their standards and guidance to better protect emergency physicians and re-enforce their right to wear PPE that they believe keeps them safe. ACEP also asked OSHA to respond as quickly as possible to formal complaints filed by emergency physicians. ACEP also shared similar information with The Joint Commission and the American Hospital Association.

The AMA has also been vocal about this issue. In April of 2020, the AMA released a statement quoting AMA President Patrice Harris, MD as saying "No employer should restrict physicians' freedom to advocate for the best interest of their patients." The AMA also has several policies addressing the issue of retaliation against whistleblowers, including "Fair Process for Employed Physicians (H-435.942)" which states "Our AMA supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity. Our AMA will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace." The AMA policy "Physician and Medical Staff Member Bill of Rights (H-225.942)" states in part that "Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:… the right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities." In a policy entitled "The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community (H-285.910)", the AMA endorses specific language of a clause to be included in physician employment contracts and independent contractor agreements for physician services that precludes the employer from retaliating against the physician for exercising his/her right to advocate on behalf of patients' interests or good patient care.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective H – Strengthen job security and opportunity for individual members at all stages of their careers.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors. The resolution called for the College to adopt a policy prohibiting members from denying another emergency physician the right to due process regarding their medical staff privileges and prohibits members from holding management positions at entities that deny an emergency physician this right. The resolution further called for wording changes in the policy statement "Emergency Physician Rights and Responsibilities" and the adoption of a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians.

Amended Resolution 41(20) Personal Protection Equipment adopted. The amended resolution directed the College to work with relevant stakeholders to develop establish appropriate minimum standards and regulations for hospitals to maintain accessible storage of appropriate levels of personal protective equipment, to strengthen whistleblower protections for those reporting deficiencies in the quantity or quality of PPE provided to them, and to establish new policy supporting emergency physicians providing their own PPE without penalty if proper PPE is not provided.

Resolution 47(13) Supporting Political Advocacy in the ED adopted. The resolution called for the College to adopt a policy statement incorporating a provision in the AMA's Principles for Physician Employment stating that "employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter, regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests."

Resolution 45(13) Revision of "AMA Principles for Physician Employment" referred to the Board of Directors. The resolution called for ACEP to work to amend the AMA Principles for Physician Employment to state that no physician employment agreement should limit a physician's right to due process as a member of the medical staff if terminated. The AMA Section Council on Emergency Medicine recommended that the AMA Organized Medical Staff Section (OMSS) review the information and potentially submit a resolution to the AMA Interim Meeting in November 2014. However, AMA staff reported that the AMA amended the Principles for Physician Employment in June 2014 to address the issue of automatic termination of staff privileges following termination of an employment agreement (sections 3e and 5f) based on a report from the OMSS Governing Council that outlined the rationale for the amended language.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted. Called for ACEP to develop model language for emergency physician employment contracts addressing termination for any emergency physician subjected to adverse action related to involvement in quality/performance improvement, patient safety, or other medical staff activities, and specifying due process for physicians subjected to such adverse action.

Resolution 29(11) Due Process for Emergency Physicians adopted. Called for ACEP to review and update the policy statement "Emergency Physician Contractual Relationships" regarding due process and distribute the updated policy to the American Hospital Association, the American College of Health Care Executives and other entities.

Resolution 17(03) Certificate of Compliance referred. The resolution called for ACEP to require emergency physician staffing groups to comply with terms of a certificate as a prerequisite for being an exhibitor or sponsor for any ACEP activity. The certificate included multiple provisions that groups must attest to including "With the provisional period not to exceed one year, our physician group provides our emergency physicians access to predefined due process."

Amended Resolution 14(02) Emergency Physician Rights and Self-Disclosure defeated. The resolution called for ACEP to require exhibitors, advertisers, grant providers and sponsors who employ emergency physicians as medical care providers to disclose to their program audience their level of compliance with ACEP policies addressing due

process and other emergency physician rights outlined in the policy statements "Emergency Physician Rights and Responsibilities," Emergency Physician Contractual Relationships," "Agreements Restricting the Practice of Emergency Medicine," and "Compensation Arrangements for Emergency Physicians." It would require that those claiming to be in substantial compliance with the policies must be able to support the claims by producing documentation for review, and those whose self-disclosure is determined through due process to be false would be prohibited from sponsoring, exhibiting or advertising with ACEP.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted. The resolution called for ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and report back to the Council, and to continue to promote the adoption of the principles outlined in the "Emergency Physician Rights and Responsibilities" policy statement by the various emergency medicine contract management groups, the American Hospital Association and other pertinent organizations.

Substitute Resolution 10(01) Commercial Sponsorships adopted. The substitute resolution called for ACEP to continue initiatives to develop and implement policies on self-disclosure by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings regarding their compliance with ACEP physicians' rights policies.

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.

Resolution 59(95) Due Process for Emergency Physicians referred to the Board of Directors. The resolution called for ACEP to support, and incorporate into educational and advocacy efforts, promotion of the concepts of due process in all employment arrangements for emergency physicians, that any emergency physician being terminated has the right to receive the reasons for such termination and to formally respond to those reasons prior to the effective date of the termination.

Amended Resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clause and 54(94) Due Process. The amended resolution directed the College to study the issue of peer review and due process exclusion clauses in emergency physician contracts.

Resolution 52(94) Due Process Exclusion Clauses not adopted. This resolution called for ACEP to lobby to ban peer review and due process exclusion clauses from emergency physician contracts. Amended Resolution 54(94) was adopted in lieu of 52(94).

Resolution 38(90) Due Process Rights of Hospital Based Physicians not adopted. This resolution called for ACEP to work with The Joint Commission to develop standards to protect due process rights of hospital-based physicians.

Prior Board Action

June 2021, approved developing and distributing a questionnaire to all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products in which they are asked to voluntarily provide information about their organizations.

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised and approved October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the policy statement "Safer Working Conditions for Emergency Department Staff."

Amended Resolution 41(20) Personal Protection Equipment adopted.

July 2019, reviewed the updated information paper "Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships;" revised June 1997, originally reviewed July 1996.

June 2019, approved the revised policy statement "Supporting Political Advocacy in the Emergency Department;" originally approved October 2013.

September 2018, approved the policy statement "Due Process for Physician Medical Directors of Emergency Medical Services."

July 2018, reviewed the Policy Resource & Education Paper (PREP) " Emergency Physician Contractual Relationships" as an adjunct to the policy statement " Emergency Physician Contractual Relationships."

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

Resolution 47(13) Supporting Political Advocacy in the ED adopted.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted.

Resolution 29(11) Due Process for Emergency Physicians adopted.

September 2004, approved a report to the Council with a letter from the Federal Trade Commission regarding issues raised in Resolution 17(03) Certificate of Compliance and Resolution 18(03) Intention to Bid for Group Contract and agreed to take no further action on the resolutions.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted.

Substitute Resolution 10(01) Commercial Sponsorships adopted.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted.

Amended Resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clause and 54(94) Due Process.

Background Information Prepared by: Craig Price, CAE
Senior Director, Practice Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 32(21)

SUBMITTED BY: Chris Barsotti, MD, FACEP
Sarah Hoper, MD, JD, FACEP
James C. Mitchiner, MD, MPH, FACEP
Alexandra Nicole Thran, MD, FACEP
Vermont Chapter
American Association of Women Emergency Physicians Section
Diversity Inclusion & Health Equity Section

SUBJECT: Firearm Ban in EDs Excluding Active Duty Law Enforcement

PURPOSE: 1) Directs ACEP to promote and endorse that EDs become "Firearm Free" Zones, with the exception of active-duty law enforcement officers, hospital security, military policy, and federal agents; and 2) endorse and promote screening for firearms in the emergency department as well as promote public education and academic research to decrease workplace violence by decreasing firearm morbidity and mortality.

FISCAL IMPACT: Budgeted staff resources to promote and endorse the concept of EDs becoming firearm-free zones. Promoting public education to decrease workplace violence could involve an unbudgeted and undetermined cost, depending on the scope of the promotion/public relations activity involved.

WHEREAS, Workplace violence against healthcare providers occurs every day and is underreported[1]; and

WHEREAS, The healthcare sector violence is statistically most subject to workplace violence, behind law enforcement; and

WHEREAS, There are no statistically proven methods to reduce workplace violence in the healthcare setting[2]; and

WHEREAS, There are currently no specific OSHA standards for workplace violence[3]; and

WHEREAS, OSHA recommends mitigating workplace violence prevention by taking "appropriate precautions," and establishing a "zero-tolerance towards workplace violence"[4]; and

WHEREAS, ACEP has supported United States House Resolution, 1309 (H.R. 1309): The Workplace Violence Prevention for Health Care and Social Service Workers Act , a bipartisan bill which was passed by the United States House of Representatives; and

WHEREAS, H.R. 1309 was referred by the United States Senate to the Committee on Health, Education, Labor, and Pensions, and did not come up for a vote in the Senate[5]; and

WHEREAS, H.R. 1309 was re-introduced as H.R. 1195 Workplace Violence Prevention for Health Care and Social Service Workers Act[6] and has not come up for a vote in the Senate; and

WHEREAS, ACEP submitted its information paper on workplace violence, "Emergency Department Violence: An Overview and Compilation of Resources"; and

WHEREAS, ACEP and the Emergency Nurses Association (ENA) have launched "No Silence on ED Violence," a new campaign to stop these attacks and protect emergency department professionals and patients;

therefore be it

RESOLVED, That ACEP promote and endorse that Emergency Departments become "Firearm Free" Zones, with the exception of active duty law enforcement officers, hospital security, military police, and federal agents; and be it further

RESOLVED, That ACEP endorse and promote screening for firearms in the emergency department; and be it further

RESOLVED, That ACEP promote public education and academic research to decrease workplace violence by decreasing firearm morbidity and mortality.

References
[1] Phillips, J. P. (2016). Workplace Violence against Health Care Workers in the United States. *New England Journal of Medicine*, *374*(17), 1661–1669. https://doi.org/10.1056/nejmra1501998
[2] Phillips, J. P. (2016). Workplace Violence against Health Care Workers in the United States. *New England Journal of Medicine*, *374*(17), 1661–1669. https://doi.org/10.1056/nejmra1501998
[3] Department of Labor logo UNITED STATESDEPARTMENT OF LABOR. Workplace Violence - Enforcement | Occupational Safety and Health Administration. (n.d.). https://www.osha.gov/workplace-violence/enforcement.
[4] Department of Labor logo UNITED STATESDEPARTMENT OF LABOR. Workplace Violence - Enforcement | Occupational Safety and Health Administration. (n.d.). https://www.osha.gov/workplace-violence/enforcement.
[5] Courtney, J. (2019, November 21). Actions - H.R.1309 - 116th Congress (2019-2020): Workplace Violence Prevention for Health Care and Social Service Workers Act. Congress.gov. https://www.congress.gov/bill/116th-congress/house-bill/1309/all-actions?overview=closed#tabs.
[6] Courtney, J. (2021, April 19). Actions - H.R.1195 - 117th Congress (2021-2022): Workplace Violence Prevention for Health Care and Social Service Workers Act. Congress.gov. https://www.congress.gov/bill/117th-congress/house-bill/1195/all-actions?overview=closed#tabs.

Background

This resolution directs the College to promote and endorse that emergency departments become "Firearm Free" Zones, with the exception of active-duty law enforcement officers, hospital security, military policy and federal agents, and that ACEP endorse and promote screening for firearms in the emergency department as well as promote public education and academic research to decrease workplace violence by decreasing firearm morbidity and mortality.

The federal government and numerous states have enacted laws creating gun-free zones that prohibit the possession of firearms at specific locations. The federal Gun-Free School Zone Act places prohibitions on possessing a firearm within 1,000 feet of a school, and many states have passed laws to further strengthen gun possession restrictions near schools. According to a 2020 report by the RAND Corporation's "Gun Policy in America" project, 39 states have also banned firearms in state court buildings, while a few states also banned guns, under certain circumstances, in bars and restaurants. A few states have banned firearms in hospitals. Mandated gun-free zones are often accompanied by implementation of screening measures such as metal detectors and bag checks.

Proponents of gun-free zones argue that the prohibition reduces accidental and intentional gun violence in these areas by reducing the number of firearms present, while opponents contend that the zones could result in making those areas more vulnerable targets for violent criminals.

Research on the effectiveness of gun-free zones in reducing gun violence is mixed. The Crime Prevention Research Center, an organization that says it is "a research and education organization dedicated to conducting academic quality research on the relationship between laws regulating the ownership or use of guns, crime, and public safety" claims that 94% of mass public shootings from 1950 to June 2019 occurred in gun-free zones. But other research has reached a very different conclusion, including an analysis by the organization called "Everytown for Gun Safety" which claims that only 14 percent of mass shootings took place in gun-free zones. The RAND Gun Policy in America research indicates it has "found no qualifying studies that gun-free zones" increased or decreased "any of the eight outcomes we investigated." The eight outcomes included mass shootings, violent crime, and unintentional injuries and death.

ACEP has taken an active role in trying to address the problem of violence in the emergency department. A 2018 ACEP survey of more than 3,500 emergency physicians showed that nearly half had been physically assaulted at work, with the majority of those assaults occurring within the previous year. 49% of respondents also said that hospitals can do more by adding security guards, cameras, metal detectors and increasing visitor screening.

That year also saw the introduction of federal legislation, the Workplace Violence Prevention for Health Care and Social Service Workers. ACEP worked with lawmakers to ensure the legislation gives appropriate consideration to emergency department needs. The legislation, which would require OSHA to require health care employers to implement violence prevention programs, was passed in the House in 2019, but failed to come up for a vote in the Senate. It was reintroduced in February of this year. ACEP joined with the Emergency Nurses Association (ENA) to issue a joint press release in support of the reintroduced legislation.

This year, ACEP provided input on The Joint Commission's "Workplace Violence Prevention" project and, as a result of that work, TJC announced in June new requirements for accredited hospitals to ensure safer work environments. The new and revised requirements that are scheduled to go into effect January 1, 2022 include directives for hospitals to have a workplace violence prevention program; conduct annual worksite analysis related to its workplace violence prevention program; establish a process to continually monitor, report, and investigate safety incidents including those related to workplace violence; and to provide training, education and resources to leadership, staff, and licensed practitioners to address prevention, recognition, response and reporting of workplace violence.

In 2019, ACEP partnered with ENA to launch the "No Silence on ED Violence" campaign to draw more public attention to the problem of violence in the emergency department, to drive policymaker action to address the issue, and to provide resources and support to emergency physicians and emergency nurses. The campaign website, www.stopEDviolence.org, includes fact sheets and advocacy materials highlighting the severity of the issue, as well as resources for members seeking ways to reduce the incidence of violence in the ED.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence in the Emergency Department" calls workplace violence "a preventable and significant public health problem" and calls for increased safety measures in all emergency departments. It outlines nine measure hospitals should take to ensure the safety and security of the ED environment. Violence in the ED is one of the 13 topic areas that link from the ACEP website, and the link leads to a page with a wealth of resources entitled "Violence in the Emergency Department: Resources for a Safer Workplace." The site includes links to information papers on the "Risk Assessment and Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED and "Emergency Department Violence: An Overview and Compilation of Resources."

ACEP policy also addresses the issue of gun violence. The policy statement "Firearm Safety and Injury Prevention" calls for "funding, research, and protocols" to address the public health issue of injury and death from firearms. The policy lists six legislative and regulatory actions that ACEP supports, including funding for firearm injury prevention research, protecting physicians' ability to discuss firearm safety with patients, universal background checks, prohibiting high-risk and prohibited individuals from obtaining firearms, restricting the sale and ownership of weapons and munitions designed for military or law enforcement use, and prohibiting 3-D printing of firearms and their components. The policy statement "Violence-Free Society" also notes that "ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives."

In 2018, the Public Health and Injury Prevention Committee developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" that provides information on prevention of firearm injuries, including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs, and listings of community-based firearm violence prevention programs by state.

In March 2018, ACEP provided a letter of support for the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM.) The letter outlined ACEPs support of AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury, and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of

firearm-related violence. In January 2019, the Board of Directors approved a $20,000 donation to AFFIRM.

ACEP's legislative and regulatory priorities include working with members of Congress to promote efforts that may prevent firearm-related injuries/deaths and to support public/private initiatives to fund firearm research. The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on several research grants. ACEP members are represented as leaders in AFFRIM, have attended strategic planning meetings, and an ACEP staff member is also a member of their Research Council.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.
- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted staff resources to promote and endorse the concept of EDs becoming firearm-free zones. Promoting public education to decrease workplace violence could involve an unbudgeted and undetermined cost, depending on the scope of the promotion/public relations activity involved.

Prior Council Action

The Council has adopted numerous resolutions related to firearms and firearm safety, but none that are specific to EDs becoming "firearm-free zones."

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths and to support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

Resolution 55(17) Workplace Violence adopted. Directed ACEP to develop actionable guidelines and measures to ensure safety in the emergency department, work with local, state and federal bodies to provide appropriate protections and enforcement to address workplace violence and create model state legislation/regulation.

Resolution 37(13) Establishing Hospital-Based Violence Intervention Program adopted. Directed ACEP to promote awareness of hospital-based violence intervention programs and coordinate with relevant shareholders to provide resources to those wishing to establish such programs.

Prior Board Action

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted.

October 2019, approved the revised policy statement "Firearm Safety and Injury Prevention;" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013; revised and approved January 2007; reaffirmed October 2000; originally approved January 1996.

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

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

October 2017, Resolution 55(17) Workplace Violence adopted.

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;" revised and approved June 2011; revised and approved with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

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."

Resolution 37(13) Establishing Hospital-Based Violence Intervention Program adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Practice Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 33(21)

SUBMITTED BY: California Chapter
DC Chapter
Maryland Chapter
Massachusetts College of Emergency Physicians
New York Chapter
North Carolina College of Emergency Physicians
Vermont Chapter

SUBJECT: Formation of a National Bureau for Firearm Injury Prevention

PURPOSE: Support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The physician motto is to do no harm; and

WHEREAS, Physicians are often placed on the front lines of health crises; and

WHEREAS, Doctors can be encouraged to address firearm injury and death with the same tools used successfully to confront other public health concerns for decades[5,6]; and

WHEREAS, The National Highway Traffic Safety Administration (NHTSA) addressed the problem of motor vehicle death by systematically using a public health approach, promoting and implementing safety technology, supporting research into causes and contributing factors and fostering public awareness of seat belt use[3]; and

WHEREAS, NHTSA coordinated its activities to complement each other, acting synergistically to reduce injuries resulting in a motor vehicle death rate which has fallen by two-thirds[1]; and

WHEREAS, The life-saving potential of seatbelts was realized due to the synergistic use of both legislation that added laws and financial penalties for disobedience, as well as the use of media to increase public awareness of the importance of seat belt wearing; and

WHEREAS, In spite of persistent efforts to reduce firearm injury and death over the past twenty years,[9] deaths from firearm injuries have increased by over 20%[2]; and

WHEREAS, It is necessary to define firearm injury and death as public health crises and use public health methods for reduction that have been proven effective[7]; and

WHEREAS, Health professionals have actively participated in efforts to reduce firearm injury by speaking out against "gag laws,"[6,4] restrictions on firearm injury research funding[5,9]; and

WHEREAS, There have been comprehensive, multidimensional strategies created, that provide an extensive list of proposals designed to reduce firearm injury and death[6,7]; and

WHEREAS, A "call to action" from eight health organizations and the American Bar Association advocating for a series of measures aimed at reducing the health and public health consequences of firearms[4]; and

WHEREAS, Significant reductions in firearm injury can be achieved with the coordinated use of the modalities as was used to increase seatbelt use; and

WHEREAS, The synergistic coordination of multiple modalities is best accomplished through a single entity such as the NHTSA[7]; and

WHEREAS, To be maximally effective at decreasing firearm injury and deaths in the U.S., a National Bureau for Firearm Injury Prevention must be created; and

WHEREAS, A National Bureau for Firearm Injury Prevention would be run by experts in public health, medicine, engineering, communications and law enforcement working together in a transparent and nonpartisan organization charged with: 1) Setting the nation's firearm injury research agenda and developing, testing and implementing firearm safety technologies; 2) Overseeing campaigns to encourage behaviors likely to reduce firearm injuries; 3) Setting out legislative priorities for saving lives due to firearm injury; 4) Directing priorities for enforcing firearm laws in concert with the Bureau of Alcohol, Tobacco, Firearms and Explosives and state law enforcement agencies; and

WHEREAS, The creation of a National Bureau for Firearm Injury Prevention has been adopted as a cornerstone of Doctors For America's policy on firearm injury prevention and a similar position is being considered by multiple professional health groups and grassroots organizations dedicated to firearm injury prevention; therefore be it

RESOLVED, That ACEP support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

References

1. Centers for Disease Control and Prevention (CDC). Achievements in Public Health, 1900-1999 Motor-Vehicle Safety: A 20th Century Public Health Achievement. MMWR May 14, 1999 / 48(18);369-374.
2. CDC National Center for Health Statistics. https://www.cdc.gov/nchs/fastats/injury.htm
3. National Highway Traffic Safety Administration (NHTSA). Seat Belts. https://www.nhtsa.gov/risky-driving/seat-belts
4. Weinberger SE, Hoyt DB, Lawrence HC 3rd, Levin S, Henley DE, Alden ER, Wilkerson D, Benjamin GC, Hubbard WC. Ann Intern Med. Firearm-related injury and death in the United States: a call to action from 8 health professional organizations and the American Bar Association. 2015 Apr 7;16
5. Bauchner H, Rivara FP, Bonow RO et al. Death by Gun Violence—A Public Health Crisis . JAMA Psychiatry. 2017;74(12):1195-1196. doi:10.1001/jamapsychiatry.2017.3616
6. McLean RM, Harris P, Cullen, J, Maier RV et al. Firearm-Related Injury and Death in the United States: A Call to Action From the Nation's Leading Physician and Public Health Professional Organizations Ann Intern Med. 2019; 171:573-579
7. Hemenway, David. "A public health approach to firearms policy" in Mechanic, David; Rogut, Lynn B; Colby, David C; Knickman, James R. eds. *Policy Challenges in Modern Health Care*. New Brunswick, NJ: Rutgers University Press, 2005. pp. 85-98.
8. Hemenway, David; Miller, Matthew. Public health approach to the prevention of gun violence. *New England Journal of Medicine.* 2013; 368:2033-35.
9. Bailey C. More Americans killed by guns since 1968 than in all U.S. wars-combined. NBC News. https://www.nbcnews.com/storyline/las-vegas-shooting/more-americans-killed-guns-1968-all-u-s-wars-combined-n807156. October 4, 2017. Accessed October 5, 2017.

Background

This resolution calls for the College to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

As the resolution notes, this new body would be run by experts in public health, medicine, engineering,

communications, and law enforcement working together in a transparent and nonpartisan organization charged with:

1) Setting the nation's firearm injury research agenda and developing, testing, and implementing firearm safety technologies;
2) Overseeing campaigns to encourage behaviors likely to reduce firearm injuries;
3) Setting out legislative priorities for saving lives due to firearm injury; and,
4) Directing priorities for enforcing firearm laws in concert with the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and state law enforcement agencies.

The resolution further notes that the creation of a National Bureau of Firearm Injury Prevention is a policy proposal endorsed by Doctors for America (DFA), a coalition of 18,000 physicians and medical students across the country. In addition to firearms violence prevention, DFA's other policy priorities include drug affordability, addressing substance use disorder (SUD), health for all, immigrant health justice, and women's health. According to DFA's website, American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) is listed as a supporting organization for the bureau concept.

ACEP's legislative and regulatory priorities over the years have included working with members of Congress to promote efforts that may prevent firearm-related injuries/deaths and to support public/private initiatives to fund firearm research. ACEP has worked with the AMA and other stakeholders to address firearm injury prevention and research on this issue. To this end, ACEP worked successfully with other physician specialties, health care providers, and other stakeholders to restore federal funding for firearm morbidity and mortality prevention research, with $25 million split between the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) in December 2019, after a more than 20-year hiatus of federal appropriations for this purpose. ACEP continues to advocate for increased funding for the NIH and CDC to continue and expand this research and joined a March 2021 letter with more than 200 signatories urging Congress to provide $50 million for firearms injury prevention research. ACEP has also met with the National Collaborative on Gun Violence Research (NCGVR), a research collaborative with the mission to fund and disseminate nonpartisan scientific research to provide necessary data to establish fair and effective policies, in a discussion to share ACEP's policy priorities regarding firearms injury prevention.

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

In June 2019, the Board of Directors approved a survey of the ACEP Council on firearms research, safety, and policy. The preliminary report was presented to the Board in October 2019 and at the 2019 Council meeting.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about issuing public statements following a mass shooting event advocating for change consistent with the College's policies, 62.5% were in support of making public statements while 28.1% did not support such action.

ACEP' s current policy statement "Firearm Safety and Injury Prevention" was developed by a task force that was appointed in 2013. ACEP policies are reviewed on a 5- to 7-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind, or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The resolution was assigned to the PHIPC. The committee drafted a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board discussed the revised policy statement in June 2019 and referred it back to the committee for further work. It was revised and approved in October 2019.

The Public Health & Injury Prevention Committee developed an information paper, "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

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

The Research Committee was assigned an objective in 2014-15 to "Convene a Technical Advisory Group (TAG) of firearm researchers and other stakeholders to develop a research agenda and to consider the use of available research networks (including ACEP's EM-PRN) to perform firearm research." TAG members determined the research agenda would be based on questions relating to suicides, unintentional injuries, mass violence, and peer violence. An article titled "A Consensus-Driven Agenda for Emergency Medicine Firearm Injury Prevention Research" was published in *Annals of Emergency Medicine* in February 2017 outlining this work.

During the 2013-14 committee year, the Research Committee was assigned an objective to make a recommendation to the Board regarding Referred Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs. In June 2014, the Board approved the following recommendations: 1) ACEP and EMF staff convene a consensus conference of firearm researchers and other stakeholders to develop a research agenda and to consider the use of available research networks (including the proposed EM-PRN) to perform firearm research; 2) ACEP and EMF staff to identify grant opportunities and promote them to emergency medicine researchers; 3) EMF to consider seeking funding for a research grant specifically supporting multi-center firearm research; and 4) ACEP to advance the development of the EM-PRN to create a resource for representative ED-based research on this topic and others.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

The Council has adopted numerous resolutions pertaining to firearms and firearm safety, but none that are specific to supporting the creation of a National Bureau for Firearm Injury Prevention.

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted. Directed ACEP to work with stakeholders to raise awareness and advocate for research funding and legislation to address both firearm violence and intimate partner violence.

Resolution 30(19) High Threat Emergency Casualty Care adopted. Directed ACEP to set as a legislative priority the drafting of and lobbying for legislative language that will enable the development and funding of both National Transportation Safety Board-style "Go Teams" and a database into which gathered information would be entered for research purposes; and, support the development processes of both a National Transportation Safety Board-style "Go Teams" and a database of gathered information for research purposes.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 ACEP Position Paper; and that ACEP support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prior Board Action

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted.

Resolution 30(19) High Threat Emergency Casualty Care adopted.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted.

October 2019, approved the revised policy statement "Firearm Safety and Injury Prevention;" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

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

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

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

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

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

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

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

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

Resolution 27(13) Studying Firearm Injuries adopted.

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

the resolution.

Amended Resolution 31(12) Firearm Violence Prevention adopted.

Amended Resolution 41(04) Assault Weapon Ban adopted.

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

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

Amended Resolution 69(95) Firearm Legislation adopted.

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

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

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

Substitute Resolution 45(94) Firearm Possession adopted.

Substitute Resolution 44(94) Firearm Legislation adopted.

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

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

Amended Resolution 17(93) Firearm Injury Prevention adopted.

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

Amended Resolution 11(93) Violence Free Society adopted.

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

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

Substitute Resolution 16(84) Ban on Handguns adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 34(21)

SUBMITTED BY: Ohio Chapter ACEP
Pennsylvania College of Emergency Physicians

SUBJECT: Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas

PURPOSE: Engage appropriate stakeholders, including at the federal and state levels, to find innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The ACEP Rural Emergency Care Task Force (2020) outlined challenges, including reimbursement, for the staffing of rural emergency departments (EDs) by board eligible/certified emergency physicians; and

WHEREAS, More rural EDs are closing than opening; and

WHEREAS, Innovation models focused on global budgeting for facility reimbursements to maintain quality and financial viability of rural hospitals currently exist, including the Center for Medicare and Medicaid Services' (CMS's) Pennsylvania Rural Health Model and global budgeting in Maryland and other states; and

WHEREAS, Current innovation models for global budgeting are focused on facility reimbursements and not on professional physician fee reimbursement, with emergency physician reimbursement still largely dependent on patient volumes or subsidies; and

WHEREAS, The ACEP EM Physician Workforce of the Future Report (2021) estimates a looming surplus of emergency physicians, thus creating an opportunity to fill the demand for services of emergency physicians in rural and underserved areas where there is currently a dearth of emergency physicians; therefore be it

RESOLVED, That ACEP engage appropriate stakeholders, including at the federal and state levels, to find innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians.

Resources

1. https://www.healthaffairs.org/do/10.1377/hblog20210610.559255/full/
2. https://innovation.cms.gov/innovation-models/pa-rural-health-model
3. https://www.acep.org/who-we-are/ACEPLately/acep-lately-blog-articles/may-2021/
4. https://www.acep.org/contentassets/c3cef041efd54af48b71946c0cb658f0/final---board-report---2020-rural-emergency-care-task-force-oct-2020---provider-002.mcw-final-edits-002.pdf
5. https://www.acep.org/life-as-a-physician/workforce/
6. Ann Emerg Med. 2020;75(3):370-381
7. Ann Emerg Med. 2021 Apr 27;S0196-0644(21)00333-4

Background

The resolution calls for ACEP to engage appropriate stakeholders, including at the federal and state levels, to find

innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians.

According to a 2020 report by the U.S. Government Accountability Office (GAO), more than 100 rural hospitals have closed since 2013. The report found that among the rural hospitals that closed, they appeared financially distressed in the years prior and had operated under negative total facility margins. The report also found that rural hospital margins have declined over the last several years, and that the percentage of hospitals considered mid-risk or high-risk of financial distress have increased over the past five years. Additionally, there are signs that the impact of the COVID-19 pandemic has only exacerbated these challenges and that more rural hospital closures are on the horizon. As rural facilities continue to face significant uncertainty under traditional fee-for-service reimbursement models, new proposals have been put forward to maintain access to care in rural and underserved communities, such as a "Rural Emergency Hospital" designation or global budgeting models.

Broadly, a global budgeting model guarantees a fixed annual revenue (set in advance) based on an estimate of all inpatient and outpatient items and services. This model is intended to provide a level of predictability regardless of actual numbers of visits, as well as to help limit cost growth and incentivize efficient use of resources. As the resolution notes, at least two states have implemented global budgeting models for rural hospitals.

The Maryland All-Payer Model was a unique all-payer rate-setting system made possible by the state's longstanding Medicare waiver exempting it from both the Inpatient Prospective Payment System (IPPS) and the Outpatient Prospective Payment System (OPPS), affording the state with the ability to set its own rates for these services. All third-party payers paid the same rate as well. Maryland was required to limit all-payer per capita hospital cost growth (including both inpatient and outpatient care) to 3.58 percent, and additionally, the state agreed to limit Medicare growth to a rate lower than the national annual per capita growth rate for 2015-2018. While the model was successful in achieving significant savings and reaching its quality measure targets, the state's ability to sustain the necessary rate of Medicare savings and quality improvements was limited by the model's focus on the hospital setting. As such, CMS worked with Maryland to implement and test a new model, the Maryland Total Cost of Care Model (TCOC), that instead sets a per capita limit on Medicare total cost of care between 2019 and 2023, ultimately concluding in 2026. This model is targeted to achieve more than $1 billion in Medicare savings by the end of the model. Under the terms of the model, the last three model years will be used to determine whether to expand the model test, develop a new model test, or return to the national prospective payment systems.

In Pennsylvania, 18 rural hospitals currently participate in the Pennsylvania Rural Health Model, another program under the Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation (CMMI). Critical access hospitals (CAHs) and acute care hospitals in rural areas are eligible to participate in the model. Under this model, both CMS (Medicare and Medicaid) and participating commercial payers pay participating rural hospitals under a global budget that is prospectively set for each participating rural hospital, determined primarily by their historical net revenue for both inpatient and outpatient services from all participating payers. Participating payers then pay the hospitals for those services based on the payer's respective portion of the global budget. The hospitals are also required to redesign care delivery, improve quality, and better meet the needs of their communities. The state and CMS must approve a participating hospital's Rural Hospital Transformation Plan to help ensure that these facilities make meaningful and targeted improvements in quality for their communities.

Another effort to increase access to emergency services in rural areas is the implementation of a new provider designation under Medicare called "Rural Emergency Hospital" (REH). This provision was included in the Consolidated Appropriations Act, 2021 (Public Law 116-260) passed by Congress in late December 2020 and would allow critical access hospitals and small rural hospitals (with fewer than 50 beds) to convert to an REH beginning January 1, 2023. Once established, an REH will not provide any inpatient services, but must be able to provide 24/7 coverage for emergency services. They must also meet other requirements, including, but not limited to, having transfer agreements in place with a level I or II trauma center; adhering to quality measurement reporting requirements to be set by CMS; and following new emergency department conditions of participation (COPs). REHs will receive a five percent reimbursement bump for facility payments that hospitals traditionally receive for outpatient services under the Medicare OPPS and will receive an additional facility payment on top of that. However, while this new provider designation provides higher facility payments for REHs, emergency physicians will not receive higher

payments under the Medicare Physician Fee Schedule (PFS) for providing services in an REH. CMS is currently in the process of writing the regulations and processing comments on the new designation that will be included in the CY20223 OPPS rule.

As the resolution notes, global budgeting models have focused on the hospital/facility side of reimbursement, not on professional physician fee reimbursement that is still largely dependent on patient volumes or subsidies. This is also the case with hospitals under the new REH designation. The resolution suggests that the predictability afforded by a global budgeting model specifically for professional physician fee reimbursement could address this gap, decoupling emergency care from more traditional volume-dependent payment, helping incentivize and maintaining financial viability of coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians. Some in favor of this approach propose that in such a system, emergency physicians would be paid at a market-determined fixed rate, whether employed directly by a hospital under a global physician budget or employed by a practice management organization that contracts directly with the facility. Proponents of this model suggest that this would help eliminate the challenges of balancing high vs. low reimbursed visits relative to the resources expended, would help guarantee 24/7/365 coverage of rural EDs, and would also help provide a financial cushion to provide for surge capacity.

Some of the key considerations noted by proponents and observers alike are the need for a well-defined catchment area or the ability to identify an appropriate reference population needed to determine a global budget, as well as if the service area can provide a sufficient number of patients to sustain the model. Some have also noted that given the growth of new value-based payment pathways, rural hospitals may be able to adopt other payment mechanisms (e.g., managed care programs, accountable care organizations, etc.) that are easier to implement while achieving the same ultimate results in care delivery transformation. Another potential challenge may be the willingness for payers to participate in an all-payer global budgeting model and other issues posed by longstanding conflict between hospitals/systems and payers.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to the Board of Directors. The resolution called for ACEP to work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States referred to the Board of Directors. The resolution called in part for ACEP to advocate for the creation of a Critical Access Emergency Center Designation where critical access hospitals no longer exist due to natural disasters or cannot be feasibly maintained.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. The resolution called for ACEP to analyze the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where emergency departments in critical access and rural hospitals have closed.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for inclusion of emergency medicine in the National Health Service Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organizations to encourage the development and promotion of rural clerkships/ rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

January 2020, assigned Referred Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine to the Rural Emergency Task Force to review and provide recommendations to the Board to address rural emergency medicine issues.

August 2018, ACEP supported the Emergency Care Improvement Act that allows for independent freestanding EDs that meet criteria to bill Medicare for a certain amount of facility-side reimbursement, depending on geography and acuity. The legislation contained specific language to protect professional-side reimbursement by Medicare at full physician fee schedule amounts at all acuity levels and to bring the facilities under federal EMTALA requirements.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas;" reaffirmed April 2012 and October 2006; originally approved June 2000.

January 2018, assigned Referred Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States to the Federal Government Affairs Committee for action.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved policy statement "Definition of Rural Emergency Medicine."

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

October 2005, adopted Amended Resolution 37(05) Rural Emergency Medicine Workforce.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit.

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Substitute Resolution 20(01) Medical Education Debt adopted.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 35(21)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Preserving Rural Emergency Care in Rural Critical Access Hospitals and Rural Emergency Hospitals

PURPOSE: 1) Support the rural critical access hospital program, including conversion of certain rural hospitals into rural emergency hospitals; 2) support rural health services research to better understand the optimal funding mechanism for rural hospitals; 3) support cost-based reimbursement for rural critical access hospitals and rural emergency hospitals at a minimum of 101% of patient care; 4) support changes in CMS regulation to allow rural off-campus EDs and rural emergency hospitals to collect the facility fee as well as the professional fee; and 5) advocate for insurance plans to aggregate all institutional and professional billing related to an episode of care and send one unified bill to the patient.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Rural emergency departments provide access to essential care for millions of Americans yet are under constant threat of closure due to financial constraints. The majority of unprofitable hospitals in the United States are rural hospitals, with 180 rural hospitals closing since 2005[1-3]; and

WHEREAS, Major challenges facing rural hospitals include uncompensated care and inadequate Medicare and Medicaid reimbursement to cover the costs of care for an underserved and underinsured population[2,4]; and

WHEREAS, Rural critical access hospital (CAH) closure leaves rural communities without access to rural emergency care, transformation of rural CAHs to rural emergency hospitals (REHs) – facilities that provide outpatient services and 24/7 emergency services – may provide a way to preserve access to emergency care and outpatient services[4-5]; and

WHEREAS, The optimal funding model for rural CAHs and REHs remains uncertain and is an active area of health services research[2-4]; and

WHEREAS, Tremendous growth in high deductible health care policies has had a disproportionate impact on rural hospitals. Typically, all the initial care at the rural hospital is subject to the patient's high deductible, and is therefore unpaid or underpaid, while the subsequent care at the referral hospital is typically in excess of the deductible and therefore paid in full by the insurer[6]; therefore be it

RESOLVED, That ACEP support the rural critical access hospital program including the conversion of struggling rural critical access hospitals to rural emergency hospitals and state and federal governments should increase rural hospital access to low-cost capital to support the conversion of these facilities and preserve access to emergency care[1-5]; and be it further

RESOLVED, That ACEP support rural health services research, including financial analyses of rural hospitals to better define the optimal funding model for rural critical access hospitals and rural emergency hospitals[1-4]; and be it further

RESOLVED, That ACEP support cost-based reimbursement for rural critical access hospitals and rural emergency hospitals at a minimum of 101% of patient care, including emergency care, to enable rural critical access hospitals to provide a safety net for rural patients and cost-based reimbursement should be increased beyond this

101% minimum according to the proportion of Medicare, Medicaid, and uninsured patients seen in the emergency department[1-4]; and be it further

RESOLVED, That ACEP support changes in Center for Medicare and Medicaid Services regulation that would allow rural off-campus emergency departments and rural emergency hospitals to collect the facility fee as well as the professional fee, as this essential for rural emergency hospital financial viability[4]; and be it further

RESOLVED, That ACEP advocate for insurance plans to aggregate all institutional and professional billing related to an episode of care and send one unified bill to the patient for their portion to shift the burden of collecting from the patient with a high-deductible insurance plan to the insurance company and allow for more equitable payments to both the rural and referral hospitals for initial stabilization in a rural area and definitive care at a tertiary center.[6]

References

1. Rural Hospital Closures Database. Cecil Sheps Center for Health Services Research The University of North Carolina Chapel Hill.https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
2. Thomas et al. Health System Challenges for Critical Access Hospitals: Findings from a National Survey of CAH Executives. NC Rural Health Research Program Findings Brief. February 2021. https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2021/02/Health-System-Challenges-for-Critical-Access-Hospitals-Findings-from-a-National-Survey.pdf.
3. Thomas et al. Alternative to Rural Hospital Closure: Findings from a National Survey of CAH Executives. NC Rural Health Research Program Findings Brief. February 2021. https://www.shepscenter.unc.edu/product/alternatives-to-hospital-closure-findings-from-a-national-survey-of-cah-executives/
4. Dunc Williams J, Song PH, Pink GH. Estimated Costs of Rural Free Standing Emergency Departments. https://www.shepscenter.unc.edu/product/estimated-costs-of-rural-freestanding-emergency-departments/
5. American Hospitals Association. Detailed Summary of Health Provision in Consolidated Appropriations Act, 2021. https://www.aha.org/system/files/media/file/2020/12/detailed-summary-health-provisions-consolidated-appropriations-act-2021-bulletin-12-22-20.pdf
6. Hawryluk, Markian. “High-Deductible Plans Jeopardize Financial Health of Patients and Rural Hospitals.” Kaiser Health News, 10 Jan. 2020, khn.org/news/high-deductible-plans-jeopardize-financial-health-of-patients-and-rural-hospitals/.

Background

This resolution calls on ACEP to take a number of actions to increase access to emergency services in rural areas and support rural hospitals and emergency departments. Specifically, it requests that ACEP support the conversion of certain rural hospitals, like critical access hospitals, into rural emergency hospitals. Further, it calls on ACEP to support rural health services research to better understand the optimal funding mechanism for rural hospitals. Finally, it requests that ACEP work with on the legislative and regulatory fronts, as well as to reach out to private payors, to improve the payment and billing structures and processes for rural facilities.

In order to increase access to emergency services in rural areas, Congress included a provision in the Consolidated Appropriations Act (enacted last December) that would allow critical access hospitals and small rural hospitals (those with less to than 50 beds) to convert to rural emergency hospitals (REHs) starting on January 1, 2023. REHs, once established, will not provide any inpatient services, but must be able to provide emergency services 24 hours a day/7 days a week and have a physician, nurse practitioner, clinical nurse specialist, or physician assistant available at all times. Further, they must meet other requirements, including, but not limited to: having a transfer agreement in place with a level I or level II trauma center; adhering to quality measurement reporting requirements that will be set by the Centers for Medicare & Medicaid Services (CMS); and following new emergency department (ED) conditions of participation (COPs). With respect to payment, REHs will receive a five percent bump up to the facility payments that hospitals traditionally receive for outpatient services under the Medicare outpatient prospective payment system (OPPS). They will also receive an additional facility payment on top of that. It is important to note that although there will be higher facility payments for REHs, clinicians will not receive any higher payments under the Medicare physician fee schedule if they provide services in REHs.

To get REHs up and running by 2023, CMS must create all the requirements associated with the new facility-type through regulations. ACEP leadership held a meeting with CMS staff who are in charge of creating the new REH

Medicare designation in June 2021 to provide our initial feedback. Specifically, we requested that although REHs can legally be staffed by non-physician practitioners, we strongly believe that all care provided in REHs should be supervised by a board-certified emergency physician, even remotely via telehealth. ACEP also had a Congressional meeting on this before any regulations were released.

In the Calendar Year (CY) 2022 OPPS proposed rule, released in July 2021, CMS issued a large request for information (RFI) to help inform future policies. The RFI included questions on the following topics: 1) Type and Scope of Services Offered by REHs; 2) Health and Safety Standards, Including Licensure and Conditions of Participation; 3) Health Equity; 4) Collaboration and Care Coordination; 5) Quality Measurement; 6) Payment Methodology; and 7) Enrollment Process. In all, there are 29 questions in the RFI. As of August 2021, when this background section was written, ACEP was in the process of developing a comprehensive response.

In all, ACEP has expressed support for this new designation of REHs, and even worked with Congress on the legislative language that was ultimately included in the Consolidated Appropriations Act. As stated earlier, ACEP has been proactive in reaching out to CMS to help construct various REH requirements. Once REHs get up and running in 2023, ACEP will likely play a role in helping to educate hospitals, like critical access hospitals, about the possible benefits of converting to this new facility-type.

Related to the resolveds around billing and reimbursement, it is important to note that any structural changes to how Medicare reimburses critical access hospitals and REHs would require legislation from Congress and could not be achieved through regulatory means. As referenced above, the Consolidated Appropriations Act set the specific payment methodology for REHs. REHs will not be paid on a cost-basis in Medicare, but rather their payments are based off the OPPS payment rate plus a five percent bump up. With respect to critical access hospitals, Medicare pays for most inpatient and outpatient services provided to patients at 101% of reasonable costs. Clinicians practicing in critical access hospitals can either reassign their billing rights to the hospital or bill Medicare directly for their services under the physician fee schedule (PFS). If clinicians reassign their billing rights, Medicare reimburses physician professional services at a rate of 115% of the Medicare PFS allowable amount.

The last resolved requests that ACEP advocate for insurance plans to send a unified bill to patients that includes both the facility and professional fees for each episode of care. While ACEP has not engaged on this specific advocacy effort before, during the debates in Congress on surprise medical billing, ACEP did discuss with lawmakers that emergency care is billed in two separate components and that patients must sort through costs included in at least two different bills, each of which may have different cost-sharing obligations associated with it. We recommended that health plans be responsible for collecting cost-sharing from patients and distributing that amount directly to clinicians and facilities. When making that request, we noted the difficulty many emergency departments and physician groups had collecting the full cost-sharing amount from patients.

ACEP Strategic Plan Reference

This resolution aligns with the following objective.

,
Goal 1 – Improve the Delivery System for Acute Care

- Objective B- Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to Board. Directed ACEP to: 1) work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; 2) identify and promote existing training opportunities to help physicians and non-physicians in rural

settings maintain their clinical skills; 3) develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and 4) encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

Amended Resolution 29(18) Insurance Collection of Patient Financial Responsibility adopted. Directed ACEP to advocate for federal laws to require insurance companies to pay the reported professional fees directly to the provider, collect deductibles or co-payments from its covered beneficiary, and develop an information paper or legislative toolkit to assist members in advocating for applicable changes to state insurance laws.

Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States referred to the Board of Directors. The resolution called in part for ACEP to advocate for the creation of a Critical Access Emergency Center Designation where critical access hospitals no longer exist due to natural disasters or cannot be feasibly maintained.

Amended Resolution 17(16) Insurance Collection of Beneficiary Deductibles referred to the Board of Directors. The resolution requested ACEP to advocate for health insurance companies to provide full payment to physicians and leave collection of beneficiary deductibles to insurance companies. Additionally, submit a resolution to the AMA seeking the same policy at the national level

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. The resolution called for ACEP to analyze the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where emergency departments in critical access and rural hospitals have closed.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for inclusion of emergency medicine in the National Health Service Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organizations to encourage the development and promotion of rural clerkships/ rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

January 2020, assigned Referred Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine to the Rural Emergency Task Force to review and provide recommendations to the Board to address rural emergency medicine issues.

Amended Resolution 29(18) Insurance Collection of Patient Financial Responsibility adopted.
August 2018, ACEP supported the Emergency Care Improvement Act that allows for independent freestanding EDs that meet criteria to bill Medicare for a certain amount of facility-side reimbursement, depending on geography and acuity. The legislation contained specific language to protect professional-side reimbursement by Medicare at full physician fee schedule amounts at all acuity levels and to bring the facilities under federal EMTALA requirements.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved policy statement "Definition of Rural Emergency Medicine."

October 2017, approved taking no further action on Referred Amended Resolution 17(16) Insurance Collection of Beneficiary Deductibles given the scope of work on initiatives related to the repeal and/or replacement of the Affordable Care Act.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

October 2005, adopted Amended Resolution 37(05) Rural Emergency Medicine Workforce.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.
September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Substitute Resolution 20(01) Medical Education Debt adopted.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 36(21)

SUBMITTED BY: New York Chapter

SUBJECT: Mitigating the Unintended Consequences of the CURES Act

PURPOSE: Work with stakeholders to highlight patient safety issues affecting emergency department patients related to the CURES Act implementation and develop a policy statement advocating for release of records only after the treating physician and team have had sufficient opportunity to review results and discuss with the patient.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The 2020 CURES Act, implemented in April 2021, mandated immediate release of patient records and results to the patient via patient portals or other means; and

WHEREAS, The spirit of the CURES Act was to prevent "information blocking," e.g., to avail patients of important clinical information promptly, but failed to consider the consequences of releasing STAT results on diagnostic tests ordered in the ED, sometimes even prior to a physician having an opportunity to see the patient; and

WHEREAS, The immediate release of such records exposes lay patients to unfiltered information they are likely unable to interpret independently; and

WHEREAS, Patients awaiting to be seen by an ED physician or awaiting final disposition may access results during their visit which may inappropriately distress them, or perhaps worse, reassure them and lead them to elope or sign themselves out of the ED; and

WHEREAS, The CURES Act itself provides a Preventing Harm Exception, which stipulates that "it will not be information blocking for an actor to engage in practices that are reasonable and necessary to prevent harm to a patient or another person, provided certain conditions are met"[1]; and

WHEREAS, The CURES Act recognizes that "the public interest in protecting patients and other persons against unreasonable risks of harm can justify practices that are likely to interfere with access, exchange, or use of" electronic health information[2]; therefore be it

RESOLVED, That ACEP work with appropriate stakeholders to highlight patient safety issues that may disproportionately impact the emergency department population related to implementation of the CURES Act; and be it further

RESOLVED, That ACEP develop a policy statement advocating for release of records only after the treating physician and team have had sufficient opportunity and time to review those results and discuss them with the patient.

References

[1] https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf
[2] https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf

Background

The resolution calls for the College to work with appropriate stakeholders to highlight patient safety issues that may disproportionately impact the emergency department population related to the implementation of the CURES Act, and to develop a policy statement advocating for the release of records only after the treating physician and team have had sufficient opportunity and time to review those results and discuss them with the patient.

The "21st Century Cures Act" (P.L. 114-255) was broad legislation signed into law in 2016 that addressed a wide variety of topics including streamlining the drug and medical device approval process, mental health, and provisions concerning the interoperability and sharing of electronic health records (EHRs). Congress took action on the EHR interoperability issues after well-documented complaints about EHR products that were deliberately designed not to exchange health information and hospitals that refused to share patient data with other providers. From the perspective of the emergency department, a lack of interoperability and the presence of data blocking creates an extremely challenging environment for emergency physicians attempting to provide comprehensive care to patients and make potentially life or death decisions. ACEP supported the legislation and advocated for its passage in Congress.

In February 2019, the Office of the National Coordinator (ONC) for Health Information Technology issued a long-awaited proposed rule to implement certain provisions of the 21st Century Cures Act to promote interoperability. ACEP provided a detailed response to the rule on May 31, 2019, which among other issues highlighted concerns about the additional burden placed on providers under these provisions such as investing in and adopting new technologies to understanding the new definitions and exceptions around information blocking.

The resolution outlines concerns about the data sharing/blocking provisions of this rule that require immediate release of patient records and results via patient portals. The authors note that while the spirit of these provisions were to prevent "information blocking," they have resulted in unintended consequences that may affect patient safety as they require the immediate release of records that, prior to physician/health care team review and discussion with the patient, could inappropriately distress the patient or alternatively provide them with inappropriate reassurance that causes them to leave the ED.

The ACEP response to the 2019 ONC rule noted some aspects of these concerns, including how the complexity of the information blocking provisions and how they intersect with longstanding HIPAA regulations could affect a clinician's decision to either not share information or overshare information, as well as the burdensome documentation requirements regarding their decision-making process for qualifying information blocking exceptions or sub-exceptions. It also noted a lack of clarity regarding the "preventing harm" exceptions and the burden of proof that falls upon providers who want to use this exception.

The ambiguous and sometimes conflicting guidance released by ONC has led hospital systems to interpret the data blocking provisions differently, and further, health care systems to have some discretion on how to operationalize these requirements – so application of these rules often varies from system to system, or even by region or state. Many hospitals err on the side of caution against any potential data blocking, opting to release all patient information immediately. Others interpret the guidance differently, such as limiting sharing of ED information until after discharge and co-signed by the attending physician, releasing inpatient records after discharge and co-signed by the attending physician (with release after 5 days if not co-signed by the attending), and ambulatory care records essentially released in real-time (with disclaimers). While the Department of Health and Human Services (HHS) has not yet instituted penalties to physicians or providers for not complying with the requirements of the rule, given the wide discretion or variance in implementation of the rules, emergency physicians are rightly concerned about the fear of consequences or liability for not sharing data, especially when the actual policies are determined at system/local/state level. ACEP has asked CMS to clarify the guidance and consider that waiting to release records until after discharge *not* be considered data blocking, but to date has not received a response on this issue.

On March 25, 2021, ACEP met with ONC leadership, including the Chief Medical Officer, to discuss specific issues including the implementation of these requirements. In response to an ONC request during the meeting for specific feedback on how the requirements affect emergency physicians, ACEP conducted a poll of members (received 134

responses) on the data sharing requirements. The largest issue flagged by respondents concerned the timing of data sharing. More than two-thirds of respondents stated that lab results are shared immediately with patients once available, with many noting this has caused patient confusion, anger, and sadness for patients who received distressing results prior being able to discuss with their physician. Others noted examples where patients either misread or misinterpreted clinical notes and lab results, causing physicians to have to spend significant time and effort correcting those misconceptions and consoling or reassuring patients. Respondents also noted another unique challenge for emergency physicians in that most EPs do not have a pre-existing relationship with patients, potentially adding another layer of confusion or adverse consequences when patients receive information immediately (even before discharge from the ED). ACEP continues working with the relevant agencies to resolve these issues.

Fiscal Impact

Budgeted committee and staff resources.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Prior Council Action

Amended Resolution 21(15) Healthcare Information Exchanges adopted. Directed ACEP to create a minimum standard of information to be contained in Healthcare Information Exchanges (HIE), promote standardized requirements in development, identify recommended standards for ED summaries, and work with stakeholders to identify and promote standards that allow for notification in the ED EHR of applicable HIE data.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted. The resolution 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.

Resolution 22(07) Information Systems for Emergency Care – ACEP Policy adopted. Directed ACEP to update and establish policies regarding the need and utility of information systems for emergency care and produce a paper on the issue.

Prior Board Action

April 2021, approved the revised policy statement, "Health Information Technology for Emergency Care;" replacing rescinded policies "Emergency Care Electronic Data Collection and Exchange," "Health Information Technology Standards," and "Patient Information Systems;" revised June 2015, August 2008 with current title replacing "Internet Access;" rescinded August 2008, February 2003; originally approved October 1998 titled "Internet Access."

Amended Resolution 21(15) Healthcare Information Exchanges adopted.

October 2014, reviewed the information paper, Health Information Exchange in Emergency Medicine.

Substitute Resolution 21(14) ED Mental Health Information Exchange adopted.

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

Resolution 22(07) Information Systems for Emergency Care – ACEP Policy adopted

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 37(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Physician Pay Ratio

PURPOSE: 1) Support legislation to establish a Minimum Emergency Physician Pay Ratio (MEPPR) that all Contract Management Groups (CMGs) and employers are required to pay individual emergency physicians based on what is collected on the billings for the services provided by that individual emergency physician, before collection costs; 2) support that when a nominal compensation amount is stated to compensate the emergency physician, that amount must meet or exceed an established MEPPR; and 3) support legislation to establish a MEPPR that all CMGs and employers are required to pay individual emergency physicians a reasonable, prorated percentage of any other revenue that the CMG or employer receives as a direct or indirect result of the individual, or group of individuals, emergency physicians, providing his/her/their services with a suggested starting point: 0.80-0.85 (80-85%).

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Many are concerned that Contract Management Groups (CMGs) yield too much control and power in emergency medicine and take advantage of individual emergency physicians; and

WHEREAS, CMGs can use their size and control to inhibit a true free [market?] from existing; and

WHEREAS, Many CMGs do not clearly and fully disclose billing and collection information to the physicians who work for them as employees or independent contractors; and

WHEREAS, CMGs typical[ly?] set the pay, or have significant power over the compensation that emergency physicians receive for providing physician professional services in emergency departments, freestanding emergency centers and other facilities, for which the CMGs code, bill and collect under the name of the emergency physician but the CMG actually collects and/or controls the collections; and

WHEREAS, CMGs can and often collect revenue, or take expenses from the collections generated from individual emergency physician professional services for scheduling, coding, billing, medical malpractice, etc.; and

WHEREAS, CMGs often collect revenues in the form of subsidies from hospitals or governmental programs because the CMG employed individual emergency physicians cover the emergency department or provide care to the indigent or uninsured patients, or for other reasons as a direct or indirect result of individual emergency physicians providing professional services, or the CMGs receive benefits, directly or indirectly, because in[*no space] dividual emergency physicians provide emergency medicine services, (i.e., allowed to provide other service lines such as hospitalist, radiologic, anesthesiologists, orthopedic contracts, etc., billing assistance, consulting services, educational offerings, etc.); and

WHEREAS, CMGs pay emergency physicians only a fraction of the amounts they receive or collect as a direct or indirect result of the emergency physician services; and

WHEREAS, While CMGs can offer some value to emergency physicians, many question whether the amount charged, or held by the CMGs for their “services” are fair or reasonable; and

WHEREAS, Requiring CMGs to pay a Minimum Emergency Physician Pay Ratio (MEPPR), a percentage of all monies received related to the individual emergency physician’s services i.e. what is collected from billings, and

revenue generated from non-emergency physician billing but from other revenues generated by the CMG as a direct or indirect result of individual emergency physician services, similar to how insurance companies are required to pay out a minimum Medical Loss Ratio (MLR), or a percentage of the premiums collected under the Affordable Care Act for medical care and benefits to policyholders; and

WHEREAS, Many emergency physicians are compensated at a nominal pay rate that may be significantly less than what they are generating and the compensation to emergency physicians should be compensated the greater of the stated nominal pay or the MEPPR; and

WHEREAS, If a MEPPR were paid to individual emergency physicians for the value they bring to emergency medicine and patient care, it would incentivize CMGs to be as efficient as possible i.e. eliminating services that do not bring a good return on value to the individual emergency physician or patient care; and

WHEREAS, A MEPPR would incentivize CMGs to better represent the interests of the individual emergency physicians they allegedly claim they are helping; and

WHEREAS, Requiring a MEPPR would not likely cause the cost of healthcare to increase as if the CMGs tried to raise nominal costs to keep the same percentage of a higher total amount to increase total nominal profits, competitors would be able to better compete on price for contracts; therefore be it

RESOLVED, That ACEP support legislation to establish a Minimum Emergency Physician Pay Ratio that all Contract Management Groups and employers are required to pay individual emergency physicians based on what is collected on the billings for the services provided by that individual emergency physician, before collection costs; and be it further

RESOLVED, That ACEP support that when a nominal compensation amount is stated to compensate the emergency physician, the amount must meet or exceed an established Minimum Emergency Physician Pay Ratio; and be it further

RESOLVED, That ACEP support legislation to establish a Minimum Emergency Physician Pay Ratio that all Contract Management Groups and employers are required to pay individual emergency physicians a reasonable, prorated percentage of any other revenue that the contract management group or employer receives as a direct or indirect result of the individual, or group of individual, emergency physicians, providing his/her/their services with a suggested starting point: 0.80-0.85 (80-85%).

Background

The resolution directs the College to support legislation to establish a Minimum Emergency Physician Pay Ratio (MEPPR) that all Contract Management Groups (CMGs) and employers are required to pay individual emergency physicians based on what is collected on the billings for the services provided by that individual emergency physician before collection costs. It also calls for ACEP to support that when a nominal compensation amount is stated to compensate the emergency physician, that amount must meet or exceed an established Minimum Emergency Physician Pay Ratio. Finally, it calls for ACEP to support legislation to establish a Minimum Emergency Physician Pay Ratio that all Contract Management Groups and employers are required to pay individual emergency physicians a reasonable, prorated percentage of any other revenue that the contract management group or employer receives as a direct or indirect result of the individual, or group of individuals, emergency physicians, providing his/her/their services with a suggested starting point: 0.80-0.85 (80-85%).

The resolution states concerns that CMGs exert too much control over the markets, and that such groups pay emergency physicians a fraction of what the group receives either directly or indirectly from the physician's services. It also states that while CMGs may provide some value to emergency physicians, some question whether or not these arrangements are fair or reasonable. To address these issues, the resolution puts forward a "MEPPR" as a tool to require CMGs to pay a set percentage of revenues to contracted emergency physicians.

As explained in the resolution, a MEPPR is envisioned as a percentage of all monies received related to the individual emergency physician's services, such as what is collected from billings as well as revenue generated from non-emergency physician billing but from other revenues generated by the CMG as a direct or indirect result of an individual emergency physician's services. The authors liken this compensation structure to the Medical Loss Ratio (MLR), a financial measurement implemented through the Affordable Care Act (ACA) that requires insurers to use a certain percentage (generally 80/20, though there are different rates for some insurance markets or states) of every premium dollar to pay for a beneficiary's clinical services and quality improvement activities, with the remainder spent on administrative costs, marketing, profits, salaries, agent commissions, and other overhead costs. If insurers do not meet their MLR targets for a given year, they are required to pay a rebate to beneficiaries on part of the premiums paid.

ACEP policy statements "Compensation Arrangements for Emergency Physicians" and "Emergency Physician Contractual Relationships" lay out the College's existing policies regarding fair and appropriate contractual relationships. ACEP also provides a policy resource and education paper (PREP) that lays out additional background and the foundation of the "Emergency Physician Contractual Relationships" policy statement, further detailing the ideal components of contracts involving emergency physicians.

ACEP's policy statement "Compensation Arrangements for Emergency Physicians" recognizes that emergency physicians practice under a variety of compensation arrangements, e.g., independent contractor, fee for service, salary, hourly compensation, percentage of gross or net billing, or a combination of these. ACEP policy is not prescriptive in terms of how compensation methods or practice arrangements are provided, and states that regardless of these, emergency physicians are entitled to fair and equitable compensation, taking into account their experience, clinical and administrative services provided, added value to the practice, market conditions, and other appropriate circumstances or factors. ACEP strongly encourages each emergency physician to carefully evaluate and understand the health care delivery system such that they are engaging in a suitable compensation arrangement. Additionally, ACEP strongly urges transparency in disclosure of both the revenue and expenses associated with emergency medicine practice, including administration and management services, so that each emergency physician can make an informed decision in determining what is a fair compensation package for them.

The resolution also notes concerns about transparency regarding disclosure of billing or collections information by CMGs. ACEP policy also states that emergency physicians are entitled to and should be provided detailed itemized reports of all billings and collections in their name on at least a semi-annual basis regardless of whether or not billing and collection is assigned to another entity within the limits of state and federal law and have the right to audit such billings, at any time without retribution, and that emergency physicians shall not be asked to waive access to this information.

The "Emergency Physician Contractual Relationships" policy statement reinforces that ACEP does not endorse any single type of contractual arrangement between emergency physician and the contracting vendor and endorses the principle that the interests of patients are best served when emergency physicians practice in a stable, fair, equitable, and supportive environment.

ACEP's "Antitrust" policy statement states in part:

"The College is not organized to and may not play any role in the competitive decisions of its members or their employees, nor in any way restrict competition among members or potential members. Rather it serves as a forum for a free and open discussion of diverse opinions without in any way attempting to encourage or sanction any particular business practice."

"The American College of Emergency Physicians or any committee, section, chapter, or activity of the College shall not be used for the purpose of bringing about or attempting to bring about any understanding or agreement, written or oral, formal or informal, expressed or implied, among two or more members or other competitors with regard to prices or terms and conditions of contracts for services or products. Therefore, discussions and exchanges of information about such topics will not be permitted at College meetings or other activities."
"Certain activities of the College and its members are deemed protected from antitrust laws under the First Amendment right to petition government. The antitrust exemption for these activities, referred to as the Noerr-

Pennington Doctrine, protects ethical and proper actions or discussions by members designed to influence: 1) legislation at the national, state, or local level; 2) regulatory or policy-making activities (as opposed to commercial activities) of a governmental body; or 3) decisions of judicial bodies. However, the exemption does not protect actions constituting a "sham" to cover anticompetitive conduct."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective E – Pursue strategies for fair payment and practice sustainability to ensure access patient access to care.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

The Council has adopted many resolutions regarding emergency physician compensation, but none that address a minimum emergency physician pay ratio.

Amended Resolution 30(20) Protection and Transparency adopted. Directed the College to establish policy that encourages all employers, persons, or entities who contract for emergency physician services to provide information on a semi-annual basis to non-federal physicians for any and all compensation or benefit, cash, and payment-in-kind, received by the employer or CMG as a result of the physician providing his or her services without any requirement of the physician requesting it.

Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine first two resolveds adopted and the last 3 resolveds were referred to the Board of Directors. The first two resolveds directed the College to make specific revisions to the policy statements "Emergency Physician Contractual Relationships" and "Emergency Physician Rights and Responsibilities." The last three resolveds requested that ACEP: 1) adopt a new policy statement prohibiting members from denying another emergency physician access to monthly detailed information about billing and collections for their services; 2) petition state or federal legislative and regulatory bodies to require revenue cycle management entities to provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide on at least a monthly basis; and 3) adopt a new policy statement prohibiting any entity that fails to meet this standard from advertising, exhibiting, sponsoring, or otherwise being associated with ACEP

Prior Board Action

April 2021, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" revised and approved April 2015, April 2002, June 1997; reaffirmed October 2008, April 1992; originally approved June 1988.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1984 titled, "Contractual Relationships between Emergency Physicians and Hospitals."

Amended Resolution 30(20) Protection and Transparency adopted.

Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine first two resolveds adopted.

January 2019, reaffirmed the policy statement "Antitrust;" reaffirmed June 2013, October 2007; revised and approved October 2001; originally approved June 1996 replacing a policy statement with the same title approved April 1994.

July 2018, reviewed the Policy Resource & Education Paper (PREP) "Emergency Physician Contractual Relationships" as an adjunct to the policy statement "Emergency Physician Contractual Relationships."

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 38(21)

SUBMITTED BY: Kevin E. McVaney, MD
Stephen J. Wolf, MD, FACEP
Colorado Chapter

SUBJECT: Prehospital Oversight and Management of Patients Experiencing Hyperactive Delirium with Severe Agitation

PURPOSE: Advocate at the state and national levels: 1) ABEM-certified providers serve as the highest-level medical experts on the management of hyperactive delirium with severe agitation; 2) against any non-ABEM-certified specialty's assertion to having greater expertise on the management of hyperactive delirium in the prehospital setting; 3) against any non-ABEM-certified specialty's medical oversight of prehospital medical direction on the management of hyperactive delirium with severe agitation; 4) on all issues pertaining to the prehospital management of hyperactive delirium with severe agitation in partnership with NAEMSP.

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

WHEREAS, Medical direction of prehospital services is largely in the scope of emergency medicine and solely board certified by the American Board of Emergency Medicine (ABEM); and

WHEREAS, Hyperactive delirium with severe agitation is a critical patient and prehospital provider safety issue in the prehospital setting; and

WHEREAS, Pharmacologic therapeutic interventions for hyperactive delirium with severe agitation – i.e., benzodiazepines (e.g., midazolam), antipsychotics (e.g., haloperidol), and dissociative sedatives (e.g., ketamine) – are frequently required for the appropriate and safe medical management of patients experiencing hyperactive delirium with severe agitation; and

WHEREAS, Use and administration of the above stated therapeutic interventions are fully in the scope of practice of emergency medicine for the management of a variety of patient conditions, including hyperactive delirium with severe agitation; and

WHEREAS, Recent societal and political concerns have led to regulatory reviews and scrutiny of prehospital medical direction and protocols for the management of hyperactive delirium with severe agitation; and

WHEREAS, In some instances, regulators and other specialty organizations have sought to place greater emphasis on the medical expertise and opinions of non-ABEM-certified providers on this topic; and

WHEREAS, In some instances, regulators have proposed mandating non-ABEM-certified medical experts to participate in regulatory oversite of prehospital medical practice; therefore be it

RESOLVED, That ACEP advocate, at both state and national levels, that ABEM-certified providers serve as the highest level of medical experts on the matter of management of patients with hyperactive delirium with severe agitation in the prehospital and emergency medical settings; and be it further

RESOLVED, That ACEP play an active role, at both state and national levels, in advocating against any non-ABEM-certified specialty's assertion to having greater expertise in the acute therapeutic (i.e., pharmacologic and non-pharmacologic) management of patients with hyperactive delirium in the prehospital setting; and be it further

RESOLVED, That ACEP oppose any non-ABEM-certified specialty's medical oversight, in part or in whole, of prehospital medical direction, particularly when pertaining to the management of hyperactive delirium with severe agitation; and be it further

RESOLVED, That ACEP partner with the National Association of EMS Physicians (NAEMSP) to work with state and national regulators and legislators on all issues pertaining to the prehospital management of hyperactive delirium with severe agitation.

Background

This resolution requests ACEP to advocate at the state and national levels to recognize ABEM-certified providers as the highest-level medical experts on the management of hyperactive delirium with severe agitation in the prehospital and emergency department setting, and to advocate against any non-ABEM-certified specialty's assertion to having greater expertise or medical oversight of prehospital or emergency department medical direction on the management of hyperactive delirium with severe agitation. The resolution also requests ACEP to partner with the National Association of EMS Physicians (NAEMSP) to work with state and national regulators on all issues pertaining to the prehospital management of hyperactive delirium with severe agitation.

Since 2009, ACEP has made efforts to study the existence of excited delirium as a disease entity and has worked to synthesize the most current information available regarding the recognition, evaluation, and management of patients presenting with excited delirium.[1] Most recently, due to the increasingly charged nature of the term "excited delirium syndrome," ACEP has chosen to use the term "hyperactive delirium with severe agitation" when referring to patients exhibiting agitated or combative behavior associated with a delirious state where the individual is not capable of interacting with other individuals or the environment.[2] The term "hyperactive delirium with severe agitation" is more descriptive of the identified mental status and level of activity exhibited by patients of interest, and expands upon the term "hyperactive delirium," which is the term commonly used in recent research for delirium associated with increased neuromuscular activity, often accompanied by agitation.[2]

ACEP first addressed excited delirium syndrome with the 2009 task force report titled *Excited Delirium Task Force White Paper Report on Excited Delirium Syndrome*. This 20-member task force, consisting primarily of emergency physicians, provided a review of the history, epidemiology, clinical perspectives, potential pathophysiology, diagnostic characteristics, differential diagnoses, and clinical treatment of excited delirium syndrome.

In 2020, urgent questions surrounding the initial management of excited delirium was raised by ACEP membership, the scientific community, community leaders, media, and governmental agencies. In response, ACEP leadership assembled a 10-member task force to address the progress made since 2009 in the recognition, evaluation, and management of patients demonstrating dangerous degrees of agitation. To incorporate the perspectives from multiple specialties, a 17-member multispecialty review panel reviewed the document's text and recommendations. In June 2021, the ACEP Board of Directors approved the document titled *ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings*.

The approval of the *ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings* followed the American Medical Association's adoption of a policy earlier in the month opposing "excited delirium" as a medical diagnosis and underscoring the importance of emergency physician-led oversight of medical emergencies in the field.[3,4]

ACEP has a long history of working with NAEMSP on joint projects and policy statements and there are no known obstacles or barriers to collaboration on this issue.

References

1. Debard ML, Adler J, Bozeman W, et al. Excited Delirium Task Force White Paper Report on Excited Delirium Syndrome. September 2009. https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/ems-and-disaster-

preparedness/ems-resources/acep-excited-delirium-white-paper-final-form.pdf
2. Hatten BW, Bonney C, Dunne RB, et al. ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings. June 2021. https://www.acep.org/by-medical-focus/hyperactive-delirium/
3. American Medical Association Council on Science and Public Health. Use of Drugs to Chemically Restrain Agitation Individuals Outside of Hospital Settings. June 2021. https://www.ama-assn.org/system/files/2021-05/j21-handbook-addendum-ref-cmte-e.pdf.
4. American Medical Association. Press Release: New AMA policy opposes "excited delirium" diagnosis. June 2021. https://www.ama-assn.org/press-center/press-releases/new-ama-policy-opposes-excited-delirium-diagnosis.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

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

Fiscal Impact

Budgeted committee/task force and staff resources.

Prior Council Action

Amended Resolution 21(08) Excited Delirium. Directed the College to establish a multidisciplinary group to study "excited delirium" and make clinical recommendations.

Prior Board Action

June 2021, approved "ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings."

October 2009, approved "White Paper Report on Excited Delirium Syndrome." The report was distributed to the 2009 Council.

Amended Resolution 21(08) "Excited Delirium" adopted.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

Rick Murray, EMT-P
EMS & Disaster Preparedness Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 39(21)

SUBMITTED BY: Ohio Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Recommit to Lessening Opioid Deaths in America

PURPOSE: Recommit to the goal of reducing overdose deaths by working with various federal and state agencies, legislatures, and other stakeholders; and that ACEP continue to advocate for actions to decrease the supply of fentanyl and other drugs and to highlight the continued increase in overdoses and overdose deaths.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, ACEP and all 53 of the chapters have been fighting the opioid epidemic since 2012; and

WHEREAS, Most states and the District of Columbia have developed prescription drug monitoring programs; and

WHEREAS, ACEP promotes that emergency physicians develop programs to initiate buprenorphine in the emergency department linked to ongoing care to assist patients to obtain treatment; and

WHEREAS, ACEP promotes prescribing naloxone for all patients and families who are at risk for opioid use disorder; and

WHEREAS, Federal agents in El Paso, Texas report a staggering 4,000% increase in fentanyl seizures over the last three years, rising from 1 pound in 2018 to 41 pounds during the 2021 fiscal year; and

WHEREAS, As of April 2021, Customs and Border Patrol had seized 6,494 pounds of fentanyl this year, compared to 4,776 pounds in all of 2020; and

WHEREAS, Fentanyl strongly contributed to the stark rise in overdoses that killed more than 90,000 Americans during the 12-month period ending September 2020; and

WHEREAS, More than twice as many people died from overdoses than from COVID-19 in San Francisco last year; and

WHEREAS, One kilogram of fentanyl has the potential to kill 500,000 people; therefore be it

RESOLVED, That ACEP recommit to the goal of reducing overdose deaths in this country by working with Customs and Border Patrol, the Drug Enforcement Agency, state legislatures on the southern border, federal legislatures, and any other relevant stakeholders; and be it further

RESOLVED, That ACEP continue to advocate for governmental actions to decrease the supply of fentanyl and other illegal drugs entering our country by whatever means necessary and to highlight the continued increase in overdoses and overdose deaths.

Background

The resolution calls for the College to recommit to the goal of reducing overdose deaths in the U.S. by working with U.S. Customs and Border Protection (CBP), the Drug Enforcement Agency (DEA), state legislatures on the southern border, federal legislatures, and any other relevant stakeholders. (Technical note: the resolution writes this as "Customs and Border Patrol," the U.S. Border Patrol is a subsidiary organization under the purview of U.S. Customs and Border Protection – for purposes of this background information, staff assumes "Customs and Border Protection" to reflect the authors' intent given the agency's broader purview.) The resolution also directs ACEP to continue to advocate for governmental actions to decrease the supply of fentanyl and other illegal drugs entering the country by whatever means necessary and to highlight the continued increase in overdoses and overdose deaths.

The use 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. In 2020, the Centers for Disease Control and Prevention (CDC) reported more than 93,000 opioid deaths, the highest number on record and a nearly 30 percent increase from 2019. This increase was driven primarily by illicitly manufactured fentanyl and synthetic opioids, and also thought to be exacerbated by the COVID-19 pandemic. The opioid crisis also has additional impacts on public health, such as significant increases in the incidence of infectious diseases often associated with injection drug use, including acute hepatitis C virus (HCV), HIV, and other bloodborne infections. The CDC noted that over from 2010-2016, HCV cases more than tripled.

Given the impact of opioid use disorder (OUD) on ED patients, emergency physicians have unique knowledge, experience, and opportunities to help patients with OUD or other substance use disorders (SUDs). The treatment of opioid use disorder in the ED has been associated with increased rates of outpatient treatment linkage and decreased drug use when compared to patients referred to the ED. The ED has also been increasingly recognized as a venue for the identification and initiation of treatment for opioid use disorder. To this end, over the past several years the College has developed a robust set of OUD treatment resources and materials for emergency physicians and has taken a leading role in comprehensive federal and state advocacy efforts to address the opioid crisis.

Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. This has included the development of the Management of Acute Pain (MAP) in the Emergency Department Point of Care Tool. However, ED physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from opioid use disorder. The Department of Health and Human Services (HHS) has recognized the emergency department as one of the first places individuals with a substance use disorder will seek treatment.

During the 115th Congress, the College successfully advocated to include two ACEP-developed and -led bills in the SUPPORT for Patients and Communities Act (Public Law 115-271), a comprehensive bipartisan opioid package that provided federal resources for prevention, recovery, and treatment efforts. The two bills included in this package were the Alternatives to Opioids (ALTO) in the Emergency Department Act, establishing a grant program to help emergency departments implement their own ALTO programs based upon the successful ALTO program developed by current ACEP President Mark Rosenberg, DO, MBA, FACEP; and the Preventing Overdoses While in Emergency Rooms (POWER) Act that established a program to develop best practices for ED-initiated medication assisted treatment (MAT) programs to provide a "warm handoff," helping emergency physicians initiate OUD treatment for patients who have overdosed and directly connect them with more appropriate longer-term treatment options in their communities. In March 2018 as these bills were being considered in the House, Dr. Rosenberg testified before the Energy and Commerce Committee in support of the ALTO and POWER bills. And later, in recognition of the College's successful efforts, ACEP received an invitation to the White House signing ceremony for the legislation in October 2018, with former ACEP Executive Director Dean Wilkerson attending the ceremony on behalf of the College.

The ALTO program recently received a $3 million increase in the House of Representatives Labor, Health and Human Services, Education, and Related Agencies (L/HHS) appropriations bill, and in July 2021, ACEP helped facilitate introduction of legislation to reauthorize the ALTO program through 2026.

Also during the 115th Congress, ACEP helped develop legislation, the "Sharing Health Information to Ensure Lifesaving Drug Safety (SHIELDS) Act," to close the gap in the U.S. Department of Defense's (DoD's) reporting of prescriptions, including opioids, to state prescription drug monitoring programs (PDMPs). In a matter of a few short months, ACEP was able to bring this issue to Congress' attention, help develop legislation, and secure enactment of this bill as part of the fiscal year 2019 National Defense Authorization Act (NDAA). Previously, prescribing data for service members and their families was not available to emergency physicians and other providers when they sought care at non-military treatment facilities.

In 2017, the HHS Secretary declared the opioid crisis and public health emergency, which in turn spurred the ACEP Pain Management & Addiction Medicine Section to develop an updated EM-focused DATA 2000 X-Waiver training, followed by a guideline on the initiation of medication for OUD for appropriate ED patients. ACEP also continues to advocate for policy changes that lower regulatory barriers to initiating Medication-Assisted Treatment (MAT) in the ED, and support expansion of outpatient and inpatient opioid treatment programs. Additionally, ACEP has launched the Pain and Addiction Care in the Emergency Department (PACED) accreditation program.

In 2016, Congress approved the bipartisan Comprehensive Addiction and Recovery Act (CARA; P.L. 114-198) that included several important ACEP-supported provisions, including: expedited training of military medics who become civilian emergency medical technicians (EMTs); improved access to opioid overdose reversal treatments, including grants to purchase and distribute naloxone to first responders, and expand physician co-prescribing of naloxone in conjunction with opioid prescriptions for patients at elevated risk of overdose; reauthorized grants to help states establish, implement, and improve PDMPs; increased disposal sites for unwanted prescription medications; among many others.

ACEP has also supported multiple bills over the last several years to extend temporary orders by the Drug Enforcement Agency (DEA) to keep fentanyl-related substances and analogues in Schedule I of the Controlled Substances Act (CSA), giving Congress and the DEA this much-needed immediate authority as they develop a more permanent solution. The most recent extension of these temporary orders was signed into law in May 2021, and ACEP continues to urge Congress and the DEA to implement an effective and permanent mechanism to address this particular challenge.

Among ACEP's current federal legislative priorities are continued efforts to increase access to MAT. Recently, ACEP helped secure the successful passage of legislation in late 2020, the "Easy Medication Access and Treatment for Opioid Addiction (Easy MAT) Act," to allow non-waivered emergency physicians to dispense from the ED up to a three-day supply of buprenorphine at one time to a patient suffering from acute withdrawal symptoms. Previously, patients were required to return to the ED within the 72-hour window to receive additional doses as they awaited long-term treatment. Additionally, ACEP continues to work to eliminate of the "X-waiver" requirement required for health care practitioners to dispense certain narcotic drugs, including buprenorphine, for maintenance or detoxification treatment for OUD. In January 2021, the Trump Administration issued guidance to provide a broad exemption to the X-waiver requirement; however, this effort was reversed shortly after by the new Biden Administration with the reasoning that the Administration does not have the authority to relax these requirements. As Health and Human Services (HHS) Secretary Xavier Becerra noted during his confirmation hearings in Congress, the Administration supports the effort to increase access to buprenorphine, but reiterated that the Administration does not have the authority to eliminate the policy and that an act of Congress is required. This issue was also one of the advocacy items for ACEP's 2021 Leadership and Advocacy Conference (LAC).

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

with substance abuse disorders and mental illnesses. ACEP expressed our commitment to helping SAMHSA achieve the goal and identified opportunities to work together going forward.

On August 29, 2019, ACEP responded to an HHS request for information on ensuring appropriate access to opioid treatments. In the response, HHS is urged to do what is in their authority to reduce barriers to the treatment of patients with OUD. ACEP also issued a press release highlighting the major points contained in the letter.

In addition to advocating for Congress to remove the X-waiver and pushing for regulatory changes to the "three-day rule," ACEP also:

- Offers an emergency-medicine specific X-waiver training course;
- Provides clinical tools for emergency physicians to improve decision making and clinical practices; and
- Operates the EQUAL Network Opioid Initiative, which engages emergency clinicians and leverages emergency departments to improve clinical outcomes.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Amended Resolution 34(19) Opposing Naloxone Addition to the Prescription Drug Monitoring Program adopted. Directed ACEP to oppose legislation to add naloxone to the PDMP and work with chapters in developing strategies and supporting materials to stop such legislation.

Resolution 31(19) Improving Emergency Physicians Utilization of Medication for Addiction Treatment not adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for EPs to enact meaningful therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and advocate for elimination of X-waiver to initiate MAT from the ED.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed the College to work directly with DEA and SAMHSA to minimize barriers for EPs to enact meaningful therapies for patients in times of opioid crisis from the ED, advocate to DEA and SAMHSA ED-specific requirements and curriculum to reach the greatest number of patients safely and without barriers, and continue to advocate for removal of the X-waiver requirement to prescribe buprenorphine for OUD from an ED setting.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted. Directed ACEP to advocate for federal/state appropriations and/or grants for use in fully funding substance abuse intervention programs that are accessible 24/7 and will be initiated in EDs, and that ACEP advocate for federal/state funding for substance abuse intervention programs that will be accessible to their full potential by all patients regardless of

insurance status or ability to pay.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted. Directed ACEP to pursue legislation for federal/state appropriation funding and/or grants for initiating MAT in emergency departments with provided funding for start-up, training, and robust community resources for appropriate patient followup.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Prior Board Action

February 2020, approved changing the name of the ED Pain & Addiction Management Accreditation Program to Pain & Addiction Care in the ED (PACED).

Amended Resolution 34(19) Opposing Naloxone Addition to the Prescription Drug Monitoring Program adopted.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

June 2019, approved the governance charter, revised accreditation criteria, and funding for the ED Pain & Addiction Management Accreditation Program.

April 2019, reviewed the draft criteria for the ED Pan Management Accreditation Program.'

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

Amended Resolution 26(18) Funding of Substance Use Intervention and Treatment Programs adopted.

Amended Resolution 25(18) Funding for Medication Assisted Treatment adopted.

September 2018, approved creation of the Emergency Department Pain & Addiction Management Accreditation Program.

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

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

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

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

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

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

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 40(21)

SUBMITTED BY: Missouri Chapter
Ohio Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Reimbursement for Naloxone Distributed from Emergency Departments

PURPOSE: Advocate for state and federal laws requiring payers to reimburse EDs, hospitals, and other healthcare facilities for naloxone distributed but not administered to patients at risk for suffering an overdose event.

FISCAL IMPACT: Budgeted committee and staff resources to draft model legislation and federal and state advocacy initiatives.

WHEREAS, Bystander naloxone has been demonstrated to reduce mortality from opioid overdose while also being cost-effective[1,2]; and

WHEREAS, Despite the availability in many pharmacies and community organizations through standing orders and other local, state, and federally funded programs, most patients who are treated in an emergency department (ED) do not obtain naloxone within a month of their index ED visit[3]; and

WHEREAS, Emergency department initiated naloxone distribution programs are feasible and associated with increased community naloxone availability; and

WHEREAS, Medications provided to patients in the emergency department for use at home are not reimbursed by insurers or managed care organizations; and

WHEREAS, The Centers for Medicare and Medicaid Services (CMS) and most insurance companies provide coverage, often without co-pay, for prescription naloxone; and

WHEREAS, In 2021, CMS approved payment for distribution of opioid antagonist medications, specifically naloxone, under Opioid Treatment Provider medication agreements[4]; and

WHEREAS, Several states, including Colorado, are considering or have enacted laws requiring insurers and managed care organizations within that state to reimburse healthcare facilities for naloxone distributed to patients for future overdose reversals, if needed[5]; therefore be it

RESOLVED, That ACEP advocate for state and federal laws requiring payers to reimburse emergency departments, hospitals, and other healthcare facilities for naloxone distributed but not administered to patients at risk for suffering an overdose event.

References

1. Walley AY et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013 Jan 30; 346:f174.
2. Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. Ann Intern Med 2013;158:1–9.
3. Kilaru AS, Liu M, Gupta R, Perrone J, Delgado MK, Meisel ZF, Lowenstein M. Naloxone prescriptions following emergency department encounters for opioid use disorder, overdose, or withdrawal. Am J Emerg Med. 2021 Mar 24;47:154-157. doi: 10.1016/j.ajem.2021.03.056. Epub ahead of print. PMID: 33812332.
4. Opioid Treatment Programs (OTP) | CMS Accessed 6/11/2021
5. Harm Reduction Substance Use Disorders | Colorado General Assembly Accessed 6/11/2021

Background

This resolution directs the College to advocate for state and federal laws requiring payers to reimburse emergency departments, hospitals, and other healthcare facilities for naloxone distributed but not administered to patients at risk for suffering an overdose event.

Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. However, ED physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from opioid use disorder. The Department of Health and Human Services (DHHS) has recognized the emergency department as one of the first places individuals with a substance use disorder will seek treatment. In 2017, DHHS declared the opioid crisis a public health emergency, which in turn spurred the ACEP Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for Opioid Use Disorder (OUD) for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating Medication-Assisted Treatment (MAT) in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

The treatment of opioid use disorder in the ED has been associated with increased rates of outpatient treatment linkage and decreased drug use when compared to patients referred to the ED. The ED has also been increasingly recognized as a venue for the identification and initiation of treatment for opioid use disorder.[1] ACEP is preparing clinical guidance for standardizing naloxone education and prescribing in the ED so emergency physicians can submit appropriate documentation for reimbursement.

At the federal level, ACEP has asked agencies for additional reimbursement for naloxone. In the Calendar Year (CY) 2021 Physician Fee Schedule, the Centers for Medicare & Medicaid Services (CMS) instituted a policy allowing opioid treatment programs (OTPs) to offer naloxone to Medicare beneficiaries as part of a new benefit that CMS established to provide treatment to patients with OUD. This benefit only applies to services delivered by OTPs. In our comments on the regulation, ACEP stated that we believe some services allowable under the benefit, such as the administration of naloxone, should also be paid for when delivered in the ED. Specifically, we requested that CMS allow EDs to get reimbursed for administering naloxone and emergency physicians and other clinicians working in EDs to get compensated for the time that is spent counseling patients on how to appropriately use naloxone at home.

Reimbursement for naloxone distribution at the state level depends on a patchwork of hospital, insurer, pharmacy, state, and federal policies and regulations. Some communities have already established a naloxone distribution program in which local hospitals and their emergency departments participate, however this is largely on a voluntary basis without adequate reimbursement for the emergency physician's work. Certain state Medicaid programs make it possible for emergency physicians to bill the patient's insurance for naloxone and the education provided to the patient. Private insurers have been willing to pay for naloxone prescriptions through participating pharmacies, however advocacy efforts reveal that most insurers believe patients should shoulder much of the costs for naloxone.

The complexities of gaining adequate reimbursement for naloxone distribution in the ED at the state and federal level also apply to coding and billing principles. Professional service codes are determined based on the "complexity and intensity of work performed by an emergency physician and include the cognitive effort expended by the physician." The facility or technical coding guidelines reflect the "volume and intensity of resources utilized by the facility to provide patient care." Unlike professional ED Evaluation and Management (E/M) billing, the Centers for Medicaid and Medicare Services (CMS) does not have any standard guidelines for facility level coding. These coding and billing complexities make it difficult to capture the complexity and intensity of the ED encounter when distribution of naloxone is not the primary reason why a patient is seeking treatment.

Given the high prevalence of unmet substance abuse needs among ED patients, and increasing frequency of drug related ED visits, emergency physicians have an opportunity to prevent opioid overdose deaths. ED naloxone distribution is one way to provide a lifesaving intervention to patients at risk for opioid overdose.

---

[1] Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department. Hawk, Kathryn et al. Annals of Emergency Medicine, Volume 78, Issue 3, 434 – 442

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
  - Tactic 9 – Create and promote resources on fair payment issues for the membership.

Fiscal Impact

Budgeted committee and staff resources to draft model legislation and federal and state advocacy initiatives.

Prior Council Action

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed ACEP to work directly with the DEA and SAMHSA to minimize barriers emergency physicians to enact meaningful therapy for patients; advocate to the DEA and SAMHSA for ED-specific requirements and curriculum to reach the greatest number of patients safely and without onerous barriers; and continue advocating for the removal of the DEA X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine for opioid use disorder from an ED setting.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 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.

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

Resolution 38(13) Naloxone as an Over the Counter (OTC) Drug not adopted. Called for ACEP to adopt a policy in support of Naloxone becoming available as an OTC drug and promote education and safeguards for its use.

Prior Board Action

February 2021, approved "Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department." The inclusion of harm reduction strategies (including overdose education and naloxone distribution) or prescriptions is also an essential component of the ED visit.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

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

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

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

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

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

Background Information Prepared by: Adam Krushinskie, MPA
Reimbursement Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 41(21)

SUBMITTED BY: Donald E. Stader, MD, FACEP
Nathan M. Novotny
John Spartz
Emergency Medicine Residents' Association
Colorado Chapter
New Jersey Chapter
Massachusetts College of Emergency Physicians
Pain Management & Addiction Medicine Section
Social Emergency Medicine Section

SUBJECT: Take Home Naloxone Programs in Emergency Departments

PURPOSE: 1) Amend ACEP's policy statement "Naloxone Prescriptions by Emergency Physicians" to include endorsement for Take Home Naloxone programs. 2) Seek to increase distribution of naloxone from the ED. 3) Promote Take Home Naloxone programs as a best practice for patients at risk of opioid overdose. 4) Advocate for regulatory and payment reform for reimbursement to hospitals and EDs for naloxone dispensed directly to patients. 5) Promote educating emergency physicians about strategies to implement Take Home Naloxone programs in their ED.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, According to the Centers for Disease Control and Prevention, there have been 841,000 drug overdose deaths in the United States from 1999-2019[1] with 70% of overdoses involving an opioid in 2019[2]; and

WHEREAS, Deaths attributed to overdoses involving prescription opioids, synthetic opioids or heroin have increased six-fold from 1999-2019[1]; and

WHEREAS, Contamination of stimulants (e.g., cocaine, methamphetamine, etc.) with synthetic opioids has significantly increased in the past decade, increasing overdose by unintentional ingestion of synthetic opioids in opioid-naive individuals[30-32]; and

WHEREAS, Emergency department (ED) visits among people aged ≥11 years for opioid overdoses in the United States increased 29.7% overall from July 2016–September 2017[3] and opioid overdose deaths increased by 6% from 2018-2019[4]; and

WHEREAS, Available data indicate that the COVID-19 pandemic has caused opioid-related overdoses to further increase from 2020 until present [5-7]; and

WHEREAS, Research shows that people who have one overdose are more likely to have another[8] and a commission report from Delaware found that 52% of people who died of an overdose were seen in an emergency department within three months of a non-fatal opioid-involved overdose[9]; and

WHEREAS, Existing data indicates that layperson administration of naloxone is effective in preventing death and increasing the recovery rates from opioid-related overdose[10,11]; and

WHEREAS, Community members most likely to administer naloxone to reverse opioid overdoses are people who actively use drugs[12]; and

WHEREAS, Barriers such as cost, lack of insurance coverage and patient refusal lead to dismal fill rates of naloxone, including in three studies which demonstrated that approximately 1% of naloxone of ED prescriptions were filled[13,14,33]; and

WHEREAS, People who use drugs are less likely to access a pharmacy for naloxone for fear of consequences, shame, and stigma[15-17]; and

WHEREAS, Virtually all existing data on Take Home Naloxone (THN) programs demonstrate that they are markedly effective in reducing opioid-involved overdose deaths[18-23]; and

WHEREAS, One study indicates that at least two-thirds of patients using opioids indicated that they would accept naloxone given as part of a THN program[24]; and

WHEREAS, It has thus been suggested that THN programs in the ED would increase the number of people who carry naloxone and therefore the number of lives that could be saved by naloxone in an overdose; and

WHEREAS, Multiple probabilistic analyses have projected that THN programs would be cost-effective even by conservative estimates[25-27]; and

WHEREAS, Many hospitals have difficulty with reimbursement for THN and hence are dependent on grant funding or donated naloxone, thereby limiting the willingness of many hospitals and ability of many emergency physicians to adopt this proven harm reduction intervention[28,29]; and

WHEREAS, Educational measures by ACEP have predominantly targeted increasing co-prescribing and use of standing orders, a tactic that has been shown to be largely ineffective; therefore be it

RESOLVED, That ACEP amend the current policy statement "Naloxone Prescriptions by Emergency Physicians" to include endorsement for Take Home Naloxone programs in emergency departments; and be it further

RESOLVED, That ACEP seek to increase the distribution of naloxone from the emergency department by researching and advocating for a standardized, lower barrier, and cost-effective take-home model for naloxone for at risk patients; and be it further

RESOLVED, That ACEP promote Take Home Naloxone programs as a best practice for patients at risk of opioid overdose and work toward increasing the number of Take Home Naloxone programs in emergency departments, partnering with other like-minded organizations, and promoting take home naloxone as a best practice; and be it further

RESOLVED, That ACEP advocate for regulatory and payment reform that would facilitate reimbursement to hospitals and emergency departments for naloxone dispensed directly to patients as part of Take Home Naloxone programs, thus removing financial disincentives for hospitals to have Take Home Naloxone programs; and be it further

RESOLVED, That ACEP promote educating emergency physicians about strategies to implement Take Home Naloxone programs in their emergency department.

References

1. Centers for Disease Control and Prevention. CDC WONDER. Last Reviewed December 22, 2020. https://wonder.cdc.gov/
2. Mattson CL, Tanz L, Quinn K, Kariisa M, Patel P, Davis N. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States 2013–2019. *MMWR Morb Mortal Wkly Rep*. 2021;70. doi:10.15585/mmwr.mm7006a4
3. Vivolo-Kantor AM, Seth P, Gladden RM, et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses — United States, July 2016–September 2017. MMWR Morb Mortal Wkly Rep 2018;67:279–285. DOI: http://dx.doi.org/10.15585/mmwr.mm6709e1
4. Centers for Disease Control and Prevention. Understanding the Epidemic. Last Reviewed March 17, 2021. https://www.cdc.gov/drugoverdose/epidemic/index.html

5. Haley DF, Saitz R. The Opioid Epidemic During the COVID-19 Pandemic. JAMA. 2020;324(16):1615-1617. doi:10.1001/jama.2020.18543
6. Slavova S, Rock P, Bush HM, Quesinberry D, Walsh SL. Signal of increased opioid overdose during COVID-19 from emergency medical services data. Drug Alcohol Depend. 2020;214:108176. doi:10.1016/j.drugalcdep.2020.108176
7. Ochalek TA, Cumpston KL, Wills BK, Gal TS, Moeller FG. Nonfatal Opioid Overdoses at an Urban Emergency Department During the COVID-19 Pandemic. JAMA. 2020;324(16):1673-1674. doi:10.1001/jama.2020.17477
8. Suffoletto B, Zeigler A. Risk and protective factors for repeated overdose after opioid overdose survival. Drug Alcohol Depend. 2020;209:107890. doi:10.1016/j.drugalcdep.2020.107890
9. June 2019 Commission Report. Delaware Drug Overdose Fatality Review Commission. 2019. https://attorneygeneral.delaware.gov/wp-content/uploads/sites/50/2019/07/2019-Delaware-Drug-Overdose-Fatality-Review-Commission-Report-Final.pdf
10. Giglio RE, Li G, DiMaggio CJ. Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis. Inj Epidemiol. 2015;2(1):10. doi:10.1186/s40621-015-0041-8
11. Walley AY, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013;346:f174. Published 2013 Jan 30. doi:10.1136/bmj.f174
12. Rowe C, Santos GM, Vittinghoff E, Wheeler E, Davidson P, Coffin PO. Predictors of participant engagement and naloxone utilization in a community-based naloxone distribution program. Addiction. 2015;110(8):1301-1310. doi:10.1111/add.12961
13. Spivey CA, Wilder A, Chisholm-Burns MA, Stallworth S, Wheeler J. Evaluation of naloxone access, pricing, and barriers to dispensing in Tennessee retail community pharmacies. J Am Pharm Assoc (2003). 2020;60(5):694-701.e1. doi:10.1016/j.japh.2020.01.030
14. Ruff AL, Seiler K, Brady P, Fendrick AM. Naloxone fill rates after opioid overdose. J Addict Med Ther Sci. 2019;5(1):001-002. DOI: 10.17352/2455-3484.000027
15. Davis CS, Carr D. Over the counter naloxone needed to save lives in the United States. Prev Med. 2020;130:105932. doi:10.1016/j.ypmed.2019.105932
16. Green TC, Case P, Fiske H, et al. Perpetuating stigma or reducing risk? Perspectives from naloxone consumers and pharmacists on pharmacy-based naloxone in 2 states. J Am Pharm Assoc (2003). 2017;57(2S):S19-S27.e4. doi:10.1016/j.japh.2017.01.013
17. Corrigan PW, Nieweglowski K. Stigma and the public health agenda for the opioid crisis in America. Int J Drug Policy. 2018;59:44-49. doi:10.1016/j.drugpo.2018.06.015
18. Maxwell S, Bigg D, Stanczykiewicz K, Carlberg-Racich S. Prescribing naloxone to actively injecting heroin users: a program to reduce heroin overdose deaths. J Addict Dis. 2006;25(3):89-96. doi:10.1300/J069v25n03_11
19. Bird SM, McAuley A, Perry S, Hunter C. Effectiveness of Scotland's National Naloxone Programme for reducing opioid-related deaths: a before (2006-10) versus after (2011-13) comparison. Addiction. 2016;111(5):883-891. doi:10.1111/add.13265
20. Noveloso B, Singh J, Coombs S. Are take-home naloxone programs effective in reducing mortality from heroin use in patients with a history of heroin overdose?. Evidence-Based Practice. 2020;23(4)27-28. doi: 10.1097/EBP.0000000000000625
21. McDonald R, Strang J. Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria. Addiction. 2016;111(7):1177-1187. doi:10.1111/add.1332
22. Parmar MK, Strang J, Choo L, Meade AM, Bird SM. Randomized controlled pilot trial of naloxone-on-release to prevent post-prison opioid overdose deaths. Addiction. 2017;112(3):502-515. doi:10.1111/add.13668
23. Chimbar L, Moleta Y. Naloxone Effectiveness: A Systematic Review. J Addict Nurs. 2018;29(3):167-171. doi:10.1097/JAN.0000000000000230
24. Kestler A, Buxton J, Meckling G, et al. Factors Associated With Participation in an Emergency Department-Based Take-Home Naloxone Program for At-Risk Opioid Users. Ann Emerg Med. 2017;69(3):340-346. doi:10.1016/j.annemergmed.2016.07.027
25. Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal in Russian cities. J Med Econ. 2013;16(8):1051-1060. doi:10.3111/13696998.2013.811080
26. Langham S, Wright A, Kenworthy J, Grieve R, Dunlop WCN. Cost-Effectiveness of Take-Home Naloxone for the Prevention of Overdose Fatalities among Heroin Users in the United Kingdom. Value Health. 2018;21(4):407-415. doi:10.1016/j.jval.2017.07.014
27. Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal [published correction appears in Ann Intern Med. 2017 May 2;166(9):687]. Ann Intern Med. 2013;158(1):1-9. doi:10.7326/0003-4819-158-1-201301010-00003
28. Eswaran V, Allen KC, Bottari DC, et al. Take-Home Naloxone Program Implementation: Lessons Learned From Seven Chicago-Area Hospitals. Ann Emerg Med. 2020;76(3):318-327. doi:10.1016/j.annemergmed.2020.02.013
29. Kim HS, Aks SE. Take-Home Naloxone and the Need for a Publicly Funded Naloxone Supply. J Addict Med. Published online February 1, 2021. doi:10.1097/ADM.0000000000000821
30. LaRue L, Twillman RK, Dawson E, et al. Rate of Fentanyl Positivity Among Urine Drug Test Results Positive for Cocaine or Methamphetamine [published correction appears in JAMA Netw Open. 2019 Oct 2;2(10):e1916040]. JAMA Netw Open. 2019;2(4):e192851. Published 2019 Apr 5. doi:10.1001/jamanetworkopen.2019.2851
31. Ciccarone D. The rise of illicit fentanyls, stimulants and the fourth wave of the opioid overdose crisis. Curr Opin Psychiatry. 2021;34(4):344-350. doi:10.1097/YCO.0000000000000717
32. Jones CM, Bekheet F, Park JN, Alexander GC. The Evolving Overdose Epidemic: Synthetic Opioids and Rising Stimulant-Related Harms. Epidemiol Rev. 2020;42(1):154-166. doi:10.1093/epirev/mxaa011
33. Kilaru AS, Liu M, Gupta R, et al. Naloxone prescriptions following emergency department encounters for opioid use disorder, overdose, or withdrawal [published online ahead of print, 2021 Mar 24]. Am J Emerg Med. 2021;47:154-157. doi:10.1016/j.ajem.2021.03.056

Background

This resolution calls on ACEP to amend the policy statement “Naloxone Prescriptions by Emergency Physicians” to include endorsement for Take Home Naloxone programs; seek to increase distribution of naloxone from the ED; promote Take Home Naloxone programs as a best practice for patients at risk of opioid abuse; advocate for regulatory

and payment reform for reimbursement to hospitals and emergency departments for naloxone dispensed directly to patients; and promote educating emergency physicians about strategies to implement Take Home Naloxone programs in their ED.

Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. This has included the development of the Management of Acute Pain (MAP) in the Emergency Department Point of Care Tool. However, ED physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from opioid use disorder. The Department of Health and Human Services (HHS) has recognized the emergency department as one of the first places individuals with a substance use disorder will seek treatment.

In 2017, the HHS Secretary declared the opioid crisis and public health emergency, which in turn spurred the ACEP Pain Management & Addiction Medicine Section to develop an updated EM-focused DATA 2000 X-Waiver training, followed by a guideline on the initiation of medication for OUD for appropriate ED patients. ACEP also continues to advocate for policy changes that lower regulatory barriers to initiating Medication-Assisted Treatment (MAT) in the ED, and support expansion of outpatient and inpatient opioid treatment programs. Additionally, ACEP has launched the Pain and Addiction Care in the Emergency Department (PACED) accreditation program.

The opioid overdose epidemic continues to claim tens of thousands of lives in the United States each year despite an aggressive, multifaceted approach. Increased ED visits and deaths during the COVID-19 pandemic have magnified the need to invest in care for people with substance use disorders. The Centers for Disease Control and Prevention (CDC) reported more than 81,000 drug overdose deaths in the 12 months ending in May 2020, which is the highest number ever recorded in a 12-month period in the United States. Further, over 70 percent of the nearly 71,000 drug overdose deaths in 2019 involved an opioid. The treatment of opioid use disorder in the ED has been associated with increased rates of outpatient treatment linkage and decreased drug use when compared to patients referred to the ED. The ED has also been increasingly recognized as a venue for the identification and initiation of treatment for opioid use disorder.

At the federal level, ACEP has asked agencies for additional reimbursement for naloxone. In the Calendar Year (CY) 2021 Physician Fee Schedule, the Centers for Medicare & Medicaid Services (CMS) instituted a policy allowing opioid treatment programs (OTPs) to offer naloxone to Medicare beneficiaries as part of a new benefit that CMS established to provide treatment to patients with OUD. This benefit only applies to services delivered by OTPs. In our comments on the regulation, ACEP stated that we believe some services allowable under the benefit, such as the administration of naloxone, should also be paid for when delivered in the ED. Specifically, we requested that CMS allow EDs to get reimbursed for administering naloxone, and emergency physicians and other clinicians working in EDs to get compensated for the time that is spent counseling patients on how to appropriately use naloxone at home.

Reimbursement for naloxone distribution at the state level depends on a patchwork of hospital, insurer, pharmacy, state, and federal policies and regulations. Some communities have already established a naloxone distribution program in which local hospitals and their emergency departments participate, however this is largely on a voluntary basis without adequate reimbursement for the emergency physician's work. Certain state Medicaid programs make it possible for emergency physicians to bill the patient's insurance for naloxone and the education provided to the patient. Private insurers have been willing to pay for naloxone prescriptions through participating pharmacies, however advocacy efforts reveal that most insurers believe patients should shoulder much of the costs for naloxone.

The complexities of gaining adequate reimbursement for naloxone distribution in the ED at the state and federal level also apply to coding and billing principles. Professional service codes are determined based on the "complexity and intensity of work performed by an emergency physician and include the cognitive effort expended by the physician." The facility or technical coding guidelines reflect the "volume and intensity of resources utilized by the facility to provide patient care." Unlike professional ED Evaluation and Management (E/M) billing, CMS does not have any standard guidelines for facility level coding. These coding and billing complexities make it difficult to capture the complexity and intensity of the ED encounter when distribution of naloxone is not the primary reason a patient is seeking treatment.

Given the high prevalence of unmet substance abuse needs among ED patients, and increasing frequency of drug related ED visits, emergency physicians have an opportunity to prevent opioid overdose deaths. ED naloxone distribution is one way to provide a lifesaving intervention to patients at risk for opioid overdose.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed ACEP to work directly with the DEA and SAMHSA to minimize barriers for emergency physicians to enact meaningful therapy for patients in a time of opioid crisis; advocate to the DEA and SAMHSA for ED-specific requirements and curriculum to reach the greatest number of patients safely and without onerous barriers; and continue to advocate for the removal of the DEA X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine for opioid use disorder from an ED setting.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 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.

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

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

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers.

Prior Board Action

February 2021, approved "Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department." The inclusion of harm reduction strategies (including overdose education and naloxone distribution) or prescriptions is also an essential component of the ED visit.

June 2020, approved the Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department

Amended Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

Amended resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

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

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

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

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

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

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

Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director

Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Meeting
Reference Committee Members

Reference Committee C – Emergency Medicine Practice
Resolutions 42-59

L. Carlos Zapata, MD, FACEP (NY) Chair
Purva Grover, MD, FACEP (OH)
Jonathan Hansen, MD, FACEP (MD)
Jeffrey Linzer, MD, FACEP (GA)
Eric Maur, MD, FACEP (NC)
Sandra Williams, DO, FACEP (TX)

Travis Schulz, MLS, AHIP
Kaeli Vandertulip, MBA, MSLS, AHIP

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 42(21)

SUBMITTED BY: Laura Janneck, MD, FACEP
Nikkole Turgeon, BS
Disaster Medicine Section
Diversity, Inclusion, & Health Equity Section
International Emergency Medicine Section
Social Emergency Medicine Section
Young Physicians Section

SUBJECT: Administration of COVID-19 Vaccines in the Emergency Department

PURPOSE: Advocate for the administration of vaccines against COVID-19 to qualified patients that present to the ED and support development of best practices addressing vaccine hesitancy and allow for capacity building and integration of COVID-19 vaccination programs in the ED.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, COVID-19 continues to threaten the public health of communities across the United States and around the world; and

WHEREAS, New more contagious variants are experience resurgences in various communities; and

WHEREAS, Vaccination against COVID-19 is the most effective means of controlling the epidemic at a public health level[1]; and

WHEREAS, Vaccination against COVID-19 is highly effective for reducing individual risk of infection[1]; and

WHEREAS, Populations served in emergency departments are often underserved by the larger healthcare system and may have reduced access to COVID-19 vaccinations; and

WHEREAS, There are lower vaccination rates among historically marginalized communities, such as Black and Hispanic people, leaving them at increased risk for coronavirus, potentially leading to widening disparities going forward[2]; and

WHEREAS, Emergency departments often serve as safety nets for vulnerable patient populations and have played a key role many prior public health interventions[3]; and,

WHEREAS, Clinical encounters in the emergency department offer opportunity to discuss patients' questions and concerns about vaccination; and

WHEREAS, Emergency department vaccine distribution initiatives can play a critical role in mitigating the COVID-19 pandemic[4]; therefore be it

RESOLVED, That ACEP advocate for the administration of vaccines against COVID-19 to qualified patients that present to the emergency department (ED); and be it further

RESOLVED, That ACEP support the development of best practices for discussing COVID-19 vaccines with patients, clinical decision making around when to administer the vaccine, building capacity to administer vaccines to emergency department patients, and integrating ED vaccination programs into larger community vaccination efforts.

References

1. Centers for Disease Control and Prevention // Key Things to Know About COVID-19 Vaccines https://www.cdc.gov/coronavirus/2019-ncov/vaccines/keythingstoknow.html?s_cid=10493:cdc%20covid%20vaccine:sem.ga:p:RG:GM:gen:PTN:FY21 Accessed July 19th, 2021.
2. Kaiser Family Foundation. Latest data on COVID-19 vaccinations by race/ethnicity. Published July 8th, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-race-ethnicity/ Accessed July 19th, 2021.
3. Bernstein SL, D'Onofrio G. Public health in the emergency department: Academic Emergency Medicine consensus conference executive summary. Acad Emerg Med. 2009 Nov;16(11):1037-9. doi: 10.1111/j.1553-2712.2009.00548.x. PMID: 20053218.
4. ACEP // ACEP Toolkit for COVID-19 Emergency Department (ED) Vaccination Programs https://www.acep.org/contentassets/0d59136e8d4f48e19019a3874c0c5f80/acep-ed-covid-vaccine-toolkit.4.19.pdf Accessed July 19th, 2021.

Background

This resolution calls for ACEP to advocate for the administration of vaccines against COVID-19 to qualified patients that present to the ED and support the development of best practices addressing vaccine hesitancy and allow for capacity building and integration of COVID-19 vaccination programs in the ED.

Emergency departments see more than 150 million patients per year, some of whom have limited access to primary care. Therefore, EDs serve as a critical access juncture for those who may or may not have access to primary care or have other established linkages to the health care system and care. Patients coming to the ED may or may not have found the opportunity to get vaccinated and/or are hesitant. While emergency departments provide emergent care and traditionally do not address public health needs, there is some precedence for EDs giving vaccines (e.g., tetanus) and engaging in public health initiatives (e.g. offering HIV screening). ACEP supports emergency department based COVID vaccine programs and offers its members tools and resources to be vaccine advocates. Emergency physicians know that the option to get a vaccine in the ED can be an important opportunity to protect patients and promote public health and safety. As emergency physicians, ACEP members can help increase the number of people who are vaccinated. ACEP encourages its members to consider working with their emergency departments and institutions to provide vaccines to appropriate patients.

ACEP supports and advocates for ED-based COVID-19 vaccination programs and has developed and continues to update and adapt education, tools, and resources for its members to enable them to establish COVID-19 vaccination programs out of their EDs, hospitals, and institutions.

In 2020, ACEP received a federal grant from the CDC: “Frontline National Partnership to Control and Prevent Infectious Disease Threats.” Funding from this grant has been utilized to combat the COVID-19 pandemic but creating resources, tools, best practices and maintain an online resource centers, advocating and creating awareness, targeted towards both physicians and the public, and host virtual learning opportunities, live and on demand.

There are multiple open access resources that are currently available to ACEP members and anyone who is interested:

- COVID-19 Vaccination Toolkit
- COVID-19 ED Vaccination Program Resource center
- ACEP Toolkit for COVID-19 Emergency Department (ED) Vaccination Programs
- COVID-19 Vaccination Smart Phrases Now in Several Languages
- ACEP Field Guide Chapter on Vaccinations and Prevention
- COVID-19 Vaccine Resource Center
- Webinar: COVID-19 Vaccinations in the Emergency Department (on demand)

ACEP has also developed numerous resources addressing vaccine hesitancy:

- Patient Poster and Flyer from ACEP's Diversity and Inclusion Section

- Webinar: This Is Our Shot: How EM Docs Can Empower Patients to End the Pandemic (on demand)
- ACEP's Public COVID-19 Vaccine Information Center
- The Language of COVID-19 Vaccine Acceptance

We have had more than 100 members access the webinars and the number of EDs providing COVID-19 Vaccination continues to increase. ACEP continues to advocate for COVID-19 vaccinations (including prioritization of emergency physicians for the COVID-19 Booster):

- ACMT/AAEM/ACEP Joint Statement in Support of COVID-19 Vaccine
- ACEP support of the Joint Statement in Support of COVID-19 Vaccine Mandates for All Workers in Health and Long-Term Care
- Vaccine related Press Releases:
  - ACEP Urges FDA to Prioritize Emergency Physicians for COVID-19 Booster (August 13, 2021
  - Emergency Physicians Increase their Calls for Concerns around COVID-19 Delta Variant and Support Mandate to Vaccinate Healthcare Workers (July 28, 2021)
  - Emergency Physicians Encourage Vaccines and Vigilance in Face of New COVID Surge (July 21, 2021)

ACEP Now articles:
- COVID-19 Vaccine Hesitancy Info and Tips (May 18, 2021)
- Opinion: Let's Give Vaccination Programs a Shot (February 24, 2021)

Annals of Emergency Medicine publications:
- Research Forum Special Edition: COVID 2021 Abstracts
  - Implementation of an Ed-Based COVID-19 Vaccine Program. Maloney, G. et al. Annals of Emergency Medicine, Volume 78, Issue 2, S34
  - COVID-19 Vaccine Hesitancy Among Emergency Department Patients and Caregivers in New York City. Guzman, C. et al. Annals of Emergency Medicine, Volume 78, Issue 2, S12
  - Implementation of a COVID-19 Vaccine Emergency Department Education Program for Underserved Communities: A Pilot Quality Improvement Project. Bischof, J.J. et al. Annals of Emergency Medicine, Volume 78, Issue 2, S13
  - Perceptions of the COVID-19 Vaccine Amongst Health Care Workers in a Southeast Michigan Hospital: A Cross-Sectional Survey. Choi, T. et al. Annals of Emergency Medicine, Volume 78, Issue 2, S34 - S35
- The Rapid Evaluation of COVID-19 Vaccination in Emergency Departments for Underserved Patients Study. Rodriguez, Robert M.Nichol, Graham et al.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
- Objective H – Position ACEP as a leader in emergency preparedness and response.

Fiscal Impact

Budgeted committee and staff resources and funding from a CDC grant.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 43(21)

SUBMITTED BY: Paul D. Kivela, MD, MBA, FACEP
California Chapter

SUBJECT: Autonomous "Shared Governance" Due Process

PURPOSE: Directs ACEP to adopt and promote a practice of "shared governance based due process."

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Increasing numbers of emergency physicians are not owners of the medical practices and are either in independent contractor or employed status; and

WHEREAS, Many physicians were arbitrarily or punitively furloughed during the COVID-19 pandemic; and

WHEREAS, There are multiple examples during COVID that emergency physicians were not able to speak up about quality or their own personal safety without risk of losing their jobs; and

WHEREAS, The legal owners and/or decision makers of whom staffs are often not practicing physicians; and

WHEREAS, ACEP has made this a priority item by helping to sponsor federal legislation on due process; and

WHEREAS, The corporate practice of medicine doctrine encapsulates the principle that physicians must make decisions autonomously and although its application varies in the roughly 30 states that follow it, the basic idea is that a business corporation may not practice medicine or employ physicians or other clinical personnel to provide professional medical services; and

WHEREAS, Many emergency physicians have contracts that require them to forego their due process rights afforded other specialties; and

WHEREAS, Many medical groups/employers engage in a process of simply not scheduling a physician or arbitrarily removing them from a schedule instead of granting them a hearing; and

WHEREAS, It has been reported that some corporate entities are replacing emergency physicians with lower cost providers such as nurse practitioners and/or physicians assistants; and

WHEREAS, With an expected incoming surplus of emergency physicians, corporate entities may resort to replacing hire compensated experienced emergency physicians with lower cost providers; and

WHEREAS, Typical due process hearing are expensive and potentially punitive to the individual physician by being reportable to the National Practitioner Data Bank; and

WHEREAS, It is common sense that the practicing physicians at a contract have better insight to the standards of care in that community than administrators; and

WHEREAS, There is a similar paradigm in nursing where shared governance is a professional practice model that promotes nursing empowerment and shared decision making by making staff nurses accountable for decisions that impact policies, procedures, and processes at the point of care; therefore be it

RESOLVED, That ACEP adopt and promote a practice of "shared governance based due process" that has the following general qualities and that it applies to:

1. Employees of a hospital or health system.
2. Independent contractors or employees of a large group with a MSO
3. Independent contractors or employees of a small group

Definitions

1. Individual Physician (IP) requesting due process.
2. Management Service Organization (MSO) or individual or entity that makes decisions, negotiates contracts, or provides management. services. This can also apply to administrative physicians in small group or deans/chairs/administrative faculty.
3. Practicing physicians in Physician Group (PPG) would be the entity deciding that outcome of the IP and be limited to the physicians practicing in the group at that hospital in that department. Their vote would be based on number of clinical hours worked in the past six months. Groups could establish some type of seniority multiplier based on years worked or full votes to each full-time clinical physician based on a minimum hours such as 80/hours a month.

The hospital, health system, medical group, or MSO would still arrange and sign contracts with individual physicians (IP). However, in the event a hospital administration, MSO, or health system requests the immediate removal of an IP, or removes them from the schedule, or fails to schedule them for their usual numbers of shifts, the IP would have the opportunity to have a hearing before the PPG. The PPG would then determine if the IP should be immediately terminated or removed from the schedule. The proceedings/vote would be confidential, but results would be reported to the MSO. If the MSO or IP disagrees with the decision, the MSO or IP could still initiate a hospital medical staff due process complaint (if available to them), arbitration process, or legal remedy.

Background

The resolution directs the College to adopt and promote a practice of "shared governance based due process" as detailed in the resolved clause.

The shared governance (SG) concept is not uncommon among nursing staff in the hospital setting. According to an article from the Association for Nursing Professional Development (ANPD) entitled "Shared Governance: What it Is and Is Not," "shared governance is a structure and process for partnership, equity, accountability, and ownership. It puts the responsibility, authority, and accountability for practice-related decisions into the hands of the individuals who will operationalize the decision."

Some research suggests that the shared governance model has increased nurse job satisfaction and quality of care. A 2016 study in the Journal of Nursing Administration ("Nurse Engagement in Shared Governance and Patient and Nurse Outcomes") concluded that "Improving nurse engagement in SG may serve as a transformational leadership strategy to improve the patient experience—an outcome directly tied to reimbursement. Of additional financial interest to hospital administrators, greater involvement of nurses in SG is also associated with outcomes related to nurse retention and nurse-reported quality and safety of patient care."

While this structure empowers nurses to have meaningful input into decisions impacting their point-of-care practices, there are limitations on how much governance is shared. The ANPD article notes that "all involved in shared governance must have clarity that there are structures, processes, and outcomes that leadership will continue to have responsibility for, such as regulatory requirements, immediate safety concerns, performance management, and operations decisions such as hiring, salary, staffing, etc. Decisions related to practice are the ones that should be decided in a shared decision-making model."

Developing a shared governance model for physician group practices to include processes that ensure due process protections may be an extension of the typical shared governance model seen in the nursing community. The author of

the resolution provided these additional details about how such a program would work and pros and cons of the concept:

> "Nothing in this proposed solution would prevent the hospital or other entity from referring the IP to the hospital peer review, hospital-based due process, or outside third party or suspending an impaired physician or someone that provides an immediate danger to patient care. Administrative accusations would be transparent (not be subject to any confidentiality) and not be subject to any protections if done in bad faith."
>
> PROS:
> 1. Inexpensive and rapid
> 2. Not reportable to NPDB unless involves quality of care issue
> 3. Rests control to the actual doctors working the clinical shifts
> 4. Gives some innate whistleblower protections by establishing group protection
> 5. Protects physicians from impulsive and punitive moves by administration
>
> CONS:
> 1. Gives some legal protections and at the same time accountability to administration and practicing physicians
> 2. Administration/MSO can still initiate clauses of contract or not renew an IP or terminate the group
> 3. Might only give IP as little as 90 days-notice (based on contract) or as short as posted scheduled shifts. Nothing stops future non-scheduling unless number of shifts/hours written into contract."

ACEP has been working actively to improve due process protections for emergency physicians. In 2018, ACEP and seven other emergency medicine organizations signed a letter to then CMS Administrator Seema Verma. The letter noted that "Whether employed by hospitals or contracted groups, emergency physicians are often deprived of their due process rights via inclusion of a 'waiver of due process rights' clause in employment contracts. The letter requested CMS to guarantee physician due process rights by making them unwaivable and irrevocable. Also in 2018, ACEP and the other emergency medicine organizations supported the introduction of legislation that would prohibit the mandatory waiver of due process rights which many emergency physicians are forced to comply with as a condition of employment. An ACEP press release issued after introduction of the legislation quoted then president Dr. Paul Kivela, who stated "This is an important safeguard that will ensure all emergency physicians have access to a fair due process procedure."

The bill was introduced again in the 116th Congress as H.R. 6910, the "ER Hero and Patient Safety Act." A letter from then ACEP President Dr. William Jaquis was sent to the bi-partisan cosponsors of the new bill, Congressmen Raul Ruiz and Roger Marshall, reaffirming ACEP's support for legislation to ensure every emergency physician has due process rights. The letter notes, "The threat of termination or the actual termination of physicians without the right of a fair hearing prevents emergency physicians from fully advocating for their patients for fear of retribution. For these reasons, ACEP believes that all emergency physician contracts should include a due process clause regardless of whether those physicians are directly employed by a hospital or they provide emergency medical services at a hospital through a group or individual contract." ACEP is working to reintroduce the bill again in the current 117th Congress.

During the pandemic, emergency physicians have faced new threats to their employment. In a statement issued by ACEP, Dr. Jaquis stated, "Emergency physicians are prepared to handle virtually anything thrown at us as we seek to treat and heal our patients, however, we should not be forced to put our own lives at risk and have our jobs threatened simply for wearing our own supplied protective equipment."

ACEP's policy statement "Emergency Physician Contractual Relationships" includes the following provisions:

- ACEP supports the emergency physician receiving early notice of a problem with his or her performance and an opportunity to correct any perceived deficiency before disciplinary action or termination is contemplated.
- All entities contracting with or employing emergency physicians to provide clinical services, either indirectly or directly, should ensure an adequate and fair discovery process prior to deciding whether or not to terminate or restrict an emergency physician's contract or employment to provide clinical services.
- Emergency physicians employed or contracted should be informed of any provisions in the employment contract or the contracting vendor's contract with the hospital concerning termination of a physician's ability

to practice at that site. This includes any knowledge by the contracting vendor of substantial risk of hospital contract instability.

- Emergency physician contracts should explicitly state the conditions and terms under which the physician's contract can be reassigned to another contracting vendor or hospital with the express consent of the individual contracting physician.
- The emergency physician should have the right to review the parts of the contracting entities' contract with the hospital that deal with the term and termination of the emergency physician contract.

The policy statement has an accompanying Policy Resource and Education Paper (PREP), which states in part: "The core issue behind language in emergency medicine contracts having to do with termination of the physician's ability to practice is that of due process. Due process refers to the right to have a fair hearing, including input from the affected physician, prior to any decision being made about termination of the ability to practice (specifically the loss of hospital medical staff privileges). The concept of due process is felt to support the independence of a physician in advocating for patients without undue influence from extrinsic forces and preserves the sanctity of the physician-patient relationship. These forces may include non-medical concerns, such as financial, marketing, or political interests."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" addresses the due process issue with revised language adopted in April 2021 that now states in part:

> "8. Emergency physicians are entitled to due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges or their ability to see patients. Emergency physicians' medical and/or clinical staff privileges should not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law."

ACEP staff is developing a questionnaire to be distributed to all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products in which they are asked to voluntarily provide information about their organizations. The questionnaire includes an attestation that the entities fully adhere to several ACEP policy statements as they pertain to the emergency physicians in their group, including "Emergency Physician Rights and Responsibilities" and "Emergency Physician Contractual Relationships."

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Objective H – Strengthen job security and opportunity for individual members at all stages of their careers.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors. The resolution called for the College to adopt a policy prohibiting members from denying another emergency physician the right to due process regarding their medical staff privileges and prohibits members from holding management positions at entities that deny an emergency physician this right. The resolution further called for wording changes in the policy statement "Emergency Physician Rights and Responsibilities" and the adoption of a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians.

Resolution 45(13) Revision of "AMA Principles for Physician Employment" referred to the Board of Directors. The resolution called for ACEP to work to amend the AMA Principles for Physician Employment to state that no physician employment agreement should limit a physician's right to due process as a member of the medical staff if terminated. The AMA Section Council on Emergency Medicine recommended that the AMA Organized Medical

Staff Section (OMSS) review the information and potentially submit a resolution to the AMA Interim Meeting in November 2014. However, AMA staff reported that the AMA amended the Principles for Physician Employment in June 2014 to address the issue of automatic termination of staff privileges following termination of an employment agreement (sections 3e and 5f) based on a report from the OMSS Governing Council that outlined the rationale for the amended language.

Resolution 29(11) Due Process for Emergency Physicians adopted. Called for ACEP to review and update the policy statement “Emergency Physician Contractual Relationships” regarding due process and distribute the updated policy to the American Hospital Association, the American College of Health Care Executives and other entities.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted. Called for ACEP to develop model language for emergency physician employment contracts addressing termination for any emergency physician subjected to adverse action related to involvement in quality/performance improvement, patient safety, or other medical staff activities, and specifying due process for physicians subjected to such adverse action.

Resolution 17(03) Certificate of Compliance referred. The resolution called for ACEP to require emergency physician staffing groups to comply with terms of a certificate as a prerequisite for being an exhibitor or sponsor for any ACEP activity. The certificate included multiple provisions that groups must attest to including “With the provisional period not to exceed one year, our physician group provides our emergency physicians access to predefined due process.”

Amended Resolution 14(02) Emergency Physician Rights and Self-Disclosure defeated. The resolution called for ACEP to require exhibitors, advertisers, grant providers and sponsors who employ emergency physicians as medical care providers to disclose to their program audience their level of compliance with ACEP policies addressing due process and other emergency physician rights outlined in the policy statements “Emergency Physician Rights and Responsibilities,” Emergency Physician Contractual Relationships,” “Agreements Restricting the Practice of Emergency Medicine,” and “Compensation Arrangements for Emergency Physicians.” It would require that those claiming to be in substantial compliance with the policies must be able to support the claims by producing documentation for review, and those whose self-disclosure is determined through due process to be false would be prohibited from sponsoring, exhibiting, or advertising with ACEP.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted. The resolution called for ACEP to continue to study the issue of contract management groups and determine what steps should be taken by ACEP to more strongly encourage a fair and equitable practice environment and report back to the Council, and to continue to promote the adoption of the principles outlined in the “Emergency Physician Rights and Responsibilities” policy statement by the various emergency medicine contract management groups, the American Hospital Association and other pertinent organizations.

Substitute Resolution 10(01) Commercial Sponsorships adopted. The substitute resolution called for ACEP to continue initiatives to develop and implement policies on self-disclosure by sponsors, grant providers, advertisers, and exhibitors at ACEP meetings regarding their compliance with ACEP physicians’ rights policies.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted. Called for ACEP to endorse the right to have due process provisions in contracts between physicians, health systems, health plans and contract groups.

Resolution 59(95) Due Process for Emergency Physicians referred to the Board of Directors. The resolution called for ACEP to support, and incorporate into educational and advocacy efforts, promotion of the concepts of due process in all employment arrangements for emergency physicians, that any emergency physician being terminated has the right to receive the reasons for such termination and to formally respond to those reasons prior to the effective date of the termination.

Amended resolution 54(94) Due Process adopted in lieu of resolutions 52(94) Due Process Exclusion Clause and 54(94) Due Process. The amended resolution called for the College to study the issue of peer review and due process exclusion clauses in emergency physician contracts and report back to the Council.

Resolution 52(94) Due Process Exclusion Clauses not adopted. This resolution called for ACEP to lobby to ban peer review and due process exclusion clauses from emergency physician contracts. Amended Resolution 54(94) was adopted in lieu of 52(94).

Resolution 38(90) Due Process Rights of Hospital Based Physicians not adopted. This resolution called for ACEP to work with TJC to develop standards to protect due process rights of hospital-based physicians.

Prior Board Action

June 2021, approved developing and distributing a questionnaire to all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products in which they are asked to voluntarily provide information about their organizations.

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised and approved October 2015, April 2008, July 2001; originally approved September 2000.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, and August 1993 with the current title; originally approved October 1984 titled "Contractual Relationships between Emergency Physicians and Hospitals."

July 2019, reviewed the updated information paper "Fairness Issues and Due Process Considerations in Various Emergency Physician Relationships;" revised June 1997, originally reviewed July 1996.

September 2018, approved the policy statement "Due Process for Physician Medical Directors of Emergency Medical Services."

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

Resolution 29(11) Due Process for Emergency Physicians adopted.

Amended Resolution 30(11) Emergency Physician Contracts and Medical Staff Activities/Membership adopted.

September 2004, approved a report to the Council with a letter from the Federal Trade Commission regarding issues raised in Resolution 17(03) Certificate of Compliance and Resolution 18(03) Intention to Bid for Group Contract and agreed to take no further action on the resolutions.

Amended Resolution 14(01) Fair and Equitable EM Practice Environments adopted.

Substitute Resolution 10(01) Commercial Sponsorships adopted.

Amended Resolution 20(00) Due Process in Contracts Between Physicians and Hospitals, Health Systems, and Contract Groups adopted.

Amended Resolution 54(94) Due Process adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Practice Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 44(21)

SUBMITTED BY: Lauren Apgar, DO
Leslie Gailloud
Logan Jardine, MD, MPH
Hannah Janeway, MD
Diversity, Inclusion, & Health Section
Social Emergency Medicine Section
Young Physicians Section

SUBJECT: Caring for Transgender and Gender Diverse Patients in the Emergency Department

PURPOSE: 1) Promote equitable and culturally competent treatment of transgender and gender diverse patients in the ED; 2) compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the ED; 3) encourage hospitals to provide adequate and appropriate education, training, and resources to all ED physicians on the needs and best practices related to care of transgender and gender diverse patients; and 4) encourage EDs to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

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

WHEREAS, Transgender (TGD) is a gender identity that is different from the sex assigned at birth and gender diverse (e.g., non-binary, gender queer, gender non-conforming, agender, gender fluid, two spirit) is used by people who do not identify exclusively as male or female[1]; and

WHERAS, TGD patients experience higher rates of suicide, substance use disorder, poverty, homelessness, HIV, unemployment, victimization, and are less likely to have health insurance than heterosexual or LGB individuals[2,3,4,5]; and

WHEREAS, The emergency department serves as a safety-net for many vulnerable populations; and

WHEREAS, TGD patients have negative experiences in the emergency department related to their gender identity[2,3,4]; and

WHEREAS, TGD patients often avoid seeking emergency medical care due to past negative experiences or due to fear of discrimination and bias related to their gender identity[2,3,4]; and

WHEREAS, There is limited graduate and post-graduate medical education on the appropriate treatment of TGD patients[6,7]; and

WHEREAS, There are limited continuing medical education courses and resources on how to care for patients presenting the emergency department; therefore be it

RESOLVED, That ACEP promote the equitable, culturally competent, and knowledgeable treatment of transgender and gender diverse patients receiving care in the emergency department; and be it further

RESOLVED, That ACEP compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the emergency department; and be it further

RESOLVED, That ACEP encourage hospitals to provide adequate and appropriate education, training, and resources to all emergency department physicians on the needs and best practices related to care of transgender and gender diverse patients; and be it further

RESOLVED, That ACEP encourage emergency departments to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

References

1. Apa.org. 2015. Key Terms and Concepts in Understanding Gender Diversity and Sexual Orientation Among Students. [online] Available at: <https://www.apa.org/pi/lgbt/programs/safe-supportive/lgbt/key-terms.pdf> [Accessed 20 July 2021].
2. Bauer et. al. Reported Emergency Department Avoidance, Use and Experiences of Transgender Persons in Ontario, Canada: Results from a Respondent- Driven Sampling Survey, Ann Emerg Med. 2014;63:713-720
3. Chisolm-Straker M, Jardine L, Bennouna C, Morency-Brassard N, Coy L, Egemba MO, Shearer PL. Transgender and Gender Nonconforming in Emergency Departments: A Qualitative Report of Patient Experiences. Transgend Health. 2017 Feb 1;2(1):8-16. doi: 10.1089/trgh.2016.0026. PMID: 28861544; PMCID: PMC5367487.
4. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality
5. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality
6. Moll J, Krieger P, Moreno-Walton L, Lee B, Slaven E, James T, Hill D, Podolsky S, Corbin T, Heron SL. The prevalence of lesbian, gay, bisexual, and transgender health education and training in emergency medicine residency programs: what do we know? Acad Emerg Med. 2014 May;21(5):608-11. doi: 10.1111/acem.12368. PMID: 24842513.
7. Obedin-Maliver J, Goldsmith ES, Stewart L, White W, Tran E, Brenman S, Wells M, Fetterman DM, Garcia G, Lunn MR. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. JAMA. 2011 Sep 7;306(9):971-7. doi: 10.1001/jama.2011.1255. PMID: 21900137.
8. Lech, Christie A. EMRA Transgender Care Guide. Emergency Medicine Residents' Association, 2018.
9. Janeway H, Coli CJ. Emergency care for transgender and gender-diverse children and adolescents. Pediatr Emerg Med Pract. 2020 Sep;17(9):1-20. Epub 2020 Sep 2. PMID: 32805092.
10. "AACAP Statement Responding to Efforts to Ban Evidence-Based Care for Transgender and Gender Diverse Youth." Aacap.org, The American Academy of Child & Adolescent Psychiatry , 8 Nov. 2019, www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx.
11. "AAMC Statement on Gender-Affirming Health Care for Transgender Youth." AAMC, Association of American Medical Colleges, 9 Apr. 2021, www.aamc.org/news-insights/press-releases/aamc-statement-gender-affirming-health-care-transgender-youth.
12. Rafferty J; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; COMMITTEE ON ADOLESCENCE; SECTION ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH AND WELLNESS. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. Pediatrics. 2018 Oct;142(4):e20182162. doi: 10.1542/peds.2018-2162. Epub 2018 Sep 17. PMID: 30224363.

Background

This resolution asks ACEP to: 1) promote equitable and culturally competent treatment of transgender and gender diverse patients in the ED; 2) compile information on the unique needs and best practices related to care of transgender and gender diverse patients in the ED; 3) encourage hospitals to provide adequate and appropriate education, training, and resources to all ED physicians on the needs and best practices related to care of transgender and gender diverse patients; and 4) encourage EDs to foster and develop practices and policies that uphold supportive and inclusive environments and remove structural barriers to care.

The March 2014 issue of *ACEP Now* article *"Transgender Patients in the ED"* brings to light the negative experiences and discrimination transgender patients experience due to the biases of health care providers. It outlines the importance of thoughtful communication with this patient population and the need to continue to educate through evidence-based guidelines to ensure quality care is given to address the unique needs of this specific patient population.

ACEP's course Emergency Care for Transgender Patients focuses on caring for transgender patients. The Emergency Medicine Residents' Association has created the Transgender Care Guide that provides basic medical knowledge and terminology and is directed to residents. This resolution requests that ACEP develop comprehensive resources for attending physicians and include a review of recent literature while ensuring the focus of education is directed specifically on post-operation care.

ACEP has received two grants opportunities that are focused on developing non-CME digital resources in the area of diversity and health equity. As a part of a webinar series, supported by Bristol-Myers Squibb, ACEP will host a webinar panel session, scheduled for Fall 2021, that will discuss the needs of the transgender community. The recording will then be available as enduring content and will be promoted to members as a learning opportunity.

AstraZenenca has also provided support to ACEP to create a series of non-CME micro education mirroring the same topics of the webinar series. Micro education is a new digital resource that ACEP is developing as another medium to educate members by creating short, 60-90 second videos highlighting the clinical pearls developed through other educational pieces, such as webinars, CME activities, point of care tools, policies, etc. The webinar developed on transgender care will be converted into micro education content that will be available on the ACEP website and social media channels.

ACEP's policy statement " Non- Discrimination and Harassment" advocates for tolerance and respect for the dignity for all individuals and opposes all forms of discrimination against and harassment of patients and emergency medicine staff on the basis of an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, sexual orientation, or any other classification protected by local, state, or federal law.

The information paper "Disparities in Emergency Care" includes three recommendations that directly supports the need for continued education related to cultural competence, clinical decision-making, and knowledge gaps among physicians that lack post-graduate education in emergency medicine:

1. Promote the evidence-based teaching of cultural competency.
2. Emphasize the use of clinical decision tools that standardize the approach to risk stratification and potentially reduce subjective bias.
3. Explore initiatives that address the "knowledge disparity" between rural and urban providers of emergency services, including providers who do not have post-graduate training in emergency medicine

ACEP's policy statement "Cultural Awareness and Emergency Care" supports that cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP's position that resources be made available to emergency departments and emergency physicians to ensure they properly respond to the needs of all patients regardless of background.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

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

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Substitute Resolution 41(05) Non-Discrimination adopted. The resolution expressed ACEP's opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

Prior Board Action

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved

April 2020; reaffirmed April 2014; approved April 2008 with the current title' originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018 and April 2012 with the current title; originally approved October 2005 titled "Non-Discrimination."

October 2017, reviewed the information paper "Disparities in Emergency Care."

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

Background Information Prepared by: Riane Gay, MPA, CAE
Director, Corporate Development

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 45(21)

SUBMITTED BY: Quality Improvement & Patient Safety Section
Rural Emergency Medicine Section
Massachusetts College of Emergency Physicians
Rhode Island Chapter
Wisconsin Chapter

SUBJECT: ED Performance Measures Data for Small, Rural, and Critical Access Hospital EDs

PURPOSE: Define the essential operational and quality metrics that could be used for managing small, rural, or critical access hospitals and to provide regional performance measure data to the emergency departments (EDs) within these facilities in the form of free, basic, annual reports.

FISCAL IMPACT: Unbudgeted costs for additional staff and investment building the new quality measures (range $50,000 to $100,000 per measure) and into the Clinical Emergency Department Data Registry cloud infrastructure and reporting capabilities.

WHEREAS, ACEP has long championed a data-driven approach to ED management and quality improvement[1-5]; and

WHEREAS, Emergency physicians in leadership roles (i.e., medical director or patient safety officer) are commonly tasked by hospital administration with continuously improving ED efficiency and quality; and

WHEREAS, Basic performance measure data is an essential tool for operating a modern ED and fostering a departmental culture of continuous quality improvement[7-8]; and

WHEREAS, Department-level funding for efficiency and quality improvement projects is contingent upon provision of regional performance measure statistics in order to show a gap in practice standards and define improvement goals; and

WHEREAS, Multiple organizations (some affiliated with ACEP) provide subscription-based services for ED performance measure data, such as the Emergency Department Benchmarking Alliance (EDBA), Clinical Emergency Data Registry (CEDR), Centers for Medicare & Medicaid Services (CMS), etc.; and

WHEREAS, There is a precedent for ACEP sharing limited ED performance measure data publicly (*ACEPNow* articles, CEDR webinars, Rural Emergency Quality Series, previous Quality Improvement & Patient Safety Section performance measure section grant, etc.); and

WHEREAS, Small, rural, and critical access EDs are an integral part of health care delivery in the United States[6]; and

WHEREAS, Small, rural, and critical access hospital ED physician administrators commonly lack access to subscription-based regional performance measure data due to financial constraints; and

WHEREAS, Releasing an ACEP-curated, limited subset of basic ED performance measure data on an annual basis has the potential to address the data gap for small, rural, and critical access hospital EDs and also advertise the value of CEDR and other subscription-based performance measure services; therefore be it

RESOLVED, That ACEP define the essential operational and quality metrics appropriate for managing a

small, rural, or critical access ED; and be it further

RESOLVED, That ACEP provide regional performance measure data on operational and quality metrics to small, rural, and critical access hospital emergency departments in the form of a free, basic, annual report.

References

1. Strauss, R. and Mayer, T., Strauss and Mayer's emergency department management.
2. Qualified Clinical Data Registry (QCDR) & Clinical Emergency Data Registry (CEDR) Overview https://www.acep.org/globalassets/sites/cedr/cedr-overview.pdf Accessed 05.09.21
3. ACEP Emergency Department Director's Academy Curriculum. https://www.acep.org/edda/GeneralInfo/GeneralInformation/ Accessed 05.09.21
4. EQUAL and Rural Emergency Quality Series. https://www.acep.org/administration/quality/equal/emergency-quality-network-e-qual/list2/ Accessed 05.09.21
5. Quality Driven Emergency Care. https://www.acep.org/administration/quality/ Accessed 05.09.21
6. Bennett, Christopher L., et al. "National study of the emergency physician workforce, 2020." Annals of Emergency Medicine 76.6 (2020): 695-708.
7. Karpiel, Martin S. "Benchmarking facilitates process improvement in the emergency department." Healthcare Financial Management 54.5 (2000): 54-54.
8. Yiadom MYAB, Napoli A, Granovsky M, Parker RB, Pilgrim R, Pines JM, Schuur J, Augustine J, Jouriles N, Welch S. Managing and Measuring Emergency Department Care: Results of the Fourth Emergency Department Benchmarking Definitions Summit. Acad Emerg Med. 2020 Jul;27(7):600-611. doi: 10.1111/acem.13978. Epub 2020 May 8. PMID: 32248605.

Background

The resolution calls on ACEP to define essential operational and quality metrics that could be used for managing small, rural, or critical access hospitals and to provide these facilities with regional performance data on these metrics in the form of free, basic, annual reports.

The resolution indicates that data is unavailable to under-resourced EDs, including small, rural, and critical access hospital EDs, that under-resourced EDs and critical access EDs are often located in low-income or predominantly non-white zip codes, and that if ACEP does not actively work to close the operations and data-gap, then ACEP runs the risk of that gap exacerbating the existing stark health disparity outcomes. ACEP staff, the Quality & Patient Safety Committee (QPSC) & CEDR Committee, collaborate to identify key quality care gaps ideal for measurement at the ED-levels. Together with committee-selected measure subject matter experts, specifications are developed for measure concept. Each specification is then rigorously analyzed against the CEDR database for reliability, feasibility, and usability. The analyses are then presented to QPSC for review, which includes assessments of value to emergency medicine, accuracy, attributability to clinicians and hardships for community, rural, critical access, and safety-net sites. This thorough vetting of measures takes six months to one year internally. Because CMS mandates a minimum of one year of performance data before measures can be nominated for approval (two years if we are developing a concept a part of the Merit-based Incentive Payment System (MIPS)-Value Pathways system), the vetting process must start two-three years in advance of expected measure approval. ACEP staff and both committees continue to collaborate and prioritize new measures with focus on value to smaller, rural sites.

While CEDR has onboarded some small, rural, and critical access ED sites (~10% of CEDR customer sites), the data set is extremely limited to accomplish this task. ACEP would need to invest millions of dollars into site and data acquisition, site on-boarding, data mapping, data refinement, dashboard build-out and delivery, and yearly maintenance of small, rural, and critical access sites. CEDR currently does have customers in rural areas and does help emergency physicians and groups who work in these EDs to meet the requirements of the MIPS. However, this resolution calls on CEDR to broadly expand its data collection and sharing capabilities. Furthermore, the pool of current measures focuses on quality care gaps for which many smaller sites would normally transfer to other specialized facilities (e.g., septic shock, CTPA, thrombectomy). This reduces the value for smaller sites as it limits reportable measures to those which are not outcomes-based. Broadening the number of applicable measures for new rural sites to report on would at best occur on a two-to-three-year delay. The resolution's goal of "of free, basic, annual reports" may be out of scope for CEDR and would likely require expansion of CEDR's functionality and size and/or would require ACEP to explore new streamlined, cost-appropriate solutions.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Fiscal Impact

Unbudgeted costs for additional staff and invest into Quality Measure development (range $50,000 to $100,000 per measure) and Clinical Emergency Department Data Registry cloud infrastructure and reporting capabilities.

Prior Council Action

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to the Board of Directors. The resolution called for ACEP to work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States referred to the Board of Directors. The resolution called in part for ACEP to advocate for the creation of a Critical Access Emergency Center Designation where critical access hospitals no longer exist due to natural disasters or cannot be feasibly maintained.

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted. The resolution called for ACEP to analyze the use of Freestanding Emergency Centers as an alternative care model to maintain access to emergency care in areas where emergency departments in critical access and rural hospitals have closed.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for inclusion of emergency medicine in the National Health Service Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organizations to encourage the development and promotion of rural clerkships/ rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

January 2020, assigned Referred Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine to the Rural Emergency Task Force to review and provide recommendations to the Board to address rural emergency medicine issues.

January 2018, assigned Referred Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States to the Federal Government Affairs Committee for action.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved policy statement "Definition of Rural Emergency Medicine."

Amended Resolution 16(16) Freestanding Emergency Centers as a Care Model for Maintaining Access to Emergency Care in Underserved and Rural Areas of the U.S. adopted.

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

October 2005, adopted Amended Resolution 37(05) Rural Emergency Medicine Workforce.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Substitute Resolution 20(01) Medical Education Debt adopted.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Background Information Prepared by: Pawan Goyal, MD, MHA, FHIMSS
Senior Vice President, Quality

Bill Malcolm, PMP
Clinical Emergency Data Registry Program Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 46(21)

SUBMITTED BY: Stephen Epstein, MD, MPP, FACEP
Jay Mullen, MD, FACEP

SUBJECT: Effects of EM Practice Ownership on the Costs and Quality of Emergency Care

PURPOSE: Study the impact of emergency medicine practice ownership models on the cost and quality of emergency care.

FISCAL IMPACT: Estimated $200,000 to retain a research firm to conduct the research, based on Milliman's bid of $300,000 - $350,000 to conduct a broader range of research, including that called for in this resolution.

WHEREAS, ACEP is currently engaged in determining the ownership of emergency medicine practices throughout the nation; and

WHEREAS, Emergency medicine practice ownership models may impact both the cost and quality of emergency care; therefore be it

RESOLVED, That ACEP study the impact of emergency medicine practice ownership models on the cost and quality of emergency care.

Background

This resolution calls for ACEP to study the impact of emergency medicine practice ownership models on the cost and quality of emergency care.

In October 2019, the Council and the Board of Directors adopted Amended Resolution 58(19) Role of Private Equity in Emergency Medicine:

> RESOLVED, That ACEP study and report annually the market penetration of non-physician ownership, namely private equity, insurance company ownership, hospital ownership, and corporate non-physician ownership and management of emergency groups; and be it further
>
> RESOLVED, That ACEP study and report the effects on individual physicians, ACEP advocacy efforts, of the actions of private equity groups, insurance company ownership, hospital ownership, corporate non-physician ownership and management of emergency physician groups; and be it further
>
> RESOLVED, That ACEP advocate to preserve access to emergency care for patients and protect the careers of emergency physicians in the event of contract transitions, bankruptcy, etc. or other adverse events of their employer/ management company; and be it further
>
> RESOLVED, That ACEP partner with the American Medical Association, other interested national medical specialty societies, and other appropriate bodies to determine the circumstances under which corporate or private equity investment could lead or has led to market efforts that increases the cost of health care to consumers without a commensurate increase in access or quality; and be it further
>
> RESOLVED, That should there be circumstances under which corporate or private equity investment in health care could lead or has led to negative market effects that ACEP work with other interested parties to advocate for corrections to the market.

ACEP created a task force to lead the research aspects of the resolution and the task force began meeting in March

2020. The early work focused on the scope of the research project and the development of an RFP. While the task force was not specifically asked to address the third and fifth resolved statements in Resolution 58(19), there was strong support that pertinent research into possible market effects of different ownership models, particularly as they relate to cost of care and quality of care, should be sought to try to understand the impact, if any, that different models have on the public as well as physicians. The RFP outlined the following goals and objectives:

- Describe various practice models of emergency physicians and their prevalence across the country.
- Describe the pros/cons of each practice model from the standpoint of the physician and the practice and/or hospital.
- Describe any economic impacts to patients or the health care system unique to any practice model.
- Describe the growth and market forces (such as coordination of care, improved profit, decreased cost) leading to changes in ownership of emergency medicine groups.
- Describe how these changes in ownership impact physicians and cost and quality of patient care.
- Discuss how the group management landscape has been impacted by initial ramifications of the COVID-19 pandemic.

The RFP was sent to 12 research consulting firms that were identified as potentially interested and capable of managing the project, as well as to members of the ACEP Research Committee and Research Section. Seven proposals were submitted in response to the RFP. At the recommendation of the task force, the Board approved retaining Milliman, Inc. to conduct the research. While Milliman's bid for the total project was $300,000 to $350,000, the final agreement with Milliman entailed a two-phase approach. Phase 1 called for Milliman to investigate and report on data sources that could provide meaningful data to inform the various research elements sought in the initial proposal and for Milliman to provide a high-level market scan of emergency medicine ownership models. The cost of Phase 1 was $75,000. A decision on whether to proceed with Phase 2, and if so, to what extent, would be made by the Board after its review of the Phase 1 report.

Milliman presented a preliminary report on Phase 1 and options for Phase 2 research to the Board at its January 2021 meeting. Feedback from the Board during the meeting included direction that any Phase 2 work should focus on the impact different group ownership models have on physician compensation and satisfaction. In its final Phase 1 report to the Board in April 2021, Milliman informed the Board that its search for public and proprietary data sources yielded only aggregated or de-identified data that could not provide identifying information on group ownership. Milliman recommended a member survey to ask emergency physicians about the ownership of their groups as well as questions related to their job satisfaction and compensation. It was subsequently determined that such survey questions could be included in ACEP's previously planned member survey to glean that information and that ACEP would not proceed with Phase 2 of the Milliman engagement.

While unable to identify existing data that would provide meaningful group ownership information, Milliman expressed high confidence in its ability to obtain sufficient data to measure impacts on quality of care and cost of care by different ownership models (assuming ownership model was known.) Milliman expressed low and medium confidence in its ability to demonstrate different models' impacts on physician compensation and physician satisfaction, respectively. While the questions on the ACEP member survey addressed job satisfaction and compensation, no additional activity has been undertaken to collect data related to impacts on cost of care or quality of care.

ACEP is undertaking efforts to try to obtain more information about ownership of emergency physician groups. In addition to the questions on the member survey, ACEP is developing a questionnaire to be distributed to all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products in which they are asked to voluntarily provide information about their organizations, including ownership. ACEP leadership has also approached AMA leadership about considering a broader effort to improve transparency of physician ownership information throughout the house of medicine. There is also an effort underway by a member of the task force to try to obtain information on ownership of groups through an exploration and matching of various data including tax identification numbers and national provider identifier numbers. However, it is currently unclear when or if these efforts may provide sufficient data on ownership that would allow for meaningful research into the impacts of different ownership models on the cost and quality of emergency care.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Estimated $200,000 to retain a research firm to conduct the research, based on Milliman's bid of $300,000 – $350,000 to conduct a broader range of research, including that called for in this resolution.

Prior Council Action

Amended Resolution 58(19) Role of Private Equity in Emergency Medicine adopted.

Prior Board Action

April 2021, received the final report on Phase I of the Emergency Medicine Group Ownership Research Project. Determined not to utilize Milliman for Phase 2 of the project and proceed with a survey to obtain data about ownership models and their impact on physician compensation and satisfaction.

January 2021, received a preliminary report on Phase 1 and options for Phase 2 research of the Emergency Medicine Group Ownership Research Project.

September 2020, approved a budget modification of $75,000, funded from operations, for Phase 1 of the Emergency Medicine Group Ownership Research Project and revise the report to the Council regarding Amended Resolution 58(19) Role of Private Equity in Emergency Medicine to include this information and what will be accomplished in Phase 1 of the research project and include providing a report to the Finance Committee and the Council with the findings from Phase 1.

August 2020, approved moving forward with retaining Milliman to perform the research and analysis of the market penetration of various emergency medicine group ownership models and, to the extent possible, identify the impacts of different models on physicians, quality of care, and cost of care.

Amended Resolution 58(19) Role of Private Equity in Emergency Medicine adopted.

Background Information Prepared by: Craig Price, CAE
Senior Director, Practice Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 47(21)

SUBMITTED BY: Megan Dougherty, MD, FACEP
Sarah Hoper, MD, JD, FACEP
Iowa Chapter
Vermont Chapter
American Association of Women Emergency Physicians Section

SUBJECT: Family and Medical Leave

PURPOSE: 1) advocate for paid family leave, including but not limited to supporting the American Medical Association's effort to study the effects of Family Medical Leave Act expansion including paid parental leave (AMA Policy H-405.954); 2) conduct an environmental survey and develop a paper on best practices regarding maternity, paternity, and family leave for emergency physicians; and 3) develop a policy statement in support of paid family leave outside of the language in ACEP's "Family and Medical Leave" policy statement revised in 2019.

FISCAL IMPACT: Budgeted committee and staff resources. Unbudgeted and unknown costs for conducting an environmental survey. The cost will be based on the resources needed.

WHEREAS, The ACEP Council in 2017 adopted a resolution for ACEP to create a policy on paid parental leave and a white paper addressing different ways to pay for paid parental leave, but instead the ACEP "Family and Medical Leave" policy statement was revised and no language in regards to paid parental leave was included and an information paper has not been produced[1]; and

WHEREAS, The United States is one of six out of 193 countries in the United Nations that does not mandate paid maternity leave[2] and 50 countries provide six months or more of paid leave[3]; 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[4]; and

WHEREAS, Only 12% of workers in the private sector get paid maternity leave through their employers[5]; and

WHEREAS, 23% of surveyed women reported taking 2 weeks or less of maternity leave because they could not afford more[6,7]; and

WHEREAS, Women with 12 weeks of paid leave are more likely to breastfeed for six months,[8] women with 12 weeks or more of paid maternity leave have lower rates of post – partum depression,[9] and paid maternity leave is associated with lower infant mortality rates;[10] and

WHEREAS, Fathers that take paternity leave have higher satisfaction with parenting,[11] are more engaged in the care of their children nine months after birth,[12,13,14] children with engaged fathers have fewer behavioral and mental health problems,[15] and longer paternity leave with fathers caring for young children is associated with higher cognitive test scores[14,16]; 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, 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; and

WHEREAS, Unlike previous generations, most family caregivers today work at a paying job in addition to caring for ill family members[16]; and

WHEREAS, If employed caregivers lack the supports and protections needed to manage their dual responsibilities, some make changes to their work life including giving up work entirely, reducing work hours, or taking a less demanding job[17]; and

WHEREAS, Although paid family leave is primarily directed at helping workers balance caregiving responsibilities, effects extend to the workers' financial security and labor force attachment, health (of caregivers and receivers) and productivity related to turnover and absenteeism[18]; therefore be it

RESOLVED, That ACEP advocate for paid family leave, including but not limited to supporting the American Medical Association's effort to study the effects of 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, paternity, and family leave for emergency physicians; and be it further

RESOLVED, That ACEP develop a policy statement in support of paid family leave outside of the language in ACEP's "Family and Medical Leave" policy statement revised in 2019.

References

[1]ACEP Family and Medical Leave Policy Statement Revised June 2019.
[2]UNData. Maternity Leave. http://data.un.org/DocumentData.aspx?id=344
[3]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
[4]Dept of Labor. FMLA is Working. https://www.dol.gov/whd/fmla/survey/FMLA_Survey_factsheet.pdf
[5]Dept of Labor Factsheet: Paid Family and Medical Leave. https://www.dol.gov/wb/paidleave/PDF/PaidLeave.pdf
[6] Wang W, Parker K, Taylor P. Breadwinner Mom. Pew Research Center. http://www.pewsocialtrends.org/2013/05/29/breadwinner-moms/
[7] Dept of Labor Factsheet: Paid Family and Medical Leave. https://www.dol.gov/wb/paidleave/PDF/PaidLeave.pdf
[8] Mirkovic, K *et al.* Paid Maternity Leave and Breastfeeding Outcomes. Birth. Vol 43, Issue 3, September 2016, 233-239.
[9] 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.
[10] 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.
[11]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.
[12]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.
[13]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).
[14]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.
[15]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.
[16]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
[17] Feinberg LF. Paid Family Leave: An Emerging Benefit for Employed Family Caregivers of Older Adults. *Journal of the American Geriatrics Society*. 2019; 67(7):1336-1341.
[18]Wolff JL, Drabo EF, Van Houtven CH. Beyond Parental Leave: Paid Family Leave for an Aging America. *Journal of the American Geriatrics Society*. 2019; 67(7): 1322-1324.

Background

This resolution requests ACEP to advocate for paid family leave, including but not limited to supporting the American Medical Association's effort to study the effects of Family Medical Leave Act expansion including paid parental leave (AMA Policy H-405.954); conduct an environmental survey and develop a paper on best practices regarding maternity, paternity, and family leave for emergency physicians; and develop a policy statement in support of paid family leave outside of the language in ACEP's "Family and Medical Leave" policy statement revised in 2019.

Currently, federal law does not require employers to provide paid family or parental leave. 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 least 1,250 hours of service during the previous 12 months at an employer with at least 50 employees. Many 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. Several states have also 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 provides maximum leave benefit of 50% of an employee's weekly wage for up to eight weeks. 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 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. On April 28, 2021, President Biden announced his support for paid family medical leave though his American Families Plan. The plan calls for the creation a national comprehensive paid family and medical leave program that will bring America in line with competitor nations that offer paid leave programs.

ACEP first adopted a policy statement on "Parental Leave of Absence" in 1990. The current version of the policy statement, revised and approved by the Board of Directors in 2019 and now entitled "Family and Medical Leave," states:

- The health and integrity of working physicians' relationships with parents, children, and family are essential to the physicians' well-being. The ability to respond to family needs promotes work satisfaction and career longevity which, in turn, contributes to higher quality patient care.
- The leaders of physician groups and residency programs, as well as employers, should support these policies actively by informing physicians of their availability and making such leave available without undue delay or administrative burden.
- Emergency physician groups, employers, and emergency medicine residency programs should have written policies that support family leaves of absence. These policies should take into consideration what can be done to support the individual financially, if needed, during the leave of absence. These policies should also apply to a personal serious physical and mental illness, both parents for the birth or adoption of a child, the care of a seriously ill family member, and situations involving either the safety or cohesion of the family.
- Mothers, or primary caregivers of biological or adoptive children, should expect at least twelve weeks without work around the time of their child's birth or adoption; the other parent should expect four weeks at the minimum.
- Flexible work schedules for parents before and after welcoming a new child should be made available whenever possible without disrupting the availability the availability of patient care.

AMA policy entitled "Parental Leave" (H-405.954) 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."

AMA has an additional relevant policy, entitled "Paid Sick Leave" (H-440.823), which 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."

At the 2017 Annual Meeting of the House of Delegates (HOD), Resolution 416-A-17 was referred. Introduced by the New England Delegation and the Minority Affairs Section, Resolution 416-A-17 asked that the American Medical Association (AMA) advocate for: (1) improved social and economic support for paid family leave to care for newborns, infants and young children; and (2) federal tax incentives to support early child care and unpaid child care by extended family members. Board of Trustees Report 27 was submitted to the HOD at the 2018 Annual Meeting and referred back to the Board for further study.

At the 2019 Annual Meeting of the HOD, the following recommendations were adopted in lieu of Resolution 416-A-17 and the remainder of the report filed.

1. That our AMA reaffirm Policy H-440.823, which recognizes the public health benefits of paid sick leave and other discretionary paid time off, and supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member.
2. That our AMA encourage employers to offer and/or expand paid parental leave policies.
3. That our AMA encourage state medical associations to work with their state legislatures to establish and promote paid parental leave policies.
4. That our AMA advocate for improved social and economic support for paid family leave to care for newborns, infants and young children.
5. That our AMA advocate for federal tax incentives to support early child care and unpaid child care by extended family members.

The Council and the Board of Directors adopted Amended Resolution 36(17) Maternity & Paternity Leave. The resolution directed ACEP to advocate for paid parental leave for emergency physicians, develop an information paper on best practices regarding paid parental leave for emergency physicians, and provide a report to the 2018 Council. The resolution was assigned to the Well-Being Committee. The committee had already been assigned an objective to review the policy statement "Family Leave of Absence" as part of the policy sunset review process.

The committee submitted proposed revisions to the "Family Leave of Absence" policy statement to the Board in September 2018. The revisions included tenets of Amended Resolution 36(17). The Board postponed discussion to the January 30-31, 2019, meeting. At their January 2019 meeting, the Board expressed concerns about the impact on small groups, as well as the difficulty in addressing all practice settings, and suggested that the policy be aspirational and not punitive to groups that cannot meet all aspects of the policy. It was also noted that independent contractors should be addressed in the policy statement.

The Board discussed an updated draft of the "Family Leave of Absence" policy statement in April 2019. The Board recommended that the policy statement remain succinct and that additional information be included in a Policy Resource & Education Paper (PREP) instead of an information paper as requested in Amended Resolution 36(17). A PREP is an adjunct to a policy statement and is intended to provide additional background, clarification, education and/or implementation assistance. A PREP may include references, bibliographies, discussion papers,

practice applications, and "how to" information. Additionally, a PREP is subject to the Policy Sunset Review Process along with the policy statement so that the information remains relevant. (Information Papers are not subject to the Policy Sunset Review process.) This has been an ongoing objective for the committee.

In June 2021, a representative from SAEM's Academy of Women in Academic Emergency Medicine (AWAEM), who is also a member of ACEP's Well-Being Committee, approached ACEP about appointing representatives to assist in the development of a document on "Best Practices for Parental Leave for Emergency Physicians." ACEP's president and president-elect discussed the request and approved modifying the Well-Being Committee's objective to work with AWAEM on this document. The committee co-chairs were also informed of this decision. This document will present recommendations for both academic and community emergency medicine. The committee anticipates completion of the paper by the end of 2021.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
  - Tactic 6 – Identify the factors that promote a "well" workplace.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective A – Improve the practice environment and member well-being.
  - Tactic 2 – Update and promote resources on wellness burnout, practice environment improvement, resilience, and work/life balance for members in all stages of their career.

Fiscal Impact

Budgeted committee and staff resources. Unbudgeted and unknown costs for conducting an environmental survey. The cost will be based on the resources needed.

Prior Council Action

Amended Resolution 36(17) Maternity & Paternity Leave adopted. Directed ACEP to advocate for paid parental leave for emergency physicians, develop an information paper on best practices regarding paid parental leave for emergency physicians, and provide a report to the 2018 Council.

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

June 2019, approved the revised policy statement "Family and Medical Leave" with the current title; reaffirmed 2012; revised and approved October 2006, September 1999, and April 1994 titled "Family Leave of Absence;" originally approved June 1990 titled "Parental Leave of Absence."

April 2019, provided comments for addition revisions to the revised policy, "Family Leaveof Absence."

January 2019, provided comments for additional revisions to the revised policy "FamilyLeave of Absence."

October 2018, postponed discussion of the revised "Family Leave of Absence" policy statement to the January 30-31, 2019, Board of Directors meeting.

September 2018, postponed discussion of the revised "Family Leave of Absence" policy statement to the October 4, 2018, Board of Directors meeting.

Amended Resolution 36(17) Maternity & Paternity Leave adopted.

September 1988, Resolution 44(88) adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 48(21)

SUBMITTED BY: Stephen Epstein, MD, MPP, FACEP
Thomas J. Sugarman, MD, FACEP

SUBJECT: Financial Incentives to Reduce ED Crowding

PURPOSE: Study financial and other incentives that might be used to reduce emergency department crowding.

FISCAL IMPACT: Budgeted committee and staff resources. If a task force is needed, $20,000 for one in person meeting. If additional data is needed, costs could range $100-000-200,000 for a third party study.

WHEREAS, Emergency department crowding remains a vexing issue, despite known policy solutions; and

WHEREAS, Emergency department crowding is known to be detrimental to patients; and

WHEREAS, Financial incentives may be necessary to reduce emergency department crowding; therefore be it

RESOLVED, That ACEP study financial and other incentives that might be used to reduce emergency department crowding.

Background

This resolution requests that the College to study financial and other incentives that might be used to reduce emergency department crowding.

Crowding in emergency departments has been reported since at least the 1990's.[1] The literature cites many causes of crowding, commonly broken into inflow (too many patients largely blamed on non-urgent patients), throughput (workflow within the ED) and output (the ability to move a patient to an inpatient bed).[2] Studies have shown that output issues have the greatest impact on crowding. When an inpatient bed is not available, patients "board" in the ED, at times for hours and even days.

The effect of crowding has been studied. It has an impact on the quality of care provided, the number of people who leave without being seen as well as the people who leave without registering (look and go), delay in care, increase in medical errors, increase in mortality, increase morbidity, ambulance diversion, and an increase in hospital length of stay.[2,4-7] There are multiple studies that convincingly show an increase hospital cost and lost hospital and ED revenue.[8-11]

With considerable literature showing increase cost/decrease revenue, the fact that hospitals do not act to reduce boarding remains difficult to understand. In part this lack of action could be the result of not knowing the impact, not believing the impact as it is spread over multiple cost centers, or the concern that the solution could be more costly, more difficult than allowing the situation to remain. Or it may be that the cost to 'fix' crowding is more expensive, more onerous than the revenue loss of boarding itself. In fact, some hospitals may perceive a financial incentive to board because of the difference in reimbursement between patients. Hospitals receive greater reimbursement for a surgical patient than for a medical patient. They receive more for a patient with private insurance than an identical patient with government insurance. And they receive greater reimbursement for a patient out of network (transferred) than a patient in network. Patients admitted through the ED are more likely to be uninsured/underinsured with medical

disorders, and to be in-network. Some institutions even try to save inpatient beds for patients with diagnoses associated with better reimbursement.

Although the hospital may profit overall by boarding patients in the ED, it negatively impacts the profitability of the ED and certainly hurts the revenue generation of emergency physicians compensated on a fee for service or productivity basis.

Boarding has increased with COVID-19, especially during the Delta variant surge. An informal survey of ACEP members in July 2021 showed that 70% reported crowding conditions worse than pre pandemic. During this time period, crowding is more widespread and with greater numbers forcing some EDs to abandon their ED footprint that is now filled with boarders, and see patient hallways, the waiting room, tents and even converted conference rooms and parking lots.

While crowding is a global issue, the cause may vary among countries. The UK, Ireland, Canada, Australia all have some form of 'targets' for ED length of stay. While these have not been uniformly successful, because their healthcare is largely reimbursed from a single source, penalties can be easily assessed. While the US has some of control through CMS and through groups like The Joint Commission, there have been few attempts by these agencies to curtail, or even quantitate, boarding in the ED. There have been a few state-wide programs, most notably the Department of Health for the State of New York who gathered data on the number of boarders in the ED for many years but would not share that data outside the department. Other states such as Massachusetts has done some very credible work, but this issue remains in that state. Solutions such as Full Capacity Protocol, smoothing the OR schedule, discharges out by noon, and 7 day a week hospital programs exist [7] but few hospitals are willing to entertain these, or sustain them over time.

It could be challenging to overcome the perceived financial and personnel incentives already in place. One option would be through the ED Accreditation Program currently being considered by ACEP. A task force has been appointed by ACEP President Mark Rosenberg DO, FACEP. The program is charged with ensuring that a person's "zip code does not define the emergency care they receive." Accreditation programs can be powerful tools to align administration and staff to improve care, in this case, emergency care. While seeking accreditation can be important for market share and to improve the brand of a hospital, losing accreditation can be devastating to an institution and an issue for their Board of Trustees. Measurements of boarding/crowding can be added to the accreditation and progressively require greater attention to boarding.

It also may be possible for ACEP to work with Federal agencies to address the issue of boarding/crowding. Many of these have been involved in prior actions including CMS and The Joint Commission. However, none of the metrics they instituted actually changed conditions within an institution. With new attention on emergency care from the current pandemic, additional meetings with these groups may lead to efforts that actually improve boarding/crowding.

Background References

[1]Gibbs, N. Do You Want to Die? TIME. May 28, 1990:58-65.
[2]Asplin BR, Magid DJ, Rhodes KV, Solberg LI, Lurie N, Camargo CA Jr. A conceptual model of emergency department crowding. *Ann Emerg Med*. 2003;42(2):173-80.
[3]Handel DA, Sklar DP, Hollander JE, et al. Institute of Medicine/Association of American Medical Colleges Panelist Group Society for Academic Emergency Medicine. Association of Academic Chairs in Emergency Medicine Panel. Executive summary: the Institute of Medicine report and the future of academic emergency medicine: the Society for Academic Emergency Medicine and Association of Academic Chairs in Emergency Medicine Panel: Association of American Medical Colleges annual meeting. *Acad Emerg Med.* 2007;14(3):261-7.
[4]Sun BC, Hsia RY, Weiss RE, et al. Effect of emergency department crowding on outcomes of admitted patients. *Ann Emerg Med*. 2013;61(6):605-11.
[5]Rasouli HR, Esfahani AA, Nobakht M, et al. Outcomes of Crowding in Emergency Departments; a Systematic Review. *Arch Acad Emerg Med*. 2019;7(1):e52.
[6]Abir M, Goldstick JE, Malsberger R, et al. Evaluating the impact of emergency department crowding on disposition patterns and outcomes of discharged patients. *Int J Emerg Med.* 2019;12:4.
[7]ACEP EM Practice Committee. Emergency Department Crowding: High Impact Solutions. 2016. Accessed [8]/13/2021.
8Krochmal P, Riley TA. Increased health care costs associated with ED overcrowding. *Am J Emerg Med.* 1994;12(3):265-6.
[9]Bayley MD, Schwartz JS, Shofer FS, et al. The financial burden of emergency department congestion and hospital crowding for chest pain patients awaiting admission. *Ann Emerg Med.*. 2005;45(2):110-7.
[10]Falvo T, Grove L, Stachura R, et al. The opportunity loss of boarding admitted patients in the emergency department. *Acad Emerg Med.* 2007;14(4):332-7.

[11]Falvo T, Grove L, Stachura R, et al. The financial impact of ambulance diversions and patient elopements. *Acad Emerg Med.* 2007;14(1):58-62.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
  - Tactic 2 – Work with organizations including the American Hospital Association, The Joint Commission, CMS, and other medical societies, to identify and remove barriers to the efficient practice of emergency medicine.
  - Tactic 5 – Continue to advocate to measure and reduce boarding and improve patient throughput.

Fiscal Impact

Budgeted committee and staff resources. If a task force is needed, $20,000 for one in person meeting. If additional data is needed, costs could range $100-000-200,000 for a third party study

Prior Council Action

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted. Directed ACEP to work with the U.S. Department of Health and Human Services, the U.S. Public Health Service, The Joint Commission, and other appropriate stakeholders to determine action steps to reduce ED crowding and boarding.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Also directed that ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

Resolution 28(08) Nationwide ED Crowding Crisis not adopted. The resolution directed ACEP members to work with state medical associations and/or health departments to encourage hospitals and health care organizations to develop mechanisms to increase availability of inpatient beds. Salient provisions of this resolution were included in Substitute Resolution 25(08) State Department of Health Crowding Surveys.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted. Directed ACEP to investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding, encourage members to work with their state medical associations and/or state health departments to develop appropriate mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients, identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. Directed ACEP to develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate crowding and treatment delays affecting ED and other hospital patients.

Amended Resolution 26(07) Hallway Beds adopted. The resolution directed ACEP to revise the policy statement "Boarding of Admitted and Intensive Care Patients in the ED," work with state and national organizations to promote the adoption of such policies, and to distribute information to the membership and other organizations related to patient safety outcomes caused by the boarding of admitted patients in the ED.

Resolution 39(05) Hospital Emergency Department Throughput Performance Measure referred to the Board of Directors. Called for ACEP to work with CMS and other stakeholders to develop measures of ED throughput that will

reduce crowding by placing the burden on hospitals to manage their resources more effectively.

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted. Directed ACEP to endorse the concept that overcrowding is a hospital-wide problem and the most effective care of admitted patients is provided in an inpatient unit, and in the event of emergency department boarding conditions, ACEP recommends that hospitals allocate staff so that staffing ratios are balanced throughout the hospital to avoid overburdening emergency department staff while maintaining patient safety.

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted. Directed ACEP to develop a specific strategy to coordinate all activities related to emergency department and hospital crowding to support state efforts, analyze information and experiences to develop a resource tool to assist chapters in efforts to seek solutions to emergency department and hospital crowding at the local level.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. The resolution called for ACEP to meet with appropriate regulatory agencies, including the AMA, JCAHO, and the American Hospital Association and other interested parties to establish monitoring criteria and standards that are consistent with ACEP's policy "Boarding of Admitted and Intensive Care Patients in the Emergency Department." The standard should address the prompt transfer of patients admitted to inpatient units as soon as the treating emergency physician makes such a decision.

Prior Board Action

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

June 2017 approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department;" revised and approved April 2011, April 2008, January 2007; originally approved October 2000.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

June 2016, reviewed the updated information paper, "Emergency Department Crowding High-Impact Solutions"

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper "Crowding and Surge Capacity Resources for EDs."

October 2006, reviewed the information paper "Approaching Full Capacity in the Emergency Department."

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 49(21)

SUBMITTED BY: New York Chapter

SUBJECT: Forced EMS Diversion

PURPOSE: Work with other stakeholders to discourage the use of forced EMS diversion to substitute for system-wide hospital admission load balancing and collect data on the clinical impact of EMS diversion policies.

FISCAL IMPACT: Budgeted committee, section, and staff resources. Potential unbudgeted and unknown costs for a data analyst depending on the type of data to be collected.

WHEREAS, Individual States have imposed surge capacity restrictions on hospitals during the COVID-19 pandemic such that they may not have more than 85% admission capacity for example; and

WHEREAS, Individual hospitals have responded by using EMS diversion in order to comply with strict Department of Health policies regarding hospital capacity; and

WHEREAS, EMS diversion is hazardous to individual patients who may suffer from delays in access to care; and

WHEREAS, EMS diversion should only be activated in situations dictated by conditions in an individual Emergency Department (ED) based on regionally approved polices with input from ED and EMS system leadership; and

WHEREAS, EMS diversion across regions should be managed by the State EMS Medical Director with the knowledge and understanding of the systemwide impact of such diversion; therefore be it

RESOLVED, That ACEP work with other stakeholders to discourage states and hospitals from using forced EMS diversion to substitute for system-wide hospital admission load balancing; and be it further

RESOLVED, That ACEP collect data on the clinical impact of EMS diversion policies.

Background

This resolution calls for the College to work with other stakeholders to discourage the use of forced EMS diversion to substitute for system-wide hospital admission load balancing and collect data on the clinical impact of EMS diversion policies.

Hospital resources such as the emergency department capacity, surgical availability, available critical care beds, and even hospital bedding capacity may occasionally be overwhelming and they may not be able to provide the usual level of care for varying periods of time. There are several factors that may contribute to this problem including a shortage of available health care providers, a lack of hospital-based resources, and an unusually high demand for emergency services. The current COVID-19 pandemic has placed a huge strain on the nation's health care delivery system including the EMS system. EMS diversion is being used as one means to attempt to address this issue.

EMS diversion is not a new phenomenon and has been around since the early 1990s in various forms. The College has addressed EMS diversion issues in the past through various policy statements and a Policy Resource Education Paper

(PREP). These were consolidated with other policy statements in January 2018 into a new policy statement "Emergency Medical Services Interfaces with Health Care Systems" in an effort to reduce the number of single topic policy statements where feasible. The other policy statements that were consolidated addressed related topics such as Emergency Ambulance Destination, EMS Regionalization of Care, and Interfacility Transportation of the Critical Care Patient and Its Medical Direction. The current policy statement addresses EMS destination protocols.

Historically EMS Diversion is most effectively handled at the local or regional level. The medical directors and administration of the local hospitals and EMS services typically meet and agree on a plan to address the specific needs of the local system. Coordination between all involved parties and an agreement to follow a planned solution is essential to the success of the system.

ACEP can collaborate with other stakeholder organizations to discourage states and hospitals from using forced EMS diversion instead of system or regional hospital admission load balancing through means such as developing policy statements, sharing best practices, and encouraging local EMS and healthcare systems to work together to address solutions specific to their local needs. ACEP can monitor the environment through member feedback on the EMS Section engagED site to gauge the level of success or if additional actions are needed. Collecting data on the clinical impact of EMS diversion policies may require the assistance of a data analyst depending on the type of data to be collected.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote for efficient, sustainable, and fulling clinical practice environments
  - Tactic 5 – Continue to advocate to measure and reduce boarding and improve patient throughput.

Fiscal Impact

Budgeted committee, section, and staff resources. Potential unbudgeted and unknown costs for a data analyst depending on the type of data to be collected.

Prior Council Action

Amended Resolution 40(00) Ambulance Diversion adopted. The resolution called for data collection and practice guidelines that address ambulance diversion and effective communications plan for the public.

Prior Board Action

February 2018, approved the policy statement "Emergency Medical Services Interfaces with Health Care Systems;" replaced four rescinded policy statements "Ambulance Diversion," "Emergency Ambulance Destination," "EMS Regionalization of Care," and "Interfacility Transportation of the Critical Care Patient and Its Medical Direction."

Amended Resolution 40(00) Ambulance Diversion adopted.

October 2006, reviewed the information paper "Approaching Full Capacity in the Emergency Department."

October 1999, reviewed by the ACEP Board of Directors the Policy Resource Education Paper (PREP) "Guidelines for Ambulance Diversion"

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 50(21)

SUBMITTED BY: Michael Carius, MD FACEP
Roneet Lev, MD FACEP
Gregory Shangold, MD FACEP
Thomas J. Sugarman, MD, FACEP
Connecticut College of Emergency Physicians
Rhode Island Chapter

SUBJECT: Harms of Marijuana

PURPOSE: Develop a policy statement on the harms of marijuana as seen in EDs and provide education and guidance to emergency physicians for documentation and overall awareness of cannabis-related ED diagnoses.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Several studies have shown that emergency department (ED) visits with a cannabis related diagnosis have increased[1][2][3]; and

WHEREAS, The National Poison Data System reported 28,630 exposures from 2017 – 2019 due to cannabis exposure and 27% of the calls were for children under 10-year-old[4]; and

WHEREAS, Youth access to cannabis has significant long-term and short-term negative effects on cognitive ability and can induce devastating mental health issues; and

WHEREAS, Cannabis induced psychosis is common, especially with current availability of high potency smoked and ingested THC products and daily cannabis use has a 5 times increased odds ratio of developing a psychotic disorder when using high potency cannabis[5][6][7][8][9][10]; and

WHEREAS, ED boarding of psychiatric patients remains a major concern in emergency department across the country, and a percentage of patients with psychosis related ED boarding is due to cannabis related psychosis; and

[1] Monte AA, et al. Acute Illness Associated with Cannabis Use by Route of Exposure: An Observational Study. Annals of Internal Medicine, 2019. https://www.acpjournals.org/doi/10.7326/M18-2809
[2] San Diego Marijuana Prevention Initiative 2020 Report. https://www.ccrconsulting.org/media/attachments/2020/05/04/mpi-report-5.4.2020-corrections.pdf
[3] Shen JJ, et al. Trends and Related Factors of Cannabis Associated Emergency Department Visits in the United States 2006-2014. J Addict Med, 2019.
[4] Dilley JA, Graves JM, Brooks-Russell A, Whitehill JM, Liebelt EL. Trends and Characteristics of Manufactured Cannabis Product and Cannabis Plant Product Exposures Reported to US Poison Control Centers, 2017-2019. *JAMA Netw Open.* 2021;4(5):e2110925. doi:10.1001/jamanetworkopen.2021.10925
[5] Mustonen A, Niemelä S, Nordström T, Murray GK, Mäki P, Jääskeläinen E, Miettunen J. Adolescent cannabis use, baseline prodromal symptoms and the risk of psychosis. Br J Psychiatry. 2018 Apr;212(4):227-233. doi: 10.1192/bjp.2017.52. PMID: 29557758.
[6] Bourque J, Afzali MH, Conrod PJ. Association of Cannabis Use With Adolescent Psychotic Symptoms. *JAMA Psychiatry.* 2018;75(8):864–866. doi:10.1001/jamapsychiatry.2018.1330
[7] Carney, R et al. "Cannabis use and symptom severity in individuals at ultra high risk for psychosis: a meta-analysis." *Acta psychiatrica Scandinavica* vol. 136,1 (2017): 5-15. doi:10.1111/acps.12699
[8] Arianna Marconi, Marta Di Forti, Cathryn M. Lewis, Robin M. Murray, Evangelos Vassos, Meta-analysis of the Association Between the Level of Cannabis Use and Risk of Psychosis, *Schizophrenia Bulletin*, Volume 42, Issue 5, September 2016, Pages 1262–1269, https://doi.org/10.1093/schbul/sbw003
[9] Moore THM, et al. Cannabis use and risk of psychosis or affective mental health outcomes: a systemic review. The Lancet, 2007.
[10] Forti MD, et al. The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe: a multicentre case-control study. The Lancet, 2019.

WHEREAS, Cannabis Hyperemesis syndrome can be a frequent ED diagnosis[11]; and

WHEREAS, Increased use of cannabis leads to increased trauma including motor vehicle fatalities and workplace injuries; and

WHEREAS, Smoking and vaping cannabis is associated with lung injury such as reactive airway disease, pneumothorax, and cancer risk[12][13][14]; and

WHEREAS, Patients may present to the ED with seizures that are exacerbated by cannabis use[15][16]; and

WHEREAS, Patients have presented to the ED with bleeding complications due to drug interactions of anti-coagulants and cannabis use[17]; and

WHEREAS, Many medical organizations have published position statements on cannabis harms related to their specific specialty such as the American Academy of Pediatrics, American College of Obstetrics and Gynecology, American Glaucoma Foundation, American Heart Association, American Lung Association, and International Association for the Study of Pain; and

WHEREAS, ACEP has a public health and education duty for disease prevention, including the harms of marijuana that present to the ED; and

WHEREAS, Some emergency physicians may not be aware of associated cannabis related harms and drugs interactions, thereby under reporting the incidence of cannabis related ED visits; therefore be it

RESOLVED, That ACEP develop a policy statement on the harms of marijuana as seen in emergency department presentations; and be it further

RESOLVED, That ACEP provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses.

Background

This resolution calls for ACEP to develop a policy statement on the harms of marijuana as seen in emergency departments and provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses.

The legalization of both recreational and medicinal use of cannabis continues to be highly controversial, enhanced by conflicting studies demonstrating various effects experienced in states where marijuana use has been legalized. The medical use of cannabis is legalized in thirty-six states, four out of five permanently inhabited U.S. territories, and the District of Columbia. Twelve other states have laws that limit THC content for the purpose of allowing access to products that are rich in cannabidiol (CBD). The recreational use of cannabis is legalized in eighteen states, the

[11] Monte AA, Shelton SK, Mills E, Saben J, Hopkinson A, Sonn B, Devivo M, Chang T, Fox J, Brevik C, Williamson K, Abbott D. Acute Illness Associated With Cannabis Use, by Route of Exposure: An Observational Study. Ann Intern Med. 2019 Apr 16;170(8):531-537. doi: 10.7326/M18-2809. Epub 2019 Mar 26. PMID: 30909297; PMCID: PMC6788289.
[12] Callaghan, R.C., Allebeck, P. & Sidorchuk, A. Marijuana use and risk of lung cancer: a 40-year cohort study. *Cancer Causes Control* **24,** 1811–1820 (2013). https://doi.org/10.1007/s10552-013-0259-0
[13]Boyd CJ, McCabe SE, Evans-Polce RJ, Veliz PT. Cannabis, Vaping, and Respiratory Symptoms in a Probability Sample of U.S. Youth. J Adolesc Health. 2021 Feb 22:S1054-139X(21)00047-1. doi: 10.1016/j.jadohealth.2021.01.019. Epub ahead of print. PMID: 33676824.
[14] Wayne R. Ott, Tongke Zhao, Kai-Chung Cheng, Lance A. Wallace, Lynn M. Hildemann,
Measuring indoor fine particle concentrations, emission rates, and decay rates from cannabis use in a residence,
Atmospheric Environment: X,Volume 10,2021,100106,ISSN 2590-1621, https://doi.org/10.1016/j.aeaoa.2021.100106.
[15] de Havenon, Adam et al. "The secret "spice": an undetectable toxic cause of seizure." *The Neurohospitalist* vol. 1,4 (2011): 182-6. doi:10.1177/1941874411417977
[16] Malyshevskaya, O., Aritake, K., Kaushik, M.K. *et al* Natural (Δ-THC) and synthetic (JWH-018) cannabinoids induce seizures by acting through the cannabinoid CB_1receptor. *Sci Rep* **7,** 10516 (2017). https://doi.org/10.1038/s41598-017-10447-2
[17] Drugs.com drug interaction checker with cannabis and cannabidiol

District of Columbia, the Northern Mariana Islands, and Guam. Another thirteen states and the U.S. Virgin Islands have decriminalized its use. Although the use of cannabis remains federally illegal, some of its derivative compounds have been approved by the Food and Drug Administration (FDA) for prescription use. For non-prescription use, cannabidiol derived from industrial hemp is legal at the federal level, but legality and enforcement varies by state.

Over time the American Medical Association has modified its position on recreational and medicinal use of marijuana through the adoption of new and revised policies that include:

- Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924 (Recently Modified)
- Public Health Impacts of Cannabis Legalization D-95.960 (Recently Modified)
- Regulation of Cannabidiol Products H-120.926 (Recently Modified)
- Cannabis Legalization for Medicinal Use D-95.969
- Cannabis and Cannabinoid Research H-95.952

Recently, ACEP members have published multiple articles and editorials:

- The perils of recreational marijuana use: relationships with mental health among emergency department patients (JACEP Open; March 8, 2020)
- Indications and preference considerations for using medical Cannabis in an emergency department: A National Survey (The American Journal of Emergency Medicine; July 10, 2020)
- Letter to Editor: A National Survey of US Medicine Physicians on their Knowledge Regarding State and Federal Cannabis Laws (Cannabis & Cannabinoid Research; December 2020)
- The emergency department care of the cannabis and synthetic cannabinoid patient: a narrative review (International Journal of Emergency Medicine; February 2021)

ACEP has developed education that is available on demand related to ED presentations related to marijuana, which include:

- Deadly Spice: A CME Now Case Study (352 enrollments)
- Legal and Legit? Vices of the Young:
    - ACEP20 course (30 enrollments)
    - ACEP19 on demand course (68 enrollments)
- Still Dope: New on the Scene 2020:
    - ACEP20 course (95 enrollments)
    - ACEP19 on demand course (64 enrollments)

Based on direction in Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis and recommendation from the Federal Government Affairs Committee, ACEP Supported H.R. 3797, the "Medical Marijuana Research Act of 2019," introduced by Representatives Earl Blumenauer (D-OR) and Andy Harris, MD (R-MD). This legislation was consistent with ACEP policy, amending the Controlled Substances Act to establish a less burdensome registration process specifically for marijuana research, and providing approved researchers with the ability to acquire cannabis needed for their studies. The House of Representatives approved the ACEP-supported "Medical Marijuana Research Act" at the conclusion of the 116th Congress, but it was not enacted into law. This legislation was intended to ensure a supply of marijuana for research purposes through the National Institute on Drug Abuse Drug Supply Program, directed the FDA to issue guidelines on the production of marijuana, and encouraged authorized researchers and manufacturers to produce marijuana. ACEP continues to monitor legislative efforts in the 117th Congress to expand clinical trials of the effects of medical-grade cannabis on the health outcomes of covered veterans diagnosed with chronic pain and those diagnosed with PTSD.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted. Directed ACEP to support rescheduling of cannabis to facilitate well-controlled studies of cannabis and related cannabinoids for medical use.

Resolution 37(18) ACEP Policy Related to "Recreational" Cannabis not adopted. Called for ACEP to align ACEP policy on recreational use of cannabis with current AMA policy on the issue.

Resolution 54(17) Use of Cannabis as an Exit Drug for Opioid Dependency not adopted. Called for ACEP to adopt a policy stating that a chronic pain patient in a pain management program should not be eliminated from the program solely because they use cannabis as recommended by their physician.

Resolution 53(17) Supporting Research in the Use of Cannabidiol in the Treatment of Intractable Pediatric Seizure Disorders not adopted. Directed ACEP to publicly and officially state support for scientific research to evaluate the risks and benefits of cannabidiol in children with intractable seizure disorders who are unresponsive to medications currently available.

Resolution 42(17) ACEP Policy Related to Cannabis not adopted. Directed that ACEP not take a position on the medical use of marijuana, cannabis, or synthetic cannabinoids and not support the non-medical use of marijuana, cannabis, synthetic cannabinoids and similar substances.

Resolution 30(16) Treatment of Marijuana Intoxication in the ED referred to the Board of Directors. Directed ACEP to determine if there are state or federal laws providing guidance to emergency physicians treating marijuana intoxication in the ED; investigate how other specialties address the treatment of marijuana intoxication in clinical settings; and provide resources to coordinate the treatment of marijuana intoxication.

Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use referred to the Board. The resolution directed ACEP to adopt and support a national policy for decriminalization of small amounts of marijuana possession for personal and medical use and submit a resolution to the AMA for national action on decriminalization of possession of small amounts of marijuana for personal use.

Resolution 16(15) Decriminalization and Legalization of Marijuana not adopted. Directed ACEP to support decriminalization for possession of marijuana for recreational use by adults and to support state and federal governments to legalize, regulate, and tax marijuana for adult use.

Resolution 15(15) CARERS Act of 2015 not adopted. Directed ACEP to endorse S. 683 and require the AMA Section Council on Emergency Medicine to submit a resolution directing the AMA to endorse this legislation.

Resolution 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19(14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal;

object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23(13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25(11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 20(10) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 16(10) Classification Schedule of Marijuana as a Controlled Substance not adopted. The resolution requested ACEP to convene a Marijuana Technical Advisory Committee to advocate for change in the classification status of marijuana from a DEA Schedule I to a Schedule II drug.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

Prior Board Action

June 2019, approved the policy statement: Medical Cannabis

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted.

June 2017, approved the Emergency Medicine Practice Committee's recommendation to take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolved 3 (assign to the Tox Section or other body for additional work) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication).

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Kaeli Vandertulip, MBA, MSLS, AHIP
Clinical Practice Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 51(21)

SUBMITTED BY: Georgia College of Emergency Physicians

SUBJECT: Medical Bill of Rights for Detained and Incarcerated Persons While Receiving Emergency Medical Care

PURPOSE: Adopt a Medical Bill of Rights for detained and incarcerated persons in reference to patients presenting under custody for medical evaluation and work with stakeholders to develop federal legislation requiring health care facilities to inform patients in custody about their rights as a patient.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Detained, arrested, and/or incarcerated patients have the right to medical neutrality from their treating physician regardless of their status as a detained or incarcerated person[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to speak with their provider confidentially[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to removal of physical restraints for the purpose of a physical exam at the discretion of the treating physician[4]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to medical care at a facility that has a protocol for and supports ongoing quality improvement of medical care for the incarcerated patient[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to privacy and protection from inquiry regarding charges, conviction, or duration of sentence unless immediately pertinent to patient care[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to informed consent; to be adequately informed of diagnoses, treatment options, risks and alternatives, and follow-up plans with respect to educational status and literacy as necessary[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to refuse care, diagnostic testing, nutrition, laboratory studies, medications, and procedures, for as long as the patient has medical decision making capacity as deemed by the treating physician or is not at immediate risk of harm to self or others[5]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to timely administration of all interventions and necessary consultations while in the emergency department as deemed by the attending physician[1]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to make their healthcare decisions independent of law enforcement officials when competent, and to appoint an appropriate surrogate medical decision-maker in the event they become incompetent. Wardens, sheriffs, guards, police officers, prison administrators, and other law enforcement officials are not eligible medical decision-makers[2]; and

WHEREAS, Detained, arrested, and/or incarcerated persons have the right to consultation by their medical decision-maker according to state laws regardless of the policies of law enforcement or carceral institutions[1]; and

WHEREAS, The term “capacity” is defined by physicians and represents a patient’s ability to make decisions

and is separate from the legal term "competency" in this document[3]; therefore be it

RESOLVED, That ACEP adopt the following Medical Bill of Rights for detained and incarcerated persons in reference to patients presenting under custody for medical evaluation:

Detained, arrested, and incarcerated persons have the right to:

1. Medical neutrality – equal evaluation and treatment for emergency medical conditions regardless of their status as a detained or incarcerated person.
2. Speak with their provider privately.
3. Removal of physical restraints for the purpose of a physical exam at the request of the treating physician.
4. Medical care at a facility that has a protocol for and supports quality analysis of medical care.
5. Privacy and protection from inquiry regarding charges, conviction, or duration of sentence unless expressly pertinent to delivery of care.
6. Informed consent – to be adequately informed of diagnoses, treatment options, risks and alternatives, and follow-up plans.
7. Refuse care and diagnostic testing, including nutrition, laboratory studies, medications, and procedures, with the exception of psychoactive medications if the patient is deemed a potential harm to self or others if psychoactive medications are withheld OR with the exception of previously set forth state policies or contracts determining otherwise.
8. Administration of interventions and requests for consultations in a timely manner consistent with local standards of care.
9. Make their healthcare decisions independently, if deemed competent, and to appoint an appropriate surrogate medical decision-maker in the event they become incompetent. Wardens, sheriffs, guards, police officers, prison administrators, and other law enforcement officials are not eligible medical decision-makers.
10. Visitation by their medical decision-maker according to state laws regardless of the policies of law enforcement or carceral institutions.; and be it further

RESOLVED, That ACEP work with interested parties and key stakeholders to develop federal legislation requiring health care facilities to inform patients in custody about their rights as a patient.

Background

The resolution calls for the College to adopt a Medical Bill of Rights (as outlined in the first resolved) for detained and incarcerated persons in reference to patients presenting under custody for medical evaluation and for ACEP to work with interested parties and key stakeholders to develop federal legislation requiring health care facilities to inform patients in custody about their rights as a patient.

According to the U.S. Department of Justice Bureau of Justice Statistics, as of 2018, more than 2.1 million people were incarcerated in U.S. prisons or jails. This is the largest incarcerated population in the world, as well as the highest per-capita incarceration in the world. Nearly two dozen U.S. states have incarceration rates higher than every other country on earth, with 70 percent of convictions for criminal offenses resulting in incarceration.

The incarcerated population presents specific underlying health challenges and burdens when compared to the general population, with higher rates of serious diseases such as Hepatitis C, HIV, tuberculosis; higher risks of serious injuries from beatings or rape; or high rates of serious mental health issues. The COVID-19 pandemic has also brought these existing public health challenges into sharp relief, with an already vulnerable population at greater risk, as well as the downstream effects and risks for individuals who work at or interact with correctional/detention facilities. The ACEP COVID-19 Field Guide section, Incarcerated Population, details some of the background, unique challenges, best practices, and guidelines for prevention and treatment of COVID-19 in these populations.

Rapid assessment and treatment of incarcerated populations pose unique challenges for emergency physicians. These individuals are subject to limitations on their access to care, including emergency care. When transport to an emergency department is deemed necessary by the correctional officer(s) or facility, incarcerated individuals must

undergo searches and careful scrutiny by both health care personnel and security personnel before gaining clearance for transport. Access to primary care, specialty care, or other alternative health care providers is exceptionally limited, often leaving the emergency department as the first and only option for medical care outside of a correctional facility.

Other significant barriers may also affect the ability or willingness to seek treatment for medical conditions, such as fear, lack of privacy, stigma, or even a perception that they do not have the right to seek medical care. Incarcerated persons may also be subject to unconscious or implicit bias by physicians and other health care personnel that may affect their treatment and outcomes as well. An ACEP resource document developed by the Public Health Committee in 2006, "Recognizing the Needs of Incarcerated Patients in the Emergency Department," further details the scope of the problem, barriers to care, historical perspectives, considerations for provision of care, as well as guidelines for and other information on emergency medical care for incarcerated individuals.

The 1976 Supreme Court decision in *Estelle v. Gamble* established what is essentially the foundation of legal standards of medical care for incarcerated individuals, establishing the principle that deliberate indifference to serious medical needs of prisoners was a violation of the Eighth Amendment. Additional Supreme Court and lower court cases have expanded upon the precedent established in *Estelle*, laying out a set of basic rights for incarcerated individuals, and Congress has also enacted legislation in the years since to outlaw particularly egregious and inhumane aspects of care for this population. While these rights to care have been outlined by the federal legislature and judiciary, incarcerated individuals are still at greater risk of receiving substandard treatment from the health care system due to the myriad challenges unique to this population.

ACEP has maintained a liaison relationship with the National Commission on Correctional Health Care (NCCHC) since at least 1987. NCCHC is a non-profit organization with a mission to "improve the quality of health care in jails, prisons and juvenile confinement facilities" and establishes standards for care in correctional facilities, offers accreditation for facilities, and provides other related resources.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 16(00) Support of the National Commission on Correctional Health Care (NCCHC) adopted. Directed the College to continue supporting the liaison relationship with the NCCHC.

Prior Board Action

Amended Resolution 16(00) Support of the National Commission on Correctional Health Care (NCCHC) adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 52(21)

SUBMITTED BY: Utah Chapter

SUBJECT: Standardization of Medical Screening Exams of Arrested Persons Brought to the ED

PURPOSE: Work with interested state chapters, law enforcement personnel, and other stakeholders to: 1) develop protocols and standards for the medical screening examination of individuals in law enforcement custody when the arresting agency requests a medical evaluation of that individual prior to processing into a detention center; and 2) develop best practice guidelines for the conveying of an arrested person's pertinent medical information to medical personnel at the receiving correctional facility, consistent with medical ethics and medical privacy laws.

FISCAL IMPACT: Budgeted committee or task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 – $30,000 for an in- person meeting depending on the size of the group.

WHEREAS, Law enforcement personnel will frequently bring arrested persons to emergency departments for "medical clearance" exams prior to booking the arrested person into a correctional facility; and

WHEREAS, Currently no national protocols or standards exist that define the most appropriate medical screening exam or expectations of the emergency physician in this situation; and

WHEREAS, It is not clear under what circumstances the medical information obtained on an arrested individual should or can legally be conveyed to medical personnel at the receiving correctional facility, nor is there a standardized, confidential way in which to do so; and

WHEREAS, This creates confusion and may put the arrested individual at medical risk and the emergency physician at medicolegal risk if the arrested person later develops an emergency medical condition after being booked into a correctional facility; therefore be it

RESOLVED, That ACEP work with interested state chapters, law enforcement personnel, and other stakeholders to develop protocols and standards for the medical screening examination of individuals who are in law enforcement custody when the arresting agency requests a medical evaluation of that individual prior to processing into a detention center; and be it further

RESOLVED, That ACEP develop best practice guidelines for the conveying of an arrested person's pertinent medical information to medical personnel at the receiving correctional facility, consistent with medical ethics and medical privacy laws.

Background

This resolution requests ACEP to work with interested state chapters, law enforcement personnel, and other stakeholders to develop protocols and standards for the medical screening examination of individuals who are in law enforcement custody when the arresting agency requests a medical evaluation of that individual prior to processing into a detention center and to develop best practice guidelines for the conveying of an arrested person's pertinent medical information to medical personnel at the receiving correctional facility, consistent with medical ethics and medical privacy laws.

ACEP recognizes the importance of protection of patient information. ACEP's policy statement *"*Confidentiality of

Patient Information" includes:

"ACEP believes confidentiality of patient information is an important but not absolute principle. Confidential patient information may be disclosed when patients or their legal surrogates agree to disclosure, when mandated by law, or when there exist overriding and compelling grounds for disclosure, such as the prevention of substantial harm to identifiable other persons." This was further supported and more specifically addressed in the Policy Resource Education Paper (PREP) "Hippocrates to HIPPA: Privacy and Confidentiality in Emergency Medicine" Part I and Part II. The PREP discusses HIPAA and exceptions outlined in federal law. ACEP's policy statement "Law Enforcement Information Gathering in the Emergency Department" applies indirectly to treatment and patient health information regarding the patient's condition as mandated by law and ethical decisions by physicians.

ACEP's information paper: "Recognizing the Needs of Incarcerated Patients in the Emergency Department" addresses patients presenting from prisons, already incarcerated in local jails, and in police custody from the street and discusses each of these scenarios as applied to the patients right to refusal, implicit bias, thorough medical examination, safety, and information sharing.

ACEP's information paper: *"*Implicit Bias and Cultural Sensitive: Effects on Clinical and Practice Management*"* also addresses bias and implied bias and uses a patient in police custody as an example.

An article written by ACEP member Robert A. Bitterman, MD, JD, FACEP: *"*Federal law, EMTALA, and state law enforcement: Conflict in the ED?*"* discusses CMS regulations regarding Medical Clearance for the incarcerated also referred to as "Jail Clearance" and parameters for medical clearance.

Several other references include:

- "When your patient is in police custody" from the Nursing 2021 Journal. The article discusses follow up care and documentation.
- "Q and A: The Hospital, The Law, And the Patient" from Patient Safety & Quality Healthcare (PSQH). Discusses the necessity for hospital policies regarding patients in custody and references an incident in Utah where a nurse was arrested for refusing to comply with what was found to be an unlawful order.
- "Law Enforcement and Healthcare: When Consent, Privacy and Safety Collide" published in the Journal of Urgent Care Medicine. Discusses further compliance issues, EMTALA, requests for patient health information, and limitations of those requests.

ACEP has maintained a liaison relationship with the National Commission on Correctional Health Care (NCCHC) since at least 1987. NCCHC is a non-profit organization with a mission to "improve the quality of health care in jails, prisons and juvenile confinement facilities" and establishes standards for care in correctional facilities, offers accreditation for facilities, and provides other related resources.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.
- Objective C – Establish and promote the value of emergency medicine as an essential component of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

Objective A – Improve the practice environment and member well-being.

Fiscal Impact:

Budgeted committee or task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 –

$30,000 for an in- person meeting depending on the size of the group.

Prior Council Action

Amended Resolution 16(00) Support of the National Commission on Correctional Health Care (NCCHC) adopted. Directed the College to continue supporting the liaison relationship with the NCCHC.

Prior Board Action

June 2017, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" revised and approved April 2010; originally approved September 2003.

April 2017, reviewed the information paper "Implicit Bias and Cultural Sensitive: Effects on Clinical and Practice Management."

January 2017, approved the revised policy statement "Confidentiality of Patient Information" with the current title; reaffirmed October 2008, October 2002, and October 1998; originally approved January 1994 titled "Patient Confidentiality."

April 2006, reviewed the information paper "Recognizing the Needs of Incarcerated Patients in the Emergency Department."

January 2005, reviewed the Policy Resource Education Paper (PREP)-"Hippocrates to HIPPA: Privacy and Confidentiality in Emergency Medicine" Part I and Part II.

Amended Resolution 16(00) Support of the National Commission on Correctional Health Care (NCCHC) adopted.

Background Information Prepared by: Patrick R. Elmes, EMT-P
EMS and Disaster Preparedness Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 53(21)

SUBMITTED BY: Taylor Nichols, MD
Alexander Schmalz, MD, MPH
Kevin Durgun, MD
California Chapter
Young Physicians Section

SUBJECT: Reporting of Injuries Suspected or Reported to be Resulting from Law Enforcement Actions

PURPOSE: 1) Support a reporting process to an independent entity regarding injuries suspected or reported to be resulting from law enforcement actions; and 2) create an educational toolkit regarding identifying and reporting injuries suspected or reported to be resulting from law enforcement actions.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Use of force by law enforcement continues to be a dominant issue among public health officials, politicians, and the general public; and

WHEREAS, Physicians are often mandated reporters for injuries suspected or reported to be from assaultive or abusive conduct in vulnerable populations, with all 50 states mandating that child abuse be reported to state authorities and 47 states mandating that elder abuse be reported to state authorities or local law enforcement[1] ; and

WHEREAS, Physicians in most states are also mandated reporters of assault by firearm or other deadly weapon as well as for severe injuries, sexual assault, or other "injuries that result from a criminal act"[1]; and

WHEREAS, ACEP encourages research regarding the epidemiology of abuse and neglect in these vulnerable populations as well as an understanding of best practice approaches to screening, assessment and intervention for these victims[2-3]; and

WHEREAS, "Prisoners" are a specifically protected category of people in medical ethics, as indicated by the customary conventions of the Department of Health and Human Services, Institutional Review Boards at institutions conducting research involving human subjects, and that patients in police custody are functionally imprisoned and therefore consistent with other vulnerable populations[4]; and

WHEREAS, The currently established channels available for reporting of injuries suspected or reported to be resulting from assaultive or abusive conduct, including of injuries suspected or reported to be resulting from law enforcement actions, are most often to report directly to local law enforcement agencies; and

WHEREAS, There is a conflict of interest in reporting injuries suspected or reported to be resulting from law enforcement actions directly to the law enforcement agencies of the officer(s) involved in said assaultive or abusive conduct; and

WHEREAS, Patients may underreport injuries resulting from law enforcement actions due to this conflict of interest in currently available reporting mechanisms; and

WHEREAS, In our role as emergency physicians we both work with law enforcement agencies on a regular basis and care for victims of police violence, and therefore we have a conflict of interest in best serving caring for our patients while having to report directly to these law enforcement agencies; and

WHEREAS, Emergency physicians may under-recognize and therefore underreport injuries resulting from law enforcement actions due to a lack of adequate information and training tools on this topic[5]; and

WHEREAS, This underreporting further contributes to the lack of adequate data collected regarding injuries resulting from law enforcement actions, which contributes to further the underrepresentation of this public health problem and the mistrust between law enforcement and the communities they serve [6]; and

WHEREAS, There is a precedent for the establishment of an independent entity for the reporting of abuse and neglect in vulnerable populations[1]; and

WHEREAS, The establishment of an independent entity to whom physicians could report suspected or reported assault by law enforcement would help resolve these conflicts of interest as well as improve reporting, epidemiological monitoring, and data gathering from which we could perform research to improve our care as emergency physicians; therefore be it

RESOLVED, That ACEP issue a statement regarding support for a reporting process to an independent entity regarding injuries suspected or reported to be resulting from law enforcement actions, as doing so will allow emergency physicians to avoid conflicts of interest, improve reporting, data gathering and epidemiologic monitoring, which will better enable us to research how we can best provide the most safe and appropriate care to our patients; and be it further

RESOLVED, That ACEP create an educational toolkit regarding identifying and reporting injuries suspected or reported to be resulting from law enforcement actions similar to that which exists regarding child and elder or dependent abuse or neglect, thereby enhancing physician understanding of these injuries and improving reporting.

References

1. Sachs CJ. Mandatory Reporting of Injuries Inflicted by Intimate Partner Violence. *AMA Journal of Ethics: Virtual Mentor.* 2007;9(12):842-845. doi.org/10.1001/virtualmentor.2007.9.12.oped1-0712
2. ACEP // Domestic Family Violence. https://www.acep.org/patient-care/policy-statements/domestic-family-violence/. Accessed August 31, 2020.
3. ACEP // American College of Emergency Physicians. https://www.acep.org/imports/clinical-and-practice-management/resources/violence/domestic-family-violence/. Accessed August 31, 2020.
4. Title 45: Public Welfare, Part 46- Protection of Human Subjects, 46.303 Definitions. Electronic Code of Federal Regulation. Depart of Health and Human Services. https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=83cd09e1c0f5c6937cd9d7513160fc3f&pitd=20180719&n=pt45.1.46&r=PART&ty=HTML#se45.1.46_1303. Accessed November 5, 2020.
5. Reinenger A, Robinson E, McHugh M. Mandated training of professionals: A means for improving reporting of suspected child abuse. *Child Abuse and Neglect*. 1995; 19(1): 63-69. doi.org/10.1016/0145-2134(94)00105-4
6. Wanted: better data on police shootings to reduce mistrust between the police and the communities they serve. *Nature*. 2019;573(7772):5. doi.org/10.1038/d41586-019-02614-4

Background

This resolution directs the College to issue a statement supporting a process to report to an independent entity any injuries suspected or reported to be resulting from law enforcement actions and to create an educational toolkit that would further enhance the emergency physician's knowledge and understanding regarding the identification and reporting of such suspected injuries.

There currently exists a process for reporting child and elder abuse or dependent abuse or neglect. Having a standardized reporting process would allow emergency physicians to avoid possible conflicts of interest when dealing with and reporting these types of injuries. It would also facilitate improved reporting and data gathering during epidemiology monitoring to advance related research activities.

The College has a history of developing and disseminating policy statements that address violence prevention and reporting abuse and injuries to the appropriate authorities. This issue of suspected injuries resulting from law enforcement actions falls within the College's support for the goal of a violence free society. There are definite challenges to be addressed considering the close relationship between law enforcement and emergency physicians in

the emergency department. An appropriate set of checks and balances to validate any suspected injuries would be an important part of the reporting system.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A- Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective B-Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.
- Objective C-Establish and promote the value of emergency medicine as an essential component of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective A-Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None that are specific to a reporting process to an independent entity regarding injuries suspected or reported to be resulting from law enforcement actions or educational resources about such reporting.

Substitute Resolution 49(20) Strangulation Policy Statement and Education Resources adopted. The resolution directed that ACEP acknowledges the hazard associated with air-choke holds, strangulation and carotid restraint and educate its members and relevant stakeholders on the hazards and the recognition and appropriate management of patients who present to the ED with injuries associated with air-choke holds, strangulation and carotid restraint maneuvers in various settings.

Resolution 39(20) Urging the Prohibition of Law Enforcement Use of Rubber Bullets and Tear Gas for Crowd Control not adopted. The resolution called for condemning the use of rubber bullets and tear gas to control or disperse crowds.

Resolution 22(10) Policy Pursuits not adopted. Called for the College to strongly encourage the use of safer alternatives to police pursuits, support the enactment of laws requiring law enforcement agencies to accept responsibility for their actions with respect to police pursuits, and support mandatory tracking of pursuit-related injury data by the National Highway Traffic Safety Administration (NHTSA).

Resolution 26(96) Mandatory Reporting of Domestic Violence referred to the Board of Directors. The resolution called for ACEP to oppose the mandatory reporting of domestic violence and support other ways to help identify victims.

Amended Resolution 25(96) Domestic Violence – Effects on Children adopted. Directed ACEP to investigate the development of guidelines to encourage and facilitate collaborative efforts between EDs and child protective agencies.

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

Substitute Resolution 45(92) Domestic Violence adopted. Directed ACEP to develop a plan for addressing domestic violence.

Prior Board Action

Substitute Resolution 49(20) Strangulation Policy Statement and Educational Resources adopted.

February 2020, approved the revised policy statement "Use of Patient Restraints," revised and approved April 2014; reaffirmed October 2007; revised April 2001, June 2000, January 1996; originally approved January 1991.

April 2019, approved the revised policy statement "Domestic Family Violence;" reaffirmed June 2013; originally approved October 2007, replacing rescinded policies: "Child Abuse," "Domestic Violence," "Emergency Medicine and Domestic Violence," "Management of Elder Abuse and Neglect," "Support for Victims of Family Violence," and "Mandatory Reporting of Domestic Violence to Law Enforcement and Criminal Justice Agencies."

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013; revised and approved January 2007; reaffirmed October 2000; originally approved January 1996.

April 2016, approved the revised policy statement "Protection from Violence in the Emergency Department" with the current title; revised and approved June 2011; revised April 2008 titled "Protection from Physical Violence in the Emergency Department Environment;" reaffirmed October 2001 and October 1997; originally approved January 1993 titled "Protection from Physical Violence in the Emergency Department."

Amended Resolution 25(96) Domestic Violence – Effects on Children adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Substitute Resolution 45(92) Domestic Violence adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 54(21)

SUBMITTED BY: Diversity, Inclusion, & Health Equity Section
International Emergency Medicine Section
Social Emergency Medicine Section

SUBJECT: Understanding the Effects of Law Enforcement Presence in the Emergency Department

PURPOSE: Support research, development, and adoption of best practices for emergency physicians regarding law enforcement presence in the ED consistent with transparency and patient rights and advocate for chapter development of toolkits outlining state specific policies and laws related to law enforcement presence in EDs.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The Emergency Department serves a safety net for many vulnerable patient populations, particularly racial minorities, undocumented immigrants, and incarcerated persons who have been historically marginalized[1]; and

WHEREAS, In medical ethics, "prisoners" are a specifically protected group of individuals as indicated by the Department of Health and Human Services, Institutional Review Board at institutions conducting research involving human subjects, and that patients in police custody are functionally imprisoned and therefore consistent with other vulnerable populations[2]; and

WHEREAS, The courts have interpreted the ED as an extension of public streets which enable law enforcement to conduct highly intrusive investigations within the ED which can violate patient privacy, confidentiality, and processes for informed consent[1]; and

WHEREAS, When hospital policies regarding law enforcement access to the ED are unclear, or when emergency medicine professionals fulfill law enforcement requests without adhering to hospital policies, the patient-physician relationship and patient health outcomes can be negatively impacted[3]; and

WHEREAS, The presence of law enforcement in the ED is a deterrent for vulnerable patients seeking care, has been shown to cause medical mistrust, and compounds biases and racial disparities that already exist in healthcare and law enforcement[3]; and

WHEREAS, The undocumented community will avoid interactions with official agencies or entities, including hospitals, because of fear that if their status were revealed they would be deported and this results in many patients putting off seeking health services for as long as possible[4]; and

WHEREAS, ACEP believes that emergency physicians have a fundamental professional responsibility to protect the confidentiality of their patients' personal health information[5]; and

WHEREAS, Law enforcement information gathering should not interfere with essential patient care[5]; and

WHEREAS, The World Medical Association International Code of Medical Ethics states that there are "particular challenges for health professionals throughout the world when the subordination of the patient's interests to state or other purposes risks violating the patient's human rights"[6]; and

WHEREAS, When emergency physicians do not have an understanding of state specific laws or hospital

policies, this increases the risk of violating the rights of vulnerable patient populations, especially incarcerated and undocumented patients when seeking care in the ED; and

WHEREAS, Establishing best practices through a patient rights-centered approach and encouraging awareness and state-specific educational material for emergency physicians would help resolve some of the conflicts of interest between emergency physicians and law enforcement officials; therefore be it

RESOLVED, That ACEP support the research, development, and adoption of best practices for emergency physicians regarding law enforcement presence in the ED to create transparency and protect the rights of its vulnerable patient populations; and be it further

RESOLVED, That ACEP advocate for state chapters to create easily accessible transparent toolkits that outline state-specific policies and laws regarding law enforcement presence in the ED, thereby enhancing physician understanding of patient and physician rights in their interactions with law enforcement within the ED as well as their own rights as physicians.

References

1. Seon Song J. Policing the Emergency Room. *Harvard Law Review*. June 2021; 134(8): 2647-2719. https://harvardlawreview.org/2021/06/policing-the-emergency-room/
2. Title 45: Public Welfare, Part 46- Protection of Human Subjects, 46.303 Definitions. Electronic Code of Federal Regulation. Depart of Health and Human Services. https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=83cd09e1c0f5c6937cd9d7513160fc3f&pitd=20180719&n=pt45.1.46&r=PART&ty=HTML#se45.1.46_1303 . Accessed July 16, 2021.
3. Working Group on Policing and Patient Rights. Police in the Emergency Department. A Medical Provider Toolkit for Protecting Patient Privacy. https://www.law.georgetown.edu/health-justice-alliance/wp-content/uploads/sites/16/2021/05/Police-in-the-ED-Medical-Provider-Toolkit.pdf
4. Caballero A. ICE in the ER: How U.S. Policies are Causing an Immigrant Health Crisis. *Physicians for Human Rights Resources Blog*. Decemeber 2018. https://phr.org/our-work/resources/ice-in-the-er-how-u-s-policies-are-causing-an-immigrant-health-crisis/ Accessed July 25th, 2021.
5. ACEP // Law Enforcement Information Gathering in the Emergency Department https://www.acep.org/patient-care/policy-statements/law-enforcement-information-gathering-in-the-emergency-department/ Accessed July 16, 2021.
6. World Medical Association. International Code of Medical Ethics. https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/ Accessed July 16, 2021.

Background

The resolution calls for ACEP to support research, development, and adoption of best practices for emergency physicians regarding law enforcement presence in the emergency department consistent with transparency and patient rights and advocate for chapter development of toolkits outlining state specific policies and laws related law enforcement presence in emergency departments.

For a variety of reasons law enforcement officers may be present in the emergency department in conjunction with a presenting patient. Increasingly, such officers while observing and overhearing patient interactions may be wearing body cameras or engaging in other forms of investigative activity.

While recognizing the interest of law enforcement officers in gathering information for investigation, emergency physicians express concerns that the presence of such officers will cause persons in need of emergency care to forego treatment. In addition to patient access concerns, it is noted that the presence of persons in the emergency department without the consent of the patient or a specified interest in patient treatment or payment may run afoul of the patient privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), similar state based privacy laws, and various laws related to consent, implied or otherwise, in both a legal and healthcare environment. The role of hospital policy creates an additional complexity. All of these considerations come into play in the context of the interest of physicians in advocating for best practices for protecting patients while providing patient care consistent with ACEP's Code of Ethics for Emergency Physicians.

National ACEP could recommend that chapters create the state-specific toolkits requested in the resolution and/or work with them to do so. However, as independently incorporated entities, ACEP chapters have autonomy to determine their own actions, within the parameters of ACEP and chapter bylaws and may not choose to work with ACEP as directed the resolution.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted committee and staff resources

Prior Council Action

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted. Required revisions to the existing policy statement on "Law Enforcement Information Gathering in the Emergency Department" to reflect the recent relevant court decisions regarding consent for searches with or without a warrant to provide clarification and guidance to emergency physicians on their ethical and legal obligations on this issue.

Resolution 22(16) Court Ordered Forensic Evidence Collection in the ED adopted. Directed ACEP to study the ethical and moral implications for emergency physicians acting in compliance with court orders requiring collection of evidence from a patient in the absence of consent and develop a policy statement addressing the issue.

Resolution 30(15) Use of Body Cameras Worn by Law Enforcement in the Emergency Department referred to the Board of Directors.

Amended Resolution 20(97) Permissive Reporting of Blood Alcohol Content (BAC) to Law Enforcement Authorities adopted. Directed the BAC Reporting Task Force to develop a position paper, policy, and/or PREP.

Prior Board Action

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement adopted.

June 2019, approved the revised policy statement "Audiovisual Recording in the Emergency Department" with the current title; revised and approved January 2017 titled "Recording Devices in the Emergency Department;" originally approved April 2011.

June 2017, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" originally approved September 2003.

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

Resolution 22(16) Court Ordered Forensic Evidence Collection in the ED adopted.

November 2015, assigned Referred Resolution 30(15) Use of Body Cameras Worn by Law Enforcement in the Emergency Department to the Ethics Committee.

Amended Resolution 20(97) Permissive Reporting of Blood Alcohol Content (BAC) to Law Enforcement Authorities adopted.

Background Information Prepared by: Harry Monroe
State Legislation Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 55(21)

SUBMITTED BY: New York Chapter

SUBJECT: Patient Experience Scores

PURPOSE: 1) Acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy. 2) Define standardized inclusion and exclusion criteria for patient experience survey populations. 3) Define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias and appropriate power calculations so that sufficient surveys are collected to yield more statistically valid results. 4) Advocate for patient experience survey validity and work with CMS and other stakeholders to implement change to current ED practices.

FISCAL IMPACT: Budgeted staff resources. Investment in new ED Accreditation Program.

WHEREAS, ACEP's existing policy statement stipulates Emergency Department (ED) patient experience survey tools should be standardized[1], yet neither institutions nor survey vendors have established widespread standardization of survey tools, populations, or methodologies; and

WHEREAS, ACEP's policy statement stipulates the survey should be "based on statistically valid sample size" yet many hospitals and survey vendors sample only a fraction of a percentage of the patients seen in the ED, resulting in statistically invalid surveys; and

WHEREAS, ACEP's policy statement stipulates the survey should be "free from selection bias"[2] yet survey methodologies, including inclusion and exclusion criteria have not been consistently applied and patients who are admitted are typically excluded, resulting in biased surveys[3,4]; and

WHEREAS, Emergency physicians appropriately give a disproportionate amount of time and attention to their sickest patients, while not having an opportunity to have this care evaluated by those very patients if they happen to be admitted; and

WHEREAS, Despite a prolonged trial of Emergency Department Patient Experience of Care (EDPEC), a subsequent trial of Emergency Department Consumer Assessment of Healthcare Providers and Systems (ED CAHPS), and nearly a decade of testing survey instruments, CMS has still not validated nor issued standard ED surveys; and

WHEREAS, Factors leading to poor patient experience scores, including wait times, are often related to factors extrinsic to ED operations and outside the control of the staff working in the ED[5]; therefore be it

RESOLVED, That ACEP acknowledge and affirm that current iterations of patient satisfaction instruments are in clear violation of existing ACEP policy; and be it further

RESOLVED, That ACEP define standardized inclusion and exclusion criteria for patient experience survey populations; and be it further

RESOLVED, That ACEP define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias, and appropriate power calculations such that sufficient surveys are collected to yield more statistically valid results; and be it further

RESOLVED, That ACEP aggressively advocate for patient experience survey validity and work with CMS and other stakeholders to implement prompt, actionable change to current ED survey practices.

References

[1] https://www.acep.org/globalassets/new-pdfs/policy-statements/patient.experience.of.care.surveys.pdf
[2] https://www.acep.org/globalassets/new-pdfs/policy-statements/patient.experience.of.care.surveys.pdf
[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/ED
[4] https://www.cms.gov/files/document/edpec-dtc-survey-recommended-guidelines-february-2020.pdf
[5] Sonis et al. J Patient Exp. 2018 Jun;5(2):101-106.

Background

This resolution asks ACEP to acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy. It also directs ACEP to define standardized inclusion and exclusion criteria for patient experience survey populations, and to define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias, and appropriate power calculations such that sufficient surveys are collected to yield more statistically valid results. Finally, it directs ACEP to advocate for patient experience survey validity and work with CMS and other stakeholders.

ACEP's policy statement "Patient Experience of Care Surveys" states:

> *"The American College of Emergency Physicians (ACEP) recognizes that patient experience of care surveys that are methodologically and statistically sound can be a valid measure of the patient's perception of health care value and that patient outcome can be related to perceived patient experience of care.*
> *Patient experience of care survey tools should be:*
> - *Standardized and validated for the average education level of those being surveyed.*
> - *Administered and tabulated as close to the date of service as possible.*
> - *A measure of the specific components of service received in the emergency department (ED) with discrete data points.*
> - *Based on a statistically valid sample size free from selection bias.*
> - *Transparent in the administration and analysis methodologies.*
> - *Explicit in the intended purpose and use.*
> - *Addressing meaningful aspects of the patient's perception of care in the ED.*
>
> *Due to the difficulty in segregating whether patient experience of care scores are a result of physician performance or due to demands and restrictions of the current health care system or other factors out of the control of the physician, patient experience of care methods that have not been validated should not be used for purposes such as credentialing, contract renewal, and incentive bonus programs.*
>
> *Using patient experience of care scores for credentialing, contract renewal, and incentive bonus programs could have potential negative impacts on quality patient care, including safe prescribing of controlled substances, use of antibiotics and imaging. Emergency department patient experience of care measurement should incorporate the experience of admitted patients, to whom emergency physicians provide timely and intensive critical services.*
>
> *ACEP recommends that the topic of patient experience of care measurement be incorporated into the training of residents in emergency medicine."*

In the recent past, and with input from ACEP members, CMS worked with the RAND Corporation on the Emergency Department Patient Experience of Care (EDPEC) survey, now renamed the Emergency Department Consumer Assessment of Healthcare Providers & Systems (ED CAHPS) survey. ACEP members Thom Mayer, MD, FACEP, and Jay Kaplan, MD, FACEP, were members of the Technical Expert Panel that modified the original ED PEC survey, making it more physician friendly. Even in its revised format, it was 24 questions long with an additional 11 demographic questions. CMS has decided to not make the ED CAHPS survey mandatory.

ACEP can define standardized inclusion and exclusion criteria for the patient populations and define improved methodologies. Unfortunately, ACEP's influence over patient survey companies is limited. At the moment, there is no incentive to change.

ACEP could create its own survey tool for hospitals to use, but it is unlikely that hospitals will pay for two surveys of the same patient. ACEP could work with CMS to utilize the longer ED CAHPS described above.

ACEP could define a minimum number of survey responses as a statistically valid sample for an individual physician. Currently, CMS states the minimum number is 30, and recommend 50, however that standard is not uniformly applied by physician groups and hospitals when they act on these scores. CMS estimates a cost of $10-20 per survey depending on the vendor.[1] The most recent reported response rate to Press Ganey surveys was 16.5% .[2] Therefore, to get an additional 10 responses, the hospital would bear the additional cost of $500-$1,200 per physician per survey period.

It should be noted that the use of patient experience scores during the pandemic has had greater detrimental effect. It is widely known that boarding and crowding affect patient experience scores, particularly when they include the question "did you receive timely care."[6]

In 2021, ACEP President Mark Rosenberg, DO, FACEP, established an ED Accreditation Program Task Force to investigate the feasibility of ACEP creating a program for emergency departments. If the Board of Directors approves moving forward with this program, ACEP could start accrediting programs as early as the fall of 2022. As ACEP would establish the standards, it would be reasonable to include the proper use/interpretation of patient experience scores as one of the criteria.

Background References

[1]Pines JM, Iyer S, Disbot M, Hollander JE, Shofer FS, Datner EM. The effect of emergency department crowding on patient satisfaction for admitted patients. *Acad Emerg Med*. 2008 Sep;15(9):825-31.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical environments.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost-effective manner.

Fiscal Impact

Budgeted staff resources. Investment in new ED Accreditation Program.

Prior Council Action

Resolution 39(15) Patient Satisfaction Surveys in Emergency Medicine referred to the Board. Called for the College to acknowledge that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, many components of medical care not under physician control, and to oppose the use of patient satisfaction surveys for physician credentialing or for emergency medicine financial incentives or disincentives.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non -evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Resolution 43(13) Patient Satisfaction Scores not adopted. Called for the College to take a clear public stance to reject

the continued use of non-valid patient satisfaction scoring tools in emergency medicine and that current patient satisfaction surveys should not be used to determine ED physician compensation and reimbursement. Referred to the Board of Directors.

Resolution 26(12) Patient Satisfaction Scores and Pain Management not adopted. Called for the College to work with appropriate agencies and organizations to exclude complaints from ED patients with chronic non -cancer pain from patient satisfaction surveys; to oppose new core measures that relate to chronic pain management in the ED; to continue to promote timely, effective treatment of acute pain while supporting treating physicians' rights to determine individualized care plans for patients with pain; and to bring the subject of patient satisfaction scores and pain management to the American Medical Association for national action.

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted. Directed ACEP to disseminate information to educate members about patient satisfaction surveys, including how emergency physicians armed with more knowledge can assist hospital leaders with appropriate interpretation of the scores and encourage hospital and emergency physician partnership to create an environment conducive to patient satisfaction.

Substitute Resolution 12(98) Benchmarking adopted. Directed ACEP to study and develop appropriate criteria for methodology and implementation of statistically valid patient satisfaction surveys in the ED.

Resolution 51(95) Criteria for Assessment of EPs adopted. States that ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by an individual emergency physician.

Prior Board Action

June 2016, approved the revised policy statement "Patient Experience of Care Surveys;" originally approved September 2010 titled "Patient Satisfaction Surveys."

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

June 2013, reviewed the information paper "Patient Satisfaction Surveys."

February 2013, approved "Crowding" policy statement. Originally approved January 2006.

June 2011, reviewed the information paper "Emergency Department Patient Satisfaction Surveys."

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted.

Substitute Resolution 12(98) Benchmarking adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 56(21)

SUBMITTED BY: Diversity, Inclusion, & Health Equity Section
Social Emergency Medicine Section
District of Columbia Chapter

SUBJECT: Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities

PURPOSE: Issue a statement to the membership denouncing the validity of the use of race-based science and its detrimental impact in the care of diverse populations and commit to the education of ACEP members by denouncing the use of race-based calculators in clinical policies.

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

WHEREAS, ACEP was founded in 1968, the year the Fair Housing Act was passed and four years after the Civil Rights Act of 1964. In the 53 years since its founding, institutional racism has persisted within the field of emergency medicine and has perpetuated disparities in the quality of and access to care among Black, Indigenous, and People of Color (BIPOC) communities; and

WHEREAS, This disparity has devastated the health of generations of people in our country; and

WHEREAS, Emergency medicine, in its capacity as a safety net, must prioritize an antiracist approach to healthcare; and

WHEREAS, From the mid-1800s, the dogma of racial inferiority meant that racial-genetic explanations were invoked as biological justification for discriminatory and genocidal policies.[1,2] In the last half of the 20th century and extending into the present, the utility of race has been viewed from two distinct perspectives: as a descriptive category—necessary to document health inequalities—and as a causal explanation of ill health—through unspecified genetic influences[3]; and

WHEREAS, We believe the biological effects of racism should be recognized and a biological basis for differences among races be denounced; and

WHEREAS, Race science, the notion of race being a biologically rooted form of difference, has provided a form of scientific legitimacy, and thereby supported institutional racism; and

WHEREAS, From a distinct formula for eGFR[4] to the myth of different pain tolerances among races, science has allowed for a different standard of care among patients of different races; and

WHEREAS, Biologic racism (pseudoscience), craniology, psychometry, and polygenism failed to be supported by factual evidence, their effects and consequences on society remain extremely large[5]; and

WHEREAS, For decades, race-adjusted calculations have affected disease management, led to delays in critical interventions such as dialysis and renal transplantation, and contributed to disparities in the morbidity and mortality in the BIPOC patient population[6]; therefore be it

RESOLVED, That ACEP issue a statement to the membership regarding the lack of validity in race-based science and its detrimental impact on the health of Black, Indigenous, and People of Color patients and communities;

and be it further

RESOLVED, That ACEP commit to the education of its membership by denouncing the use of race-based calculators in its clinical policies.

References

1. Montagu A. Man's most dangerous myth: The fallacy of race. AltaMira, New York, 1997
2. Cooper R. Use of race in public health surveillance: Perspective of a health scientist. *MMWR* 42: 11–12. 1993
3. Copper RS. Health and the social status of blacks in the United States. *Ann Epidemiol. 1993* Mar; 3(2):137-44.
4. Junyan Shi et al. Calculating estimated glomerular filtration rate without the race correction factor: Observations at a large academic medical system.*Clinica Chimica Acta* **520**, 16-22. 2021
5. "Ostensibly scientific": cf. Theodore M. Porter, Dorothy Ross (eds.) The Cambridge History of Science: Volume 7, The Modern Social Sciences Cambridge University Press, p. 293. 2003
6. Vyas DA, Eisenstein LG, Jones DS. Hidden in plain sight—reconsidering the use of race correction in clinical algorithms. *N Engl J Med*. 2020;383(9):874–82.

Background

This resolution asks ACEP to issue a statement to the membership denouncing the validity of the use of race-based science and its detrimental impact on the health of Black, Indigenous, and People of Color (BIPOC) patients and communities and commit to the education of ACEP members by denouncing the use of race-based calculators in clinical policies.

A recent article highlights the NFL's reversal of "race norming" and highlights the prominence of it that still remains in medicine. The NFL was using stereotypes about African Americans cognitive function as part of its concussion settlement fund. This practice was discriminatory and denied Black players equal compensation for damages sustained from playing football.

ACEP's policy statement "Cultural Awareness and Emergency Care" supports that cultural awareness is essential to the training of healthcare professionals in providing quality patient care. It also confirms ACEP's position that resources be made available to emergency departments and emergency physicians to assure they properly respond to the needs of all patients regardless of background. This is important to the subject of implicit bias, as cultural awareness helps combat negative assumptions and associations. The implementation of a policy will help bring awareness to outdated practices such as the use of race-based calculators.

In July 2021, ACEP held a congressional panel discussion during the 2021 Leadership and Advocacy Conference (LAC), entitled "Breaking Down Barriers: Improving Health Equity Through the Emergency Department." The panel featured congressional staff that ACEP has worked with on health equity issues to provide insight on how emergency physicians can engage with legislators on these topics.

In March 2021, ACEP submitted a response to the Senate Health, Education, Labor, and Pensions (HELP) Committee hearing on COVID-19-related health disparities, detailing issues identified in the emergency department and strategies for prevention, screening, and mitigation.

In October 2020, ACEP responded to a request for information (RFI) from the House of Representatives Committee on Ways and Means Chairman Richard Neal regarding racial health inequities and specific questions about the misuse of race and ethnicity in clinical decision support (CDS) tools and algorithms. ACEP's response included specific efforts and initiatives the College has undertaken to reduce disparities and improve outcomes for communities of color, including efforts to reduce unconscious or implicit bias in the delivery of emergency care. It also detailed disparities resulting from or exacerbated by COVID-19 that were identified in the ACEP COVID-19 Field Guide. Additionally, the letter addressed questions about the use of race and ethnicity in CDS tools and clinical algorithms and how this was an ongoing topic of discussion and study not just within emergency medicine, but also the broader field of medicine.

In November 2020, the Ways and Means Committee followed up with additional questions, specifically about the use of the STONE Score for Uncomplicated Ureteral Stone in the emergency department. As part of this effort, a virtual

meeting was held with Chairman Neal's staff to discuss the STONE Score and the concerns of race and ethnicity in clinical tools. ACEP Public Affairs staff also reached out to one of the authors of the STONE Score and discussed the reasoning behind the inclusion of ethnicity in the score and potential benefits or disadvantages associated with removing the variable. In December 2020, ACEP submitted a formal response to the committee about ACEP's efforts to review and reevaluate the use of race and ethnicity in tools like the STONE Score, what guidance the College could provide to members to redirect clinicians' use of these algorithms, and insights on various options for remedies to address these challenges, as well as the role of the federal government and ACEP in implementing these remedies. ACEP continues to engage with the Committee as federal attention to this particular issue moves forward, and has also proactively reached out to the three leaders of the Committee's Racial Equity Initiative to share the College's ongoing advocacy priorities and efforts and open up additional lines of communication with federal legislators.

In March of 2018, ACEP, as a recommendation of the Diversity & Inclusion Task Force, launched the one-hour accredited CME course Unconscious Bias in Clinical Practice. This course focuses on the following objectives:

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

ACEP's policy statement "Non-Discrimination and Harassment" reinforces that "ACEP acknowledges that implicit and explicit biases, attitudes, or stereotypes affect our understanding, actions, and decisions."

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

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

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted. The resolution directed ACEP to promote transparency in institutional data to better identify disparities and biases in medical care; continue to encourage training to combat discrimination for all clinicians; and continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted. Directed ACEP to develop and publicize a policy statement that encourages implicit bias training for all physicians and that ACEP continue to create and advertise CME-eligible online training relations to implicit bias at no charge to ACEP members.

Substitute Resolution 41(05) Non-Discrimination adopted. The resolution expressed ACEP's opposition to all forms of discrimination against patients on the basis of gender, race, age, creed, color, national or ethnic origin, religion, disability, or sexual orientation and against employment discrimination in emergency medicine on the same principles as well as physical or mental impairment that does not pose a threat to the quality of patient care.

Prior Board Action

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved

April 2020; reaffirmed April 2014; approved April 2008 with the current title' originally approved October 2001 titled "Cultural Competence and Emergency Care."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018 and April 2012 with the current title; originally approved October 2005 titled "Non-Discrimination."

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted.

Amended Resolution 14(19) Implicit Bias Awareness and Training adopted.

October 2017, reviewed the information paper "Disparities in Emergency Care."

April 2017, reviewed the information paper "Implicit Bias and Cultural Sensitivity: Effects on Clinical and Practice Management."

Substitute Resolution 41(05) Non-Discrimination adopted.

Background Information Prepared by: Riane Gay, MPA, CAE
Director, Corporate Development

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 57(21)

SUBMITTED BY: Nikkole J. Turgeon
Anna G. Wright, MD
Laura Janneck, MD, FACEP
Dominique Gelmann
Betty Chang, MD, FACEP
Daniel B. Gingold, MD, MPH
International Emergency Medicine Section
Social Emergency Medicine Section

SUBJECT: Social Determinants of Health Screening in the Emergency Department

PURPOSE: Support research of evidence-based social determinants of health (SDH) screening and interventions in the ED to develop feasible interventions for implementation in the ED, advocate for resources (both private and public) to identify and address SDH in the ED, and work towards systemic solutions through advocacy efforts.

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

WHEREAS, Social determinants of health (SDH), such as economic stability, social and community context, neighborhood and built environment, health care and quality, and education access and quality, influence overall health outcomes to a much greater degree than medical care alone[1,2]; and

WHEREAS, The efficacy of medical treatment decreases in the absence of understanding and addressing relevant SDH[3]; and

WHEREAS, The emergency department reaches patients who are not cared for in other healthcare settings; and

WHEREAS, SDH (such as racism, joblessness, mental health conditions, and homelessness) correlate with repeated emergency department visits among patients (both adult and pediatric) with chronic disease[4]; and

WHEREAS, The emergency department can play a crucial role in screening, evaluating, and mitigating SDH which adversely affect patients[5]; and

WHEREAS, The field of emergency medicine is still developing evidence-based, comprehensive, and standardized ED screenings to SDH; and

WHEREAS, Effectively addressing SDH includes not only screening, but also interventions, including advocacy, community collaboration, and program development; and

WHEREAS, The body of existing research into emergency department SDH interventions involves addressing seven broad categories of SDH – access to care, discrimination, violence, food insecurity, housing insecurity/instability, literacy (health and language), and poverty[6]; and

WHEREAS, Current research into emergency department modification of SDH, while encouraging, focuses predominantly on access to care and the impact of exposure to violence and crime, but contains a paucity of research into affecting change in the other categories of SDH[6]; therefore be it

RESOLVED, That ACEP seek to improve the recognition of, and attention to, social determinants of health (SDH) by supporting research of evidence-based SDH screening and interventions in the ED with a focus on the unique strengths and challenges the ED setting poses for identifying and influencing SDH in order to develop interventions feasible for implementation in the ED; and be it further

RESOLVED, That ACEP advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and be it further

RESOLVED, That ACEP push for legislative and political action to achieve broad, systemic solutions to those social determinants of health that create inequity in health status and outcomes so that to the greatest extent possible, addressing social determinants of health is considered integral to improving the health of the country.

References

1. Centers for Disease Control and Prevention // Social Determinants of Health https://www.cdc.gov/socialdeterminants/index.htm Accessed on July 21st, 2021
2. Hsieh D. Achieving the Quadruple Aim: Treating Patients as People by Screening for and Addressing the Social Determinants of Health. *Annals of Emergency Medicine*. 74(5):S19-24.
3. Anderson ES, Lippert S, Newberry J, Bernstein E, Alter HJ, Wang NE. Addressing Social Determinants of Health from the Emergency Department through Social Emergency Medicine. *West J Emerg Med*. 2016;17(4):487-489. doi:10.5811/westjem.2016.5.30240
4. Duquette E, Khan A. Social Determinants of Health Associated with Emergency Department Recidivism in Patients with Diabetes. *Annals of Emergency Medicine*. 2019;74(4):S117.
5. Samuels-Kalow ME, Ciccolo GE, Lin MP, Schoenfeld EM, Camargo Jr. CA. The Terminology of Social Emergency Medicine: Measuring Social Determinants of Health, Social Risk, and Social Need. *JACEP Open*. 2020;1(5):852-856.
6. Walter LA, Schoenfeld EM, Smith CH, et al. Emergency Department-based interventions affecting social determinants of health in the United States: A Scoping Review. *Academic Emergency Medicine*. 2021;28(6):666-674.

Background

Support research of evidence-based social determinants of health (SDH) screening and interventions in the ED to develop feasible interventions for implementation in the ED, advocate for resources (both private and public) to identify and address SDH in the ED, and work towards systemic solutions through advocacy efforts.

The World Health Organization (WHO) defines SDH as "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grown, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems." The WHO further notes the influence of these factors and notes that numerous studies suggest that SDH account for between 30-55% of health outcomes.

There are a growing number of tools for assessing SDH within a community. These include measure indices – mapping tools to determine SDH in a specific population or location. Examples of tools include the Health Resources and Services Administration (HRSA) Area Deprivation Index, subsequent Neighborhood Atlas, County Health Rankings and Roadmaps, and more. Additionally, tools to measure individual social risk factors are also available. Tools include the CMMI The Accountable Health Communities Health-Related Social Needs Screening Tool, toolkits, guides, and even electronic tools. Some EDs have adopted SDH models, such as coordinating care services that combine social services with medical care. Other examples include substance use disorder screening, intervention, and referral.

Some believe that emergency medicine is uniquely positioned to address SDH as emergency physicians treat more than 25% of all acute care in the U.S. with more than 50% of that for the uninsured. Additionally, EDs are often referred to as society's "safety net," leading some to define the ED as a de facto environment for incorporating social context into patient care. EDs also see a growing demand for serving lower socioeconomic patients with unmet social needs. The ICD-10-CM codes (Z55-Z65) now include categories of potential health hazards related to a patient's socioeconomic or psychosocial environment, and other factors that can influence their health status. Others believe that taking on a SDH perspective could overburden already overwhelmed EDs and that it would interfere with the ED's primary mission of caring for acute medical issues, while others rebuttal that without treating patients adequately (to include SDH) patients will likely continue to return. Others opposed recognize the added costs, lack of

available follow up services, and the potential impact on ED throughput. One study that looked at the feasibility of incorporating a SDH screening process within an ED. It found that while they were able to demonstrate the ability to systematically screen and refer for needs, ensuring buy-in from staff conducting the screening was critical as well as ensuring that there were available resources within the community.

In 2017, ACEP hosted thought leaders in social emergency medicine to hold a consensus conference to establish the framework for how to incorporate social context within the structure and practice of emergency medicine. Around the same time, the Social Emergency Medicine Section was formed. Other efforts within the College include calling on the House Committee on Ways and Means to address SDH and racial health inequalities, responding to RFIs addressing health equity, and working through other regulatory processes to address structural SDH issues.

ACEP's policy statement "Safe Discharge from the Emergency Department" states:

> "ACEP recognizes the social, societal, and physical determinants of health that often affect patients discharged after an emergency encounter, but also recognizes that there are unique procedural and resource limitations that differentiate inpatient and emergency department (ED) discharges. As such, ACEP believes the decision to discharge a patient from the ED should be a clinical decision by the emergency department physician or provider who cares for that patient and deems the patient stable and safe for discharge. ACEP opposes local, state, federal, and other externally mandated "safe" discharge requirements that supersede the clinical judgment of a treating emergency physician or provider."

ACEP's policy statement Social Work and Case Management in the ED" and the Policy Resource & Education Paper (PREP) "Social Work and Case Management in the Emergency Department" address the importance of access to community resources for medical and social reasons after discharge from the emergency department. The policy statement affirms that ACEP "supports the development and maintenance of case management services that are available to ED patients, that such services include appropriate clinical personnel as well as partnerships with community-based organizations, governmental agencies, and other appropriate entities to ensure prompt access to community services for its patients."

ACEP's policy statement "Human Trafficking" supports EDs including approaches to interfacing with outside entities such as social service organizations to care for patients.

ACEP's legislative and regulatory priorities include "promote legislative options and solutions to identify and eliminate health disparities, address structural racism, and improve health equity in the health care system."

The Emergency Medicine Foundation (EMF) has awarded a $50,000 COVID-19 research grant "Social Determinants of Health and COVID-19 Infection in North Carolina: A Geospatial and Qualitative Analysis." Additionally, EMF has approved funding of $50,000 each for two health disparities grants during the FY 21-22 grant cycle: EMF Health Disparities Grant and the EMF/ENAF Health Disparities Grant.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted. Directed ACEP to reaffirm the importance of recognizing and addressing the social determinants of health including systemic racism as it pertains to emergency care, continue to explore models of health care that would make equitable health care

accessible to all, and continue to use its voice to support members to seek to reform discriminatory systems and advocate for policies promoting the social determinates of health with historically disenfranchised communities at the institutional, local, state and national level.

Amended Resolution 19(20) Framework to Assess the Work of the College through the Lens of Health Equity adopted. Directed ACEP to create or select a framework to assess the future work of the College through the lens of health equity and provide members a biennial assessment of the work as it pertains to health equity.

Amended Resolution 50(19) Social Work in the Emergency Department adopted. Directed CEP to promote the inclusion of social workers and/or care coordinators within the ED team, educate hospitals on including social workers in team-based care, compile best practices on ED care models that included social workers or care coordinators, and advocate for payment for care coordination services in emergency medicine.

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted. Directed ACEP to pursue reimbursement strategies to promote coordination of care, effective ED information sharing, and performance incentives for case management of high utilizers.

Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted. Directed that ACEP develop a rapid integration of care toolkit to focus on transitions of care and care coordination, provide best practices based upon hospital type and location, tools/resources for the design and implementation of rapid integration of care programs, and measures to report success of efforts.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted. Directed ACEP to define the role of emergency medicine in transitions of care for emergency medicine patients; to participate in all significant forums of discussion with regulatory entities, Department of Health and Human Services, Centers for Medicare & Medicaid Services, The Joint Commission, National Quality Forum, related to performance parameters and proposed standards for emergency medicine transitions of care; to monitor and have input into any reimbursement issues tied to transitions of care, including performance incentives and accountable care organization collaboration; and to identify resources and educational materials to improve transitions of care for emergency patients.

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

Prior Board Action

October 2020, approved the revised policy statement "Social Work and Case Management in the ED" with the current title; revised and approved April 2019; reaffirmed June 2013; originally approved October 2007 titled "Patient Support Services."

October 2020, reviewed the Policy Resource & Education Paper (PREP) "Social Work and Case Management in the Emergency Department."

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted.

Amended Resolution 19(20) Framework to Assess the Work of the College through the Lens of Health Equity adopted.

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; originally approved April 2008 with the current title replacing "Cultural Competence and Emergency Care" approved October 2001.

Amended Resolution 50(19) Social Work in the Emergency Department adopted.

June 2019, approved the policy statement "Safe Discharge from the Emergency Department."

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018; revised and approved April 2012 with the current title; originally approved October 2005 titled "Non-Discrimination."

October 2017, reviewed the information paper "Disparities in Emergency Care."

April 2017, reviewed the information paper "Unconscious Bias and Cultural Sensitivity and their Effects on Clinical Practice Management."

January 2017 revised and approved "Code of Ethics for Emergency Physicians." Revised and approved June 2016 and June 2008. It was reaffirmed October 2001. It was revised and retitled in June 1997. Originally approved January 1991 titled "Ethics Manual." Part II D defines the role of the emergency physicians with society.

April 2016, approved the policy statement "Human Trafficking."

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted.

October 2014, reviewed the Rapid Integration of Care Toolkit.

Resolution 36(13) Development of a Rapid Integration of Care Toolkit adopted.

October 2012, reviewed the information paper, Transitions of Care Task Force Report. The information paper recommended strategies for emergency medicine. The 2012 Council Town Hall meeting focused on Transitions of Care and highlighted aspects of the task force report.

Amended Resolution 22(11) Emergency Medicine and Transitions of Care adopted.

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

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 58(21)

SUBMITTED BY: Missouri Chapter
Pennsylvania College of Emergency Physicians

SUBJECT: Updating and Enhancing ED Buprenorphine Treatment Training and Support

PURPOSE: 1)Support the development of training sessions focused on the implementation of buprenorphine induction and prescribing in the ED to replace the previously required 8-hour X-waiver training; and 2) develop an online peer mentoring platform for emergency physicians, that utilizes the expertise of members of the College to support the development and implementation of ED substance use disorder practices.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Buprenorphine therapy is associated with reductions in illicit opioid use, mortality, HIV, Hepatitis C, criminal activity, and healthcare costs[1-6]; and

WHEREAS, Buprenorphine treatment initiated in the ED is associated with reduction in illicit opioid use and significant increase in post-ED addiction treatment[7,8]; and

WHEREAS, Regulations governing buprenorphine treatment and, specifically, ED buprenorphine treatment continue to evolve; and

WHEREAS, An X-waiver is required to prescribe buprenorphine; and

WHEREAS, Historically, X-waiver applicants have been required to complete 8 hours of dedicated training before being eligible to apply; and

WHEREAS, The Department of Health and Human Services released practice guideline exemptions on 4/27/2021 indicating that physicians are no longer required to complete dedicated buprenorphine or opioid use disorder (OUD) treatment training in order to apply for an X-waiver[9]; and

WHEREAS, ACEP and emergency physician experts in OUD management had previously developed emergency medicine-specific training to fulfill the 8-hour training requirement; and

WHEREAS, Eight-hour duration is a barrier to many emergency physicians being able to complete such training; and

WHEREAS, Many emergency physicians are not comfortable with initiating or prescribing buprenorphine therapy due in part to a lack of experience or training[10]; and

WHEREAS, Among the College are experts in addiction and opioid use disorder management who have shared expertise and experience with colleagues both formally and informally; and

WHEREAS, Training sessions for practicing emergency physicians focused on incorporation of buprenorphine management including current regulations, medication induction, and prescribing best practices remains practically necessary even if no longer required for X-waiver certification; and

WHEREAS, Increasing the comfort level and implementation of evidence-based buprenorphine and other

opioid use disorder interventions in the ED will improve the care provided to patients and reduce individual and societal harms associated with opioid use and overdose; and

WHEREAS, Both real-time and asynchronous mentoring will benefit emergency physicians throughout the College to support and encourage ongoing expansion of service delivery and maintain comfort with an evolving regulatory landscape; and

WHEREAS, The ACEP Council has consistently reaffirmed the importance of ED buprenorphine treatment in recognition of the large and growing body of evidence supporting such interventions; therefore be it

RESOLVED, That ACEP support the development of training sessions focused solely on the implementation of buprenorphine induction and prescribing in the emergency department setting to replace the 8-hour training that had previously been required for X-waiver applications; and be it further

RESOLVED, That ACEP develop an online peer mentoring platform, similar to Providers Clinical Support System, but limited to emergency physicians, that utilizes the expertise of members of the College to support the development and implementation of ED substance use disorder practices while responding to specific practice-based challenges that arise in an asynchronous messaging forum available to all ACEP members.

References

1. Bart G. Maintenance Medication for Opiate Addiction: The Foundation of Recovery. *J Addict Dis.* 2012 July; 31(3): 207-225.
2. Weiss, R.D.; Potter, J.S.; Griffin, M.L. et al. Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. *Drug and Alcohol Dependence* 150:112-119, 2015
3. Tsui JI et al. Opioid agonist therapy is associated with lower incidence of hepatitis C virus infection in young adult persons who inject drugs. *JAMA Intern Med.* 2014 December; 174(12): 1974-1981.
4. Schuckit MA. Treatment of Opioid-Use Disorders. *N Engl J Med.* 2016 July 28; 375: 357-368
5. Tkacz J, Volpicelli J, Un H, Ruetsch C. Relationship between buprenorphine adherence and health service utilization and codsts among opioid dependent patients. J Subst Abuse Treat. 2014 Apr; 46(4): 456-62
6. National Academies of Sciences, Engineering, and Medicine 2019. Medications for Opioid Use Disorder Save Lives. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310

Background

This resolution asks the College to support the development of training sessions focused on the implementation of buprenorphine induction and prescribing in the ED to replace the previously required 8-hour X-waiver training. Additionally, it asks ACEP to develop an online peer mentoring platform for emergency physicians, that utilizes the expertise of members of the College to support the development and implementation of ED substance use disorder practices.

The immense scope of opioid use disorder (OUD) and its associated public health impacts have become increasingly evident across all fields of medicine. The size of the crisis prompted the Department of Health and Human Services to declare the opioid crisis a public health emergency in October of 2017. Given the impact of OUD on ED patients, emergency physicians are taking the lead on addressing this crisis. Since 2012, ACEP has promoted the use of non-opioid analgesics to treat pain and has engaged in addressing prescribing patterns in the ED. However, emergency physicians are responsible for less than 5% of total opioid prescribing nationwide, and changing prescribing patterns does little for our patients already suffering from OUD.

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

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

ACEP had led and participated in numerous advocacy efforts over the past decades in championing the critical role of ED physicians in the fight against the opioid epidemic and removal of barriers to access to treatment. Examples of key advocacy efforts have included:

- ACEP met with the head of Substance Abuse and Mental Health Services Administration (SAMHSA), Assistant Secretary for Mental Health and Substance Use Dr. Elinore McCance-Katz, on May 15, 2019. During our meeting with Dr. McCance-Katz, we discussed issues that are extremely important to emergency physicians and our patients, including the ability to administer buprenorphine in the ED for patients with OUD and how to improve care for patients with mental health illnesses. ACEP mentioned the resources and tools that we have created to help our physicians and patients, highlighting the EM-specific DATA 2000/Medications for Addiction Treatment waiver training course that is now being offered to our members, as well as new web-based and mobile device applications around opioids and the management and treatment of suicidal patients. We expressed our commitment to helping SAMHSA achieve the goal and identified opportunities to work together going forward.
- On July 16, 2019, ACEP member Dr. Eric Ketcham participated in a panel discussion sponsored by Pew Charitable Trusts focused on how to reduce barriers that impede the ability for providers to treat patients with Substance Use Disorder (SUD). Dr. Ketcham emphasized the need to remove the X-waiver training requirement. Dr. Ketcham also discussed the importance of initiating buprenorphine in the ED, and how the X-waiver requirement creates an unnecessary barrier that impedes access to this potentially life-saving medication. Finally, he and other panelists talked about other treatment barriers to SUD, including stigma and misperception, outpatient access issues, and insurance prior-authorization, and how policy makers can best address these impediments. Representative Paul Tonko (D-NY) also was present and kicked off the panel discussion. Representative Tonko is the sponsor of the ACEP-supported H.R. 2482, the "Mainstreaming Addiction Treatment Act," which would remove the X-waiver requirement as well as address other barriers to SUD treatment. ACEP also supports the Senate companion bill, S. 2074, sponsored by Senators Maggie Hassan (D-NH) and Lisa Murkowski (R-AK).
- After the panel discussion, Dr. Ketcham and the other panelists met with Admiral Brett Giroir, the Assistant Secretary for Health at the U.S. Department of Health and Human Services (HHS). Adm. Giroir's office is looking into possibly reforming the restrictive "three-day" rule for administering buprenorphine. This rule allows non-waivered providers to administer (but not prescribe) buprenorphine to patients for a three-day period. However, the rule forces providers to administer buprenorphine one-day at a time, requiring patients to come back to the ED or other settings each day to receive treatment. ACEP has long advocated for eliminating this unnecessary hurdle and allowing providers to provide the patient with three-days' worth of treatment during one session. We have previously met with Admiral Giroir and others at HHS to discuss this issue and are encouraged that the Department is considering a policy change.
- On August 29, 2019, ACEP responded to an HHS request for information on ensuring appropriate access to opioid treatments. In the response, HHS is urged to do what is in their authority to reduce barriers to the treatment of patients with OUD. ACEP also issued a press release highlighting the major points contained in the letter.

On January 23, 2020, ACEP convened a Summit, Addressing the Opioid Stigma in the Emergency Department, gathering a diverse group of organizations and representatives to discuss and share ideas to gain insight into the prevalence, effect and targeted solutions to limit the impact of stigma on the care of ED patients with OUD. Objectives for the summit included identification of strategies and behaviors to reduce practices that perpetuate

stigma in the ED and discover innovative solutions to combat stigma in the ED. Summit participation included representation from: federal partnering organizations, representative from the health care team, key stakeholders and individuals who have experienced stigma related to a personal history of substance use. As part of the outcomes of the summit ACEP developed a short video featuring interviews with former ED patients with OUD sharing their experiences and strategies to improve care will be highlighted alongside ED physician interviews to convey the impact of Stigma around Opioid Use Disorder in the ED, and the opportunities to improve care.

ACEP has long supported legislation sponsored by emergency physician and U.S Representative Raul Ruiz (D-CA/36th) called the Easy MAT Act. The Easy MAT Act was incorporated into a short-term funding bill that was signed into law on December 11, 2020. The new law requires the Attorney General (who will delegate this to the DEA) to revise the Three-day Rule within six months so that "practitioners, in accordance with applicable State, Federal, or local laws relating to controlled substances, are allowed to dispense not more than a three-day supply of narcotic drugs to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment (or both)." The key update is that under this new law, practitioners (not just physicians) will be allowed to dispense three-days' worth of medication at one time. Therefore, patients can presumably receive one day's-worth of medication while at the ED and then take the two remaining days-worth home, saving them from having to make subsequent trips to the ED.

In June 2020, the ACEP Board approved Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department.

In late April 2021, the U.S. Department of Health and Human Services released new buprenorphine practice guidelines that remove the need for an 8-hour training course previously required to get a waiver to administer the addiction medication. Emergency physicians have cited this training as a barrier to treating more people with OUDs. The new guidelines exempt emergency physicians and other eligible practitioners from federal certification requirements related to training, counseling and other services that are part of the process for obtaining a waiver (known as the X-waiver). If providers utilize the exception of the practice guidelines, they may only prescribe up to 30 patients at a time. These 30 patients are counted against the provider limit until they are transitioned to a community provider or 30 days from the last prescription if not transitioned.

In February 2021, the ACEP Board of Directors approved the "Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department." These recommends that emergency physicians offer to initiate OUD treatment with buprenorphine in appropriate patients and provide direct linkage to ongoing treatment for patients with untreated OUD and provide strategies for OUD treatment initiation and ED program implementation, including harm reduction strategies (including overdose education and naloxone distribution) or prescriptions is also an essential component of the ED visit.

The United States is in the grips of a substance use and overdose epidemic that has escalated in the wake of the COVID-19 pandemic. More than 92,000 individuals died from a drug overdose from December 2019 through December 2020 – an almost 30 percent increase from the previous 12-month period. Over the past two decades, this unprecedented morbidity and mortality has demanded that all healthcare practitioners, institutions, and financing systems improve access to substance use disorder treatment. ACEP continues to advocate for access to and initiation of OUD treatment with buprenorphine in appropriate patients and increased provision of direct linkage to ongoing treatment for patients. ACEP continues to provide education and provide training sessions focused solely on the implementation of buprenorphine induction and prescribing in the emergency department setting, including 8 hour DATA 2000 EM MAT Waiver trainings, 4-hr EM MAT Waiver trainings (as part of the 4x4 wavier trainings), and 2-hour "core/condensed" EM MAT waiver trainings. Additionally, ACEP has also developed the following tools and resources:

- **Opioid Regulations: State by State Guide (PDF)**
- A series **of free webinars on various topics related to Opioid Use Disorder and Treatment and Management of OUD in the ED**
- **Buprenorphine in the ED Point of Care tool** that is an algorithm-like tool that walks clinicians through the process of patient evaluation and assessment through to prescription.

- Buprenorphine Initiation in Emergency Departments: Interactive Case Vignettes
- Hosted and developed an **Initiation of Buprenorphine and Pain Management in the ED-Implementation Workshop**. Topics covered in the workshop covered everything from setting up a ED-Buprenorphine program, Naloxone program, stigma, and pain management in the ED.
- E-QUAL Network Opioid Initiative

Additionally, ACEP has launched the Pain and Addiction Care in the Emergency Department (PACED) accreditation program. The primary aim of this program is to accelerate the transfer of knowledge about acute pain management and secure appropriate resources to care for patients.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care
- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical environments.
  - Tactic 4 – Develop and promote to members best practices and clinical tools, including apps, for caring for patients with important clinical conditions.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted. Directed ACEP work directly with the DEA and SAMHSA to minimize barriers for emergency physicians to enact meaningful therapy for patients in a time of opioid crisis in the unique environment in which we work; advocate to the DEA and SAMHSA for ED specific requirements and curriculum to reach the greatest number of patients safely and without onerous barriers; continue to advocate for the removal of the DEA X-waiver requirement for emergency physicians who prescribe a bridging course of buprenorphine for opioid use disorder from the ED.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted. Directed ACEP to work with Pain Management & Addiction Medicine Section to develop a guideline on the initiation of medication for OUD for appropriate ED patients, advocate for policy changes that lower regulatory barriers to initiating MAT in the ED, and support expansion of outpatient and inpatient opioid treatment programs.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted. The resolution directed ACEP to provide education to emergency physicians on ED-initiated treatment of patients with substance use disorders and support through advocacy the availability and access to novel induction programs such as buprenorphine from the ED.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted. Directed ACEP to set a standard for linking patients with a Substance Use Disorder to an appropriate potential treatment resource after receiving medical care from the ED.

Amended Resolution 42(14) Reverse an Overdose, Save a Life adopted. The resolution directed ACEP to advocate and support Naloxone use by first responders, availability of Naloxone Over the Counter (OTC), and support research of the effectiveness of ED-initiated overdose education.

Amended Resolution 44(13) Prescription Drug Overdose Deaths adopted. Directed ACEP to appoint a task force to review solutions to decrease death rates from prescription drug overdoses, provide best practice solutions to impact the epidemic of prescription drug overdoses with the goal of reducing the number of prescription overdose deaths.

Amended Resolution 17(12) Ensuring ED Patient Access to Adequate and Appropriate Pain Treatment adopted. The resolution supports chapter autonomy to establish guidelines or protocols for ED pain management, development of

evidence-based, coordinated pain treatment guidelines, opposes non-evidence-based limits on prescribing opiates, and work with government and regulatory bodies on the creation of evidence supported guidelines for responsible emergency prescribing.

Resolution 16(12) Development of Guidelines for the Treatment of Chronic Pain not adopted. Directed ACEP to support state autonomy to establish guidelines for treatment of patients with chronic pain who present to the ED requesting significant doses of narcotic pain medications or other controlled substances, including the establishment of referral networks to existing pain treatment centers

Prior Board Action

February 2021, approved "Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department." The inclusion of harm reduction strategies (including overdose education and naloxone distribution) or prescriptions is also an essential component of the ED visit.

June 2020, approved Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department

February 2020, approved changing the name of the ED Pain & Addiction Management Accreditation Program to Pain & Addiction Care in the ED (PACED).

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

Amended Resolution 47(18) Supporting Medication for Opioid Use Disorder adopted.

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

April 2017, approved the revised policy statement "Optimizing the Treatment of Acute Pain in the Emergency Department;" originally approved June 2009 with the title "Optimizing the Treatment of Pain in Patients with Acute Presentations." This is a joint policy statement with the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society for Academic Emergency Medicine.

Amended Resolution 23(16) Medical Medication Assisted Therapy for Patients with Substance Use Disorders in the ED adopted.

Resolution 21(16) Best Practices for Harm Reduction Strategies adopted.

June 2016, approved the revised policy statement "Naloxone Access and Utilization for Suspected Opioid Overdoses;" originally approved October 2015.

October 2015, approved the policy statement "Naloxone Prescriptions by Emergency Physicians."

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

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

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

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

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 59(21)

SUBMITTED BY: Laura Janneck, MD, FACEP
Nikkole Turgeon, BS
International Emergency Medicine Section
Social Emergency Medicine Section

SUBJECT: Use of Medical Interpreters in the Emergency Department

PURPOSE: Promote the use of qualified medical interpreters for all ED patient interactions in patients with limited English proficiency and provide resources for EDs on available interpreter services and challenges ACEP to envision a method for documenting that providers are qualified to interpret in a medical setting.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Use of medical interpreters has been shown to increase quality of health care provided in several settings; and

WHEREAS, Language barriers increase risks to patient safety[1]; and

WHEREAS, There is a risk of medically consequential miscommunications between emergency department staff and patients when interpreters are not used in appropriate scenarios; and

WHEREAS, The emergency department serves as the entry point into the U.S. health care system for many patients with limited English proficiency (LEP); and

WHEREAS, Under the Affordable Care Act, any healthcare provider or health insurance company receiving federal assistance must provide LEP patients with a qualified interpreter[2]; and

WHEREAS, Qualified interpretation has been associated with improvements in patient satisfaction, communication, and health care access, however, these services are largely under-utilized in emergency department settings[3]; therefore be it

RESOLVED, That ACEP promote the use of qualified medical interpreters for all emergency department patient interactions with patients with limited English proficiency unless the communicating provider has proven qualifications to self-interpret in a medical setting; and be it further

RESOLVED, That ACEP provide resources for emergency departments on available interpreter services and how providers can prove qualification for interpreting in a medical setting.

References

[1]Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. *Int J Qual Health Care*. 2007 Apr;19(2):60-7. doi: 10.1093/intqhc/mzl069. Epub 2007 Feb 2. PMID: 17277013.
[2]Department of Health and Human Services // Section 1557 of the Patient Protection and Affordable Care Act https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html Accessed on July 19th 2021.
[3]Ramirez D, Engel KG, Tang TS. Language interpreter utilization in the emergency department setting: a clinical review. *J Health Care Poor Underserved*. 2008 May;19(2):352-62. doi: 10.1353/hpu.0.0019. PMID: 18469408.

Background

This resolution calls for the College to promote the use of qualified medical interpreters for all ED patient interactions in patients with limited English proficiency unless the provider has proven qualifications to self-interpret in medical settings. Additionally asks the College to provide resources listing available interpreter services for EDs and challenges ACEP to envision a method for documenting that providers are qualified to interpret in a medical setting.

As of 2019, every state has laws on language access in healthcare settings. Thirteen states and the District of Columbia reimburse providers directly for language services used by patients on Medicaid and the Children's Health Insurance Program.[1] As of 2012, 9% of the U.S. population is at risk for an adverse event because of language barriers.[2]

In the Comprehensive Accreditation Manual for Hospitals (CAMH), The Joint Commission requires hospitals to "effectively communicate with patients when providing care, treatment and services."[3]

The AMA has a policy supporting "…efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services."[4]

The crux of the issue seems to be that the burden of providing interpreter services should fall upon the hospital, not just the ED, as all areas of the hospital must provide for interpreter services. It seems reasonable that each hospital should have a plan for interpreter coverage that would include ED patients.

According to Brenner et al, patients with limited English proficiency who require interpreter services use ED services significantly more often than those of similar ages not needing an interpreter."[5]

In June 2016, the ACEP Board of Directors approved a Clinical Emergency Data Registry (CEDR) quality measure "Interpreter Health Service Measure." After an environmental scan, the Technical Expert Panel had feasibility concerns with this measure and it was not pursued.

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states: "In accordance with regulations, translation and communication capabilities should exist for foreign languages and for the vision and/or hearing impaired."[6]

There are many online resources that can be utilized to develop a resource list of interpreters, including the National Council on Interpreting in Health Care, who has developed a Code of Ethics and National Standards for Interpreters in Healthcare. The Joint Commission allows for practitioners to communicate directly with a patient in their preferred language but "it is recommended that the organization has a process to make sure that communication with the patient in the non-English language is effective and meets the patient's needs."[7] There are more than 380 languages and dialects. Building a program to track dialects and cross referencing it with geographic availability would be a resource intensive undertaking. Most institutions have a pathway to identify qualified interpreters among their medical staff.

Background References

[1]National Health Law Program. Summary of State Law Requirements Addressing Language Needs in Health Care. 2019.
[2]Agency for Healthcare Research and Quality. Improving Patient Safety Systems for Patients with Limited English Proficiency – A Guide for Hospitals. 2012.
[3]The Joint Commission. Patient-centered communication standards for hospitals. PC.02.01.21.
[4]AMA. Interpreter Services and Payment Responsibilities H 385.917. Reaffirmed June 2021.
[5]Brenner JM, Baker EF, Iserson KV, et al. Use of interpreter services in the emergency department. *Ann Emerg Med*. 2018;72(4):432-7.
[6]ACEP. Emergency Department Planning and Resource Guidelines [policy statement]. Approved April 2021.
[7]The Joint Commission. Standards FAQs. Language Access and Interpreter Services – Understanding the Requirements. March 2021.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.
  - Strategy 6 – Advocate at the federal level and address legislation that ensures fair and appropriate reimbursement for emergency services. Support efforts with PR campaigns, as needed.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None.

Prior Board Action

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, June 2001 with the current title; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

June 2016, Approved CEDR Quality Measure "Interpreter Health Service Measure"

Background Information Prepared by: Julie Rispoli
CUAP Accreditation Manager

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2021 Council Meeting

Reference Committee Members

Reference Committee D – Scope of Practice & Workforce Resolutions 60-77

Abhi Mehrotra, MD, FACEP (NC) Chair
William Falco, MD, FACEP (WI)
Daniel Freess, MD, FACEP (CT)
Todd Slesinger, MD, FACEP (FL)
Odetolu Odufuye, MD, FACEP (D&I Section)
Scott Pasichow, MD, MPH (YPS)

Adam Krushinskie, MPA
Harry Monroe

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 60(21)

SUBMITTED BY: Emergency Medicine Residents' Association (EMRA)

SUBJECT: Accountable Organizations to Resident and Fellow Trainees

PURPOSE: Create a task force to: 1) determine which organizations or governmental entities are capable of being permanently responsible for resident and fellow interests without conflicts of interests; 2) determine how these organizations can be held accountable for fulfilling their duties to protect the rights and well-being of resident and fellow trainees; 3) determine methods of advocating for residents and fellows that are timely and effective, without jeopardizing trainees' current and future employability; and 4) In the event that no organizations or entities are identified that meet the above criteria, determine how such an organization may be created.

FISCAL IMPACT: Budgeted task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 – $30,000 for an in-person task force meeting depending on the size of the task force.

WHEREAS, The stated mission of the Accreditation Council for Graduate Medical Education (ACGME) is to, "improve healthcare and population health by assessing and advancing the quality of resident physicians' education through accreditation[1];"and

WHEREAS, To achieve its mission the ACGME has determined that it has two main purposes, "(1) to establish and maintain accreditation standards that promote the educational quality of residency and subspecialty training programs; and (2) to promote conduct of the residency educational mission with sensitivity to the safety of care rendered to patients and in a humane environment that fosters the welfare, learning, and professionalism of residents[1];" and

WHEREAS, While the ACGME has taken steps to advocate for residents, its ability to effectively and timely work on their behalf is limited by "blunt tools" related to removal of accreditation and delay in providing feedback to programs[3]; and

WHEREAS, Resident and fellow trainees still endure suboptimal training conditions with recourse to address these issues limited by multiple factors, including a high debt burden and fear of their program losing accreditation thus affecting future career prospects, ultimately making reporting even gross ACGME guideline infractions difficult to encourage[4,5];and

WHEREAS, As exemplified by the Hahnemann University Hospital closure, residents and fellow trainees are vulnerable to the negative effects of hospital closures that threaten the quality and completion of their graduate medical education, financial wellbeing, and legal status within the United States[6,7]; and

WHEREAS, The Centers for Medicare & Medicaid Services (CMS) is tasked with distributing the majority of GME funding, but is not responsible for overseeing the quality of training programs nor the wellness or treatment of trainees[9]; and

WHEREAS, None of the organizations that responded to the Hahnemann residency closures were required to by law, nor was the response coordinated, regulated, or monitored by any type of oversight organization, and an ACGME investigation of the closure of the Hahnemann University Hospital found that no existing organizations represented resident and fellow interests to the exclusion of other stakeholder interests;[2,8] therefore be it

RESOLVED, That ACEP establish a task force with the following goals:

1. Determine which organizations or governmental entities are capable of being permanently responsible for resident and fellow interests without conflicts of interests.
2. Determine how these organizations can be held accountable for fulfilling their duties to protect the rights and well-being of resident and fellow trainees.
3. Determine methods of advocating for residents and fellows that are timely and effective, without jeopardizing trainees' current and future employability.
4. In the event that no organizations or entities are identified that meet the above criteria, determine how such an organization may be created.

References

1. *ACGME Manual Of Policies And Procedures*. Originally published 06/1992, Updated 06/2020. Online. <https://www.acgme.org/Portals/0/PDFs/ab_ACGMEPoliciesProcedures.pdf> Accessed August 30 2020.
2. Nasca T, Johnson PF, Weiss KB, Brigham TP. Elevating Resident Voices in Health Systems Change: Lessons From the Closure of Hahnemann University Hospital. *Acad Med*. 2020;95(4):506-508. Doi:10.1097.
3. Lypson M, Hamstra S, Colletti L. Is the Accreditation Council for Graduate Medical Education a Suitable Proxy for Resident Unions? Acad Med. 2009;84(3)296-300. doi: 10.1097/ACM.0b013e3181971f77
4. Bernstein J. Washington's Struggling Medical Residents Need a Raise. The Nation. https://www.thenation.com/article/archive/medical-strike-seattle/ Published October 9, 2019. Accessed September 10, 2020.
5. Alker A. As coronavirus rages, medical residents are stressed to breaking point. USA Today. https://www.usatoday.com/story/opinion/hiddencommonground/2020/05/22/coronavirus-places-already-stressed-medical-residents-high-risk-column/5235163002/ Published May 22, 2020. Accessed September 10, 2020
6. Orlowski J. Displaced Hahnemann residents and attending physicians may soon lose liability insurance. AAMC. https://www.aamc.org/news-insights/displaced-hahnemann-residents-and-attending-physicians-may-soon-lose-liability-insurance Published January 7, 2020. Accessed September 10, 2020.
7. Craven J. The wide-ranging impact of hospital closures. The Hospitalist. https://www.the-hospitalist.org/hospitalist/article/220570/mixed-topics/wide-ranging-impact-hospital-closures Published April 10, 2020. Accessed September 10, 2020.
8. O'Reilly, Kevin. Grants will help residents displaced by record hospital closure. AMA news. https://www.ama-assn.org/residents-students/residency/grants-will-help-residents-displaced-record-hospital-closure. Published August 27, 2019. Accessed September 11, 2020.
9. Direct Graduate Medical Education (DGME). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME. CMS.gov. Last modified on 05/12/2020. Accessed September 11, 2020.

Background

The resolution requests ACEP to set create a task force that would: 1) determine which organizations or governmental entities are capable of being permanently responsible for resident and fellow interests without conflicts of interests; 2) determine how these organizations can be held accountable for fulfilling their duties to protect the rights and well-being of resident and fellow trainees; 3) determine methods of advocating for residents and fellows that are timely and effective, without jeopardizing trainees' current and future employability; and 4) in the event that no organizations or entities are identified that meet the above criteria, determine how such an organization may be created.

The resolution discusses the current roles of the Accreditation Council for Graduate Medical Education (ACGME) and the Centers for Medicare & Medicaid Services (CMS) in training residents and funding resident slots respectively, but states that both organizations do not truly advocate for the rights of residents when they "endure suboptimal training conditions."

The stated purpose of ACGME is to accredit institutions, residency, and fellowship programs. Beyond accreditation, ACGME does dedicate resources to specific initiatives, some of which relate to physician well-being. The ACGME also offers two ways of reporting an issue about a residency program through the Office of the Ombudsperson and by filing a formal complaint. The Office of the Ombudsperson "offers an opportunity to anonymously report issues about residency programs and institutions without impacting their accreditation or Recognition status," while formal complaints "may affect the accreditation or Recognition status(es) of a Sponsoring Institution or program and, therefore, must include the complainant's name and contact information." The ACGME states that it does not act as a "mediator or adjudicator for formal complaints. The ACGME only addresses matters regarding non-compliance with the published Institutional, Program, and/or Recognition Requirements and does not adjudicate individual disputes between persons in residency or fellowship programs or those programs' Sponsoring Institutions."

The resolution also refers to the closure of Hahnemann University Hospital (HUH). As background, on June 26, 2019, the American Academic Health System announced that HUH in Philadelphia would be permanently closed in early September. This statement created an uncertain future for the 570+ residents and fellows across 36 GME programs just as the new academic year was about to start. Based on previous program closures, residents and fellows on their own began seeking to transfer to other existing programs. On July 10, HUH announced the sale and transfer of the CMS-funded GME slots to Tower Health, where the residents would continue their training. Tower Health only had 118 trainees at the time, and not all residencies and fellowships were available. Trainees were in limbo as they were still under contract with HUH and unable to take their funding with them to continue training at a new institution. The matter was litigated in the courts. Eventually, a settlement was reached, and the residents were released with partial funding. In 2020, The AMA Council on Medical Education released two reports the "Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure" and the "Graduate Medical Education and the Corporate Practice of Medicine" examining the related issues. In response to the HUH closure, CMS revised its policy in the Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) final rule regarding resident transfers when hospitals close and/or announce that their residency programs are ending. Specifically, instead of linking temporary funding for the affected residents to the day prior to or on the day the hospital and/or residency program closes, the determining day is instead now the day that the closure was publicly announced. Further, CMS is allowing funding to be transferred temporarily for certain residents who are not physically at the closing hospital/closing program. ACEP, along with EMRA, strongly supported these changes, and wrote to CMS stating that they will help protect our residents and provide sufficient funding to teaching hospitals that take in displaced residents.

ACEP Strategic Plan Reference

This resolution aligns with the following objective.

Goal 1 – Improve the Delivery System for Acute Care

- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted task force and staff resources if a meeting is held virtually. Unbudgeted expenses of $20,000 – $30,000 for an in-person task force meeting depending on the size of the task force.

Prior Council Action

Amended Resolution 59(19) Opposition to the Sale and Commoditization of Graduate Medical Education Slots adopted. Directed ACEP to immediately support CMS in opposing the sale of GME slots and oppose any sale or other commoditization of GME slots.

Substitute Resolution 23(99) Resident Physician Safeguards in the Event of a Residency Program Closure adopted. Directed ACEP to work with appropriate organizations and agencies to develop strategies to implement protections for resident physicians to complete their training in the event of residency program closures.

Prior Board Action

June 2020, Amended Resolution 59(19) Opposition to the Sale and Commoditization of Graduate Medical Education Slots adopted.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban/Underserved Areas;" reaffirmed April 2012 and October 2006; originally approved in June 2000.

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

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

Substitute Resolution 23(99) Resident Physician Safeguards in the Event of a Residency Program Closure adopted.

Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director

Jonathan Fisher, MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 61(21)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Advocating for a Required Emergency Medicine Rotation at All U.S. Medical Schools

PURPOSE: Advocate for a required emergency medicine rotation in all allopathic and osteopathic, US-based medical schools.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, 61% of allopathic medical schools accredited by the Association of American Medical Colleges (AAMC) require a separate emergency medicine clerkship[1]; and

WHEREAS, All osteopathic medical schools accredited by the American Osteopathic Association (AOA) require a separate emergency medicine clerkship[2]; and

WHEREAS, The specialty and work environment of emergency medicine fulfills a large majority of the expectations determined by the AAMC's Physician Competency Reference Set (PCRS)[3]; and

WHEREAS, Many medical school graduates will go on to pursue fields of medicine different from several traditional core rotations; and

WHEREAS, Many hospital environments will not have one or more services or specialties represented by the medical fields of required rotations; and

WHEREAS, Most hospital settings have an emergency department where physicians take care of patients across the spectrum of age and medical/surgical pathology; and

WHEREAS, Most medical specialties will need to interact personally or clinically with the emergency department and emergency physicians pertaining to the care of mutual patients; therefore be it

RESOLVED, That ACEP advocate that all U.S. medical schools, allopathic and osteopathic, require at least one emergency medicine rotation.

References

1. AAMC. Percentage of Medical Schools with Separate Required Clerkships by Discipline: Emergency Medicine. https://www.aamc.org/data-reports/curriculum-reports/interactive-data/clinical-course-required-weeks-discipline
2. American Osteopathic Association. Student Doctors: Rotations: Planning for Rotations. https://osteopathic.org/students/rotations/planning-for-rotations/
3. AAMC. Competency Mapping (Medical School Program Expectations Mapped to Physician Competency Reference Set [PCRS]). https://www.aamc.org/data-reports/curriculum-reports/interactive-data/competency-mapping-medical-school-program-expectations-mapped-physician-competency-reference-set

Background

This resolution calls on ACEP to advocate for a required emergency medicine rotation in all allopathic and osteopathic, US-based medical schools. The American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA) currently accredits 37 osteopathic medical schools. Osteopathic programs have the

following rotations: core, elective, and audition. Emergency medicine (EM) is considered a core, four-week rotation for osteopathic medical school. The Liaison Committee on Medical Education (LCME) currently accredits more than 150 medical programs leading to an MD degree. According to AAMC data, currently 61% of medical school have a separate EM-required clerkship (up from 50% in 2011).

The majority of medical schools organize their training into pre-clinical and clinical components with rotations traditionally occurring towards the latter portion of training. Over the past decade, many medical schools have redesigned their curriculum for the first two years but have largely left the latter years untouched. Later years tend to focus on student-chosen electives aimed to encourage career decisions and increase clinical exposer to other specialties. However, some medical schools have begun to take a more integrated approach and incorporate patient interaction, hands-on experience, and clinical training much earlier in the process. Each school has its own mission, curriculum, academic schedule, and course format. While type, length, and number of rotations can vary from school to school the following specialties are usually included: surgery, psychiatry, pediatrics, obstetrics and gynecology, family medicine, and internal medicine. For most schools, other rotations are generally provided as electives. Options to explore other specialties are specialty interest groups and student sections of medical specialty societies. The COVID pandemic has complicated fourth-year clerkships with long-term impacts yet to be determined. The LCME guidance issued in March 2020 noted that, "Some required fourth year clerkships (typically, emergency medicine, critical care, neurology) may be delayed or cancelled..."

Rotations are general perceived as a way to provide patient encounters and assess an individual's fit with the perceived attributes of a potential specialty (i.e., lifestyle, intellectual challenge, geographic options, potential for research or academic track, etc.). There is some evidence that suggests that the accuracy of understanding the day-to-day experience within a specialty can most impact the type or number of students choosing that specialty. One study found that prior life experiences and early exposure to emergency medicine, as well as specialty-specific mentorship, played a role in medical students selecting EM as a specialty during their medical school experience. Additionally, another study found that EM's perception as a having a "controllable lifestyle" was a factor. Research in surgery found that mentorship, experience in surgery, stereotypes, timing of exposure and personal factors influenced a student's decision to go into surgery. Another study found that work content, type of patients and lifestyle provided influenced students in three different clerkships. A more recent study focused on pathology as a specialty, found that clinical or research opportunities, autopsy observation and involvement in specialty groups were associated with medical student selecting pathology. Most research has focused on how exposure to a specialty influences a student's decision to enter that specialty, rather than on subsequent patient outcomes or transitions of care.

A 2007 study of residency program directors (PDs) tried to determine common struggles with interns to formulate goals for curricular reform. Through semi-structured interviews with 30 PDs in the ten most common specialties they found that while 93% highly recommended students complete a sub-internship in the field in which they were applying, 27% recommended emergency medicine and ambulatory care electives. Additionally, critical care and EM rotations were encouraged because PDs believed they provided cognitive, procedural, and communications skills training that students would need across a broad range of clinical presentations. Additionally, there has been encouragement in the past calling on academic emergency physicians to advocate for EM as a specialty with the medical school curricula. Others have noted the role that education plays in the continuum of health care with a continued focus on how it will impact coordinated patient care.

ACEP's policy statement, "Guidelines for Undergraduate Education in Emergency Medicine," states that, ACEP "believes that all medical students should be taught the basic principles of emergency medicine in order to recognize a patient requiring urgent or emergency care, initiate evaluation and management, and provide basic emergency care." It also states that, "every medical student should receive clinical exposure to emergency department patients and care" and that this can be accomplished through either a, "specific curriculum designed by emergency medicine faculty," or by "incorporating essential topics of emergency medicine into the existing curriculum." The policy also states that, "the exact format of teaching emergency medicine to medical students can take a variety of designs and should be tailored to local abilities, resources or curriculum needs, but should be driven by experts board certified in the field of emergency medicine."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 39(88) Development of Emergency Medicine in Medical Schools adopted. Directed ACEP to continue to promote the development of academic divisions/departments of emergency medicine in all medical schools, work with UA/EM to encourage the implementation of the published "Guidelines for Undergraduate Education in Emergency Medicine" by all medical schools and adopt a position statement encouraging the requirement of a clinical rotation in emergency medicine as a graduation criterion for all medical schools.

Substitute Resolution 38(88) Emergency Medicine Training and Education: Medical Students adopted. Directed ACEP to assess and make available information on the status of emergency medicine in U.S. medical school and continue to support the establishment of independent academic departments of emergency medicine in all U.S. medical schools.

Resolution 38(79) Emergency Medicine Qualification for Primary Care Practice adopted. Directed ACEP to develop a rationale for emergency medicine's qualification for federal designation as primary care practice and that ACEP use its influence and means to secure that designation.

Prior Board Action

Substitute Resolution 39(88) Development of Emergency Medicine in Medical Schools adopted.

Substitute Resolution 38(88) Emergency Medicine Training and Education: Medical Students adopted.

Resolution 38(79) Emergency Medicine Qualification for Primary Care Practice adopted.

June 2021 approved the revised policy statement "Guidelines for Undergraduate Education in Emergency Medicine;" revised June 2015 and April 2008; reaffirmed October 2001; revised January 1997; originally approved September 1986.

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

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 62(21)

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

SUBJECT: Support of Telehealth Education in Emergency Medicine Residency

PURPOSE: Endorse telehealth training opportunities for residents, advocate for telehealth inclusion in The Model of the Clinical Practice of Emergency Medicine and support the development of telehealth fellowship programs in EM.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Telehealth applications in emergency medicine are ever-expanding and include physician-to-physician consults (e.g., tele-stroke, tele-radiology, tele-trauma), decision support in emergency medical services prehospital care, mobile health and medical apps, and direct physician-to-patient services (e.g., tele-screening and tele-intake)[1-4]; and

WHEREAS, The use of telehealth in emergency medicine is increasing rapidly due to improvements in technology, expanded Centers for Medicare and Medicaid Services payment policies, and a need for innovative approaches to care during the COVID-19 pandemic[5]; and

WHEREAS, There is an emerging need for trained emergency medicine physicians who can effectively deliver telehealth services, requiring a new subset of skills for the EM residency graduate; and

WHEREAS, Telehealth is an emerging field within emergency medicine, now with multiple fellowships and certification programs[6]; and

WHEREAS, Select residency programs have demonstrated successful adoption of training in telehealth with positive feedback from resident participants, such as Thomas Jefferson University Department of Emergency Medicine's implementation of a resident-led, post-ED visit telehealth follow-up program[7]; and

WHEREAS, The Emergency Medicine Residents' Association (EMRA) explicitly supports telehealth for training opportunities for residents in Section IX.III of the EMRA policy compendium[8]; and

WHEREAS, Despite these examples of innovations in telehealth practice, telehealth has not become a core competency in medical education as demonstrated by its absence in the Accreditation Council for Graduate Medical Education (ACGME) residency education milestones and The Model of the Clinical Practice of Emergency Medicine, and many emergency medicine residency programs lack training opportunities in telehealth[9]; therefore be it

RESOLVED, That ACEP promote and endorse telehealth training opportunities for emergency medicine residents; and be it further

RESOLVED, That ACEP advocate for inclusion of telehealth in *The Model of the Clinical Practice of Emergency Medicine*; and be it further

RESOLVED, That ACEP support the development of additional telehealth fellowship programs in emergency medicine.

References

1. Sikka N, Paradise S, Shu M. Telehealth in Emergency Medicine: A Primer. *ACEP Emergency Telemedicine Section*; 2014. Accessed at: https://www.acep.org/globalassets/uploads/uploaded-files/acep/membership/sections-of-membership/telemd/acep-telemedicine-primer.pdf

2. Rademacher NJ, Cole G, Psoter KJ, et al. Use of Telemedicine to Screen Patients in the Emergency Department: Matched Cohort Study Evaluating Efficiency and Patient Safety of Telemedicine. *JMIR Med Inform*. 2019;7(2):e11233. doi:10.2196/11233
3. Joshi AU, Randolph FT, Chang AM, et al. Impact of Emergency Department Tele-intake on Left Without Being Seen and Throughput Metrics. *Acad Emerg Med*. 2020;27(2):139-147. doi:10.1111/acem.13890
4. Guyette FX et al. ACEP Whitepaper: Literature Based Progress in Telehealth. *ACEP Emergency Telemedicine Section* 2019. Accessed at: https://www.acep.org/globalassets/sites/acep/blocks/section-blocks/telemd/final-whitepaper---sans-definition-8-7-19.pdf
5. Hollander JE, Carr BC. Virtually Perfect? Telemedicine for Covid-19. *NEJM*. 2020;382(18):1679-1681. doi:10.1056/NEJMp2003539
6. Neumann A, Sikka N. Telemedicine. *EMRA Fellowship Guide*. 2020. Accessed at: https://www.emra.org/books/fellowship-guide-book/26-telemedicine/
7. Papanagnou D, Stone D, Chandra S, Watts P, Chang AM, Hollander JE. Integrating Telehealth Emergency Department Follow-up Visits into Residency Training. *Cureus*. 2018;10(4):e2433. doi:10.7759/cureus.2433
8. "Section IX.III: Support for Telemedicine in EM." *EMRA Policy Compendium*; 2018. Accessed at: https://www.emra.org/globalassets/emra/about-emra/governing-docs/policycompendium.pdf
9. Pourmand A, Ghassemi M, Sumon K, Amini SB, Hood C, Sikka N. Lack of Telemedicine Training in Academic Medicine: Are We Preparing the Next Generation? *Telemedicine and e-Health*; 2020, ahead of print. doi:10.1089/tmj.2019.0287

Background

This resolution calls on ACEP to endorse telehealth training opportunities for residents, advocate for telehealth inclusion in The Model of the Clinical Practice of Emergency Medicine and support the development of telehealth fellowship programs in EM.

Connecting remote sites and providing remote consultation service were some of the initial efforts of incorporating telemedicine within EDs. Since then, telehealth has increased rapidly over the years demonstrating that not only can it increase access to healthcare but has the potential to also increase efficiency (e.g., during overcrowding to facilitate the number of patients seen by healthcare workers, etc.). and help reduce costs. Telemedicine is used not only as a physician-to-physician consult service, but also as direct-to-consumer (patient) technology. The COVID-19 pandemic further changed the landscape of telemedicine in EDs. With regulatory and administrative barriers relaxed, more convenient and improved technology available, and institutions increasingly feeling pressure to reduce healthcare workers to potential exposure due to the lack of available PPE many sites saw even more widespread adoption of telehealth. While, some barriers remain such as concerns about privacy, limitations of physician examination and concerns about the patient experience, overall telehealth seems poised to continue to grow.

ACEP's policy statement "Emergency Medicine Training, Competency, and Professional Practice Principles" states that "it is the role and responsibility of the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM) to set and approve the training standards, assess competency through board certification processes and establish processional practice principles for emergency physicians."

In 1975, ACEP and the University Association for Emergency Medicine (now known as the Society for Academic Emergency Medicine), using expert opinion, conducted a practice analysis of emergency medicine to develop a listing of common conditions, symptoms, and diseases seen and evaluated in emergency departments, known then as the Core Content of Emergency Medicine. These were revised several times over the years ultimately leading to a large, complex, and unwieldy document. Several task forces were developed to address the need for a concise core resource based on an empirical foundation that would represent the needs of the specialty. Ultimately, the Core Content Task Force II developed *The Model of the Clinical Practice of Emergency Medicine*, relying on both empirical data and the input of several expert panels. A collaborative of six emergency medicine organizations (ABEM, ACEP, CORD, EMRA, RRC-EM, and SAEM) was asked to review the 2001 EM Model and propose changes and give feedback. The work of the task force was first published in June 2005 in both *Annals of Emergency Medicine* and *Academic Emergency Medicine.* These organizations continue to collaborate to review and revise subsequent EM Models.

Currently, *The Model of the Clinical Practice of Emergency Medicine* (EM Model) serves as "the basis for the content specifications for all ABEM examinations." It is reviewed every three years by the EM Model Review Task Force. There are three components to the EM Model (assessment of patient acuity, description of the tasks that must be performed to provide appropriate emergency medical care, and a listing of medical knowledge, patient care and procedural skills) that describe the practice of EM and differentiate it from the clinical practice of other specialties. The ABEM website states that it will use the 2019 version to develop examinations beginning in the fall 2022

examinations. The EM Model is meant to represent the most essential information and skills necessary for board-certified emergency physicians to practice. Section 20.0 of the EM Model provides a list of "Other Core Competencies of the Practice of Emergency Medicine," covering topics such as communication, ethics, clinical informatics, ED operations and more. Telehealth is not explicitly listed in this section. The ACGME Milestones are, "designed only for use in evaluation of residents in the context of their participation in ACGME-accredited residency programs," and "provide a framework for the assessment and development of the resident in key dimensions of.. competence." One review of the ACGME specialty and subspeciality milestones, only one specialty (Child and Adolescent Psychiatry) mentioned telehealth.

During the pandemic, on March 18, 2020, the ACGME released a statement saying that, instead of releasing its Common Program Requirements for supervisions of telemedicine visits carried out by residents and fellows, originally planned to go into effect on July 1, 2020, they would make them "effective immediately" and that "the ACGME will permit residents/fellows to participate in the use of telemedicine to care for patients affected by the pandemic." The ACGME further stated that, "Ultimately each specialty Review Committee will choose whether to continue to allow for this type of direct supervision with telemedicine in other situations." The EM Program Requirements currently in effect (VI.A.2.c).(1).(b) allow the resident to provide care through telecommunication as long as the supervising physician is, "concurrently monitoring the patient care through appropriate telecommunication technology."

An ACEP Emergency Telehealth Section survey from 2018, found that less than 5% of U.S. and Canadian medical students were satisfied with their telemedicine training. It also found that 90.8% reported at least some interest in telemedicine and 97% who believed that telemedicine would play some role in physician practice in ten years. Additionally, some residency programs are instituting their own telehealth electives.

ACEP's "Telehealth Inclusion" policy statement states that, "All existing ACEP policy statement, where applicable, are also pertinent to the practice of emergency medicine delivered via telehealth."

The American College of Telemedicine currently lists two fellowship programs on its website. The American Telehealth Association (ATA), founded in 1993, states that it now includes more than 400 organizations. The American Board of Telehealth offers a certificate program and states on their website that they "promote a gold standard for professionals and paraprofessionals to learn best practices for implementing and using telemedicine across the care continuum."

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 36(20) Telehealth Free Choice referred to the Board of Directors. Requests ACEP to: 1) support legislation to allow patients to be at any location, allow emergency medicine physicians or other clinicians that are supervised by emergency medicine physicians, to be at any location, same or different than the patient, allow waiving of cost sharing, allow coding using any code that reflects the service provided; 2) support legislation mandating all payers to allow patients to select the physician of their choice, whether employed, within the health insurer's network, or outside of insurer's network, without restriction, to provide telehealth services for acute unscheduled care to any or all their insured patients; 3) advance the responsible implementation of telehealth practice consistent with policies and guidelines previously developed by ACEP, the American Medical Association, and specialty-specific best practices as well as ongoing assessment of patient outcomes, physician-patient relationship, 4) in collaboration with other medical

organizations, advocate for state and federal legislation that supports Medicaid, Medicare, and private payer reimbursement and coverage parity for live video physician telehealth visits as well as fair reimbursement of ancillary telehealth services such as remote patient monitoring, eConsults, and store and forward technology; and 5) oppose restrictions to telehealth care unless those restrictions are consistent with established best practices, confidentiality, or patient safety protections.

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted. Directed ACEP to develop a policy statement specifically indicating that its policies apply to all locations of emergency medicine practice whether provided remotely or in-person.

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted. Directed ACEP to investigate and evaluate the unintended consequences of telemedicine and develop policy that supports remote access to specialist care that also assures the establishment of an appropriate doctor-patient relationship.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted. The resolution directed that a group of members with expertise in telemedicine be appointed to create a telemedicine policy specific to emergency medical practice.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted. The amended resolution directed ACEP to work with appropriate parties at federal and state levels, to advocate for legislation or regulation that will provide fair payment by all payers, for appropriate services provided via telemedicine.

Prior Board Action

January 2021, approved the policy statement "Telehealth Inclusion."

February 2020, approved the revised policy statement "Emergency Medicine Telehealth;" originally approved January 2016.

October 2020, approved the "Practice Guidance for Emergency Telehealth and Acute Unscheduled Care Telehealth."

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted.

June 2016, approved the policy statement "Ethical Use of Telemedicine in Emergency Care."

Resolution 45(15) Telemedicine Appropriate Support and Controls adopted.

Resolution 36(14) Development of a Telemedicine Policy for Emergency Medicine adopted.

Amended Resolution 28(14) Fair Payment for Telemedicine Services adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 63(21)

SUBMITTED BY: Government Services Chapter

SUBJECT: Physician-Led Team Leader Training

PURPOSE: 1) Engage with the ACGME, CORD, SEMPA, AAENP, and AAPL to develop a standardized leadership curriculum for residency; 2) CME courses for those who have already completed their training; and 3) advocate for inclusion of leadership competencies in the next revision of The Model of the Practice of Clinical Emergency Medicine.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, ACEP has long held that the best emergency medical care is provided and led by ABEM- or AOBEM- certified emergency physicians, as affirmed in the 2018 Report from the Multi-Organization Emergency PA/NP Utilization Task Force; and

WHEREAS, According to that same report, emergency care must be physician-led and emergency physicians must supervise all care provided by physician assistants (PAs) and nurse practitioners (NPs); and

WHEREAS, The Society for Emergency Medicine Physician Assistants have multiple times affirmed their commitment to physician-led team based care and advocate for opportunities "to learn emergency medicine while reinforcing the physician-PA team concept"; and

WHEREAS, Emergency physicians should take an active role in the mentorship and continuing education of practicing PAs and NPs. This does not require training to the expertise of an emergency physician, but rather providing them with the knowledge, resources, and support necessary to maximize their contributions to the team within their defined role; and

WHEREAS, Physician-led teams assume physicians are skilled in how to effectively supervise NP/PAs and how foster highly effective teams to promote safety and quality of care, but few physicians are given formal leadership training; and

WHEREAS, It is also the responsibility of the supervising emergency physician to assist PAs and NPs in the care of any patient when requested, regardless of whether supervision is required by local ED policy; and

WHEREAS, Physician supervision of PA/NPs creates liability and physician can be at increased risk if they cannot establish and execute proper supervision of PA/NPs on their team; and

WHEREAS, It is important that all physicians at a site have a standardized and unified understanding of their supervisory requirements such that the entire emergency physician-led team has the same expectations; and

WHEREAS, The ACGME's Clinical Practice of Emergency Medicine details team management as an essential skill for emergency physicians, defined as the ability to "Coordinate, educate, or supervise members of the patient management team and utilize appropriate hospital resources."; and

WHEREAS, Specific curriculum for team leader training is not defined by the ACGME or any other governing bodies and no accepted curricula are available for developing educational and training products; and

WHEREAS, The disciplines of leadership development, organizational behavior, and experience from other industries such as the military and aviation can provide a framework for developing a leadership training curriculum; therefore be it

RESOLVED, That ACEP engage with the Accreditation Council for Graduate Medical Education, the Council of Residency Directors in Emergency Medicine, the Society of Emergency Medicine Physician Assistants, the American Academy of Emergency Nurse Practitioners, and the American Association of Physician Leaders, and other interested parties to develop a standardized curriculum for teaching physicians to function as team leaders in support of physician-led teams; and be it further

RESOLVED, That ACEP develop continuing medical education to instruct physician-led teams based on the curriculum identified by the stakeholders for physicians who are post residency; and be it further

RESOLVED, That ACEP advocate to the Accreditation Council for Graduate Medical Education that specific competencies in team leadership be incorporated in the next revision of *The Model of the Practice of Clinical Emergency Medicine*.

Resources

1. Position Statement, Society for Emergency Medicine Physician Assistants, Emergency Medicine Postgraduate Education for Physician Assistants Statement, Mar 23, 2020.
2. 2019 Model of the Clinical Practice of Emergency Medicine, https://www.cordem.org/globalassets/files/misc.-files/2019-em-model_website.pdf. Accessed 22 Jul 2021.

Background

This resolution calls on ACEP to engage with the ACGME, CORD, SEMPA, AAENP, and AAPL to develop a standardized leadership curriculum for residency and CME courses for those who have already completed their training. It also calls on ACEP to advocate for the inclusion of leadership competencies in the next revision of The Model of the Practice of Clinical Emergency Medicine.

A recent study of emergency medicine residents and attendings found that while 89.5% of respondents believed that learning about business topics during residency is "important" or "very important" and the majority of residents (61%) said that their program does not adequately prepare them for business and practice management issues, such as contracts and practice modes, credentialing, value-based payments, etc. Management skills and leadership have been proposed as core content within medical education. Data from 2009 found that fewer than 4% of U.S. hospitals were headed by physicians. A 2011 study that looked at the top-100 best hospitals (according to the *US News and World Report*) to see if hospitals were ranked more highly when led by medically trained physicians versus no-MD professional managers. Their analysis found that hospital quality scores were approximately 25% higher for physician-led hospitals compared to professional managers. The AMA states that, "physician assistants should be authorized to provide patient care services only so long as the physician assistant is functioning under the direction and supervision of a physician or group of physicians." ACEP considers board-certified/board-eligible emergency physician supervision as the gold standard.

Most leadership and management training takes place through external training opportunities (e.g., EMRA and ACEP Leadership program, Global Emergency Medicine Student Leadership Program, ACEP Young Physician Section Leadership Society, Chapter Leadership Development Programs, etc.), "on the job," online, insolated workshops, or through other venues, but rarely within a formal curriculum. There has been an increase in the percentage of medical school graduates completing dual MD/MBA degrees (up 50% between 2015-19). However, this represents less than 1% of graduates. Some programs, however, have made strides in integrating leadership and management training into their curriculum. These programs, for example, include rotations with leaders in finance, patient-safety, operations, etc. Other programs create a two-tier approach to introduce the fundamental principles of business, while others require a team-based innovation project as a capstone.

Currently, *The Model of the Clinical Practice of Emergency Medicine* (EM Model) serves as, "the basis for the

content specifications for all ABEM examinations." It is reviewed every three years by the EM Model Review Task Force. There are three components to the EM Model (assessment of patient acuity, description of the tasks that must be performed to provide appropriate emergency medical care and a listing of medical knowledge, patient care and procedural skills) that describe the practice of emergency medicine and differentiate it from the clinical practice of other specialties. The American Board of Emergency Medicine (ABEM) website states that it will use the 2019 version to develop examinations beginning in the fall 2022 examinations. The EM Model is meant to represent the most essential information and skills necessary for board-certified emergency physicians to practice. Section 20.0 of the EM Model provides a list of "Other Core Competencies of the Practice of Emergency Medicine," covering topics such as communication, ethics, clinical informatics, ED operations and more. Section 20.3.3 includes Leadership and management principles.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 40(88) Training Leaders in Academic Emergency Medicine adopted. The resolution called on ACEP to develop polices to ensure leaders in academic emergency medicine have access to leadership development materials.

Prior Board Action

January 2021, approved the revised policy statement "Definition of Emergency Medicine;" revised June 2015, April 2008, April 2001; reaffirmed October 1998; revised April 1994 with current title replacing "Definition of Emergency Medicine and the Emergency Physician."

June 2020, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistance and Nurse Practitioners in the Emergency Department" with the current title; approved June 2013 titled "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing "Guidelines on the Role of Physician Assistants in Emergency Departments" (2002) and "Guidelines on the Role of Nurse Practitioners" in the Emergency Department" (2000).

September 2019, "2019 Model of the Clinical Practice of Emergency Medicine" approved by ACEP, ABEM, CORD, EMRA, RRC-EM, and SAEM.

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

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 64(21)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Rural Emergency Medicine Education and Recruitment

PURPOSE: ACEP support: 1) staffing rural EDs with board-certified emergency physicians; 2) the linkage between rural hospitals and academic institutions to help create more rural medicine internships and electives; 3) the use of government funding for rural elective rotations for emergency medicine residents; 4) student loan forgiveness for physicians choosing to practice emergency medicine in rural areas

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, 42% of emergency departments in the United States are in a rural county and provide essential care to millions of Americans. Yet rural hospitals are consistently under significant financial constraint and more likely to close than their urban counterparts[1,2]; and

WHEREAS, Rural emergency departments are more likely to face staffing shortages and be staffed by non-emergency medicine board-certified physicians or advanced practice clinicians[3-7]; and

WHEREAS, Exposure to rural medicine in medical school and residency training significantly increases the likelihood that physicians will choose to practice in a rural area[5,8]; and

WHEREAS, Medical trainees with a rural background are more likely to practice in rural areas[9-11]; and

WHEREAS, The cost of medical training continues to rise, student loan forgivenesss is a major incentive for medical trainees to choose a rural medical practice[9,11]; therefore be it

RESOLVED, That ACEP support staffing rural hospitals with ED volumes greater than 5,000 patients per year with board-certified emergency physicians including cost-based reimbursement that covers the cost of 24/7 ABEM-certified physician coverage and support expanded ACEP-led rural provider education, board-certified emergency physician medical direction, and telemedicine access for all rural emergency departments including those who do not yet have full ABEM-certified physician coverage or those with extremely low volumes; and be it further

RESOLVED, That ACEP support the creation of links between rural hospitals and larger health networks and academic institutions, including medical schools and colleges, to facilitate the creation of rural medicine internships and electives for interested learners at the undergraduate and medical school level; and be it further

RESOLVED, That ACEP support the use of government funding for rural elective rotations for emergency medicine residents at rural critical access hospitals to better train residents for this work and recruit residents to rural practice, where they are most needed; and be it further

RESOLVED, That ACEP support student loan forgiveness for physicians choosing to practice emergency medicine in rural areas.

References

1. Muelleman RL, Sullivan AF, Espinola JA, Ginde AA, Wadman MC, Camargo CA Jr. Distribution of emergency departments according to annual visit volume and urban-rural status: implications for access and staffing. Acad Emerg Med. 2010 Dec;17(12):1390-7.
2. Rural Hospital Closures Database. Cecil Sheps Center for Health Services Research The University of North Carolina Chapel Hill.https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

3. Bennett, Christopher L., et al. "National Study of the Emergency Physician Workforce, 2020." Annals of Emergency Medicine. 2020 Dec; 76(6): 695–708.
4. Mk, Hall, et al. "State of the National Emergency Department Workforce: Who Provides Care Where?" Annals of Emergency Medicine. 2018 Sept; 72(3).
5. Patterson, Davis G., et al. "Preparing Physicians for Rural Practice: Availability of Rural Training in Rural-Centric Residency Programs." Journal of Graduate Medical Education. 2019 Oct; 11(5): 550–57.
6. Peterson, Lars E., et al. "Family Physicians' Contributions to Rural Emergency Care and Urban Urgent Care." The Journal of the American Board of Family Medicine. 2019 May; 32(3).
7. Pines JM, Zocchi MS, Ritsema T, Polansky M, Bedolla J, Venkat A; US Acute Care Solutions Research Group. The Impact of Advanced Practice Provider Staffing on Emergency Department Care: Productivity, Flow, Safety, and Experience. Acad Emerg Med. 2020 Nov;27(11):1089-1099.
8. Brown SR, Birnbaum B. Student and resident education and rural practice in the Southwest Indian Health Service: a physician survey. Fam Med. 2005 Nov-Dec;37(10):701-5.
9. Mohammadiaghdam N, Doshmangir L, Babaie J, Khabiri R, Ponnet K. Determining factors in the retention of physicians in rural and underdeveloped areas: a systematic review. BMC Fam Pract. 2020 Oct 23;21(1):216. doi: 10.1186/s12875-020-01279-7. PMID: 33097002; PMCID: PMC7585284.
10. Patrick FM. Rural physician supply and retention: factors in the Canadian context. Can J Rural Med. 2018;23(1):15 –20.
11. Royston PJ, Mathieson K, Leafman J, Ojan-Sheehan O. Medical student characteristics predictive of intent for rural practice. Rural Remote Health. 2012;12:2107.

Background

This resolution asks ACEP to support: 1) staffing rural emergency departments (ED) with board-certified emergency physicians; 2) the linkage between rural hospitals and academic institutions to help create more rural medicine internships and electives; 3) the use of government funding for rural elective rotations for emergency medicine residents; and 4) student loan forgiveness for physicians choosing to practice emergency medicine in rural areas.

Overall, the resolution builds off of the specific findings and recommendations included in the Rural Emergency Medicine Care Task Force Report that was submitted to the ACEP Board of Directors in October 2020. With respect to the first resolve, the report recommends that ACEP develop a policy that "advocates that hospitals without EM board certified physician coverage…have telemedicine availability for consultation." ACEP in the past has advocated for board-certified emergency physicians to oversee all care delivered in EDs in rural areas – even remotely via telehealth. Most recently, ACEP made this specific request in the context of the new designation of rural emergency hospitals (REHs). ACEP held a meeting in June 2021 with Centers for Medicare & Medicaid Services (CMS) staff who are in charge of implementing REHs and emphasized the critical importance of requiring that emergency care in REHs be provided by or overseen by board-certified emergency physicians at all times. This position will be reiterated in a response to a request for information that CMS will issue regarding REHs.

In terms of creating links between rural hospitals and larger health networks and academic institutions to facilitate the creation of rural medicine internships and electives, the Rural Emergency Care Task Force Report also highlights the benefit of conducting rural rotations to "bridge the gap between academic training and community practice" and that residents show "strong resident support for these types of training opportunities." As the resolution states, "exposure to rural medicine in medical school and residency training significantly increases the likelihood that physicians will choose to practice in a rural area."

Regarding government funding, it is important to note that CMS finalized a policy in the Fiscal Year (FY) 2020 Inpatient Prospective Payment System Final Rule that allows a hospital (such as an academic medical center) to include residents training in a critical access hospital in its FTE count if the hospital incurs the residents' salaries and fringe benefits while the residents are training at that site. In other words, hospitals can continue receiving graduate medical education (GME) payments for their residents while they are on rotation at a critical access hospital (if the hospitals continue to pay their residents' salaries). Thus, Medicare already supports rural elective rotations.

There are several physician loan repayment/forgiveness programs to encourage practicing in a variety of designated settings such as underserved areas, the Indian Health Services, or performing NIH research. However, one of the largest programs is the National Health Service Corps and unfortunately, emergency physicians are NOT eligible to participate. ACEP has previously met with Congressional staff about the possibility of including emergency medicine participation in the National Health Service Corps.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolutions 48(20) Residency Program Expansion Referred to Board of Directors. Directed ACEP to engage the ACGME and other stakeholders to construct objective criteria for new residency accreditation considering workforce needs, competitive advantages and disadvantages, geographic distribution, and demand for physicians.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for the inclusion of EM in the National Health Services Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organization to encourage the development and promotion of rural emergency medicine clerkships/rotations at medical schools and residency programs.

Substitute Resolution 20(01) Medical Education Debt adopted. The resolution directed ACEP to lobby appropriate state and federal agencies for inclusion of emergency physicians in medical education debt repayment programs, including but not limited to state programs, the National Public Health Service, rural and underserved regional grant programs, and other grants/ scholarship programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted. Directed ACEP to continue long-range planning for projecting emergency physician needs based on patient visits and physician attrition and continue to work toward preservation of adequate numbers of residency positions in emergency medicine, and to continue intensive lobbying efforts to preserve funding for adequate numbers of residency positions in emergency medicine.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted. Directed ACEP to promote the expansion of existing and the development of additional emergency medicine programs, particularly in those areas of emergency physician shortage.

Substitute Resolution 37(88) Funding for Emergency Medicine Graduate Medical Education adopted. Directed ACEP to encourage development of new models for funding graduate medical education.

Prior Board Action

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas;" reaffirmed April 2012 and October 2006; Originally approved in June 2000

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved policy statement "Definition of Rural Emergency Medicine."

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2014, discussed the proposal from the Rural Emergency Medicine Section to support the Rural Emergency Medicine Education (REME) Program and appointed a Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Substitute Resolution 20(01) Medical Education Debt adopted.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted.

Substitute Resolution 37(88) Funding for Emergency Medicine Graduate Medical Education adopted.

Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 65(21)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Rural Provider Support and a Call for Data

PURPOSE: 1) Recognize that patients presenting to rural EDs are a vulnerable ED patient population; 2) Support/ develop a comprehensive survey of rural EDs to investigate volumes, clinician staffing patterns, and common barriers of care and staffing and for the survey to be based on volume-based stratification; 3) Recognize that ABEM/AOBEM-certified physicians are underrepresented in rural EDs and low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; 4) Support rural EDS to retain ABEM/AOBEM-certified physicians to serve as ED medical directors; 5) Support staffing rural hospitals with ED volumes greater than 0.5 patients/hour with dedicated physician coverage; ABEM/AOBEM certified physicians are preferred if available; at volumes greater than 1.0 patients per hour, ABEM/AOBEM certified physician coverage is strongly encouraged; and will support cost-based reimbursement that covers the cost of 24/7 ABEM/AOBEM certified physician coverage; 6) Work with many other specialty societies, medical liability insurance carriers, health systems, physician groups, and other stakeholder organizations to develop and support a universal minimum standard for all non-emergency medicine trained physicians, NPs, and physician assistants practicing in rural EDs; 7) Evaluate and approve specific training pathways and onboarding protocols and clinical support systems (e.g., teleEM) for non-emergency medicine trained physicians, PAs and NPs working solo in extreme low volume facilities; and 8) Support and endorse rural-specific tools including telemedicine initiatives, development of regional expedited transfer agreements, regional hub and spoke model integration, and rural specific educational tools.

FISCAL IMPACT: Budgeted staff resources. Unbudgeted expenses of $150,000-200,000 for a comprehensive study and additional expenses of $20,000 – $30,000 for an in-person task force/stakeholder meeting depending on the size of the group.

WHEREAS, Patients in rural areas are especially vulnerable, suffering from higher age adjusted mortality, greater rates of chronic disease, increased high risk behaviors, and decreased life expectancy when compared to urban patients[1-3]; and

WHEREAS, Rural emergency department (ED) visit rates increased by more than 50%, while urban increased 7% from 2005-2016[15] and patient acuity in rural emergency departments is poorly understood, although data suggests rural emergency departments may see slightly less acute patients but experience worse outcomes when compared to urban emergency departments[4-8]; and

WHEREAS, Rural EDs, compared to their urban counterparts, are resource limited, financially stressed, experience higher interfacility transfer rates, and are more likely to experience prolonged ED holds due to an under-resourced EMS system.[9-15]; and

WHEREAS, Data needed to match rural ED volumes with the appropriate resources are limited and the arbitrary acute care bed cap of 25 for critical access hospitals makes correlation between beds and patient volumes unreliable, and the fact that there is no easily accessible data on who is medically staffing rural EDs[16]; and

WHEREAS, There is no ideal universal staffing model for rural emergency departments and no well-established minimal threshold ED volume (annual volume or patients per hour) to support an ABEM/AOBEM physician, even though most rural emergency departments can justify a full-time emergency physician specialist[17-21]; therefore be it

RESOLVED, That ACEP recognize that patients presenting to rural emergency departments are arguably our most vulnerable ED patient population in the U.S. and deserve increased support; and be it further

RESOLVED, That ACEP support/develop a comprehensive survey of rural emergency departments to investigate volumes, clinician staffing patterns, and common barriers of care and staffing and this survey should be volume based and stratified as follows:

Extreme Frontier	< 0.25 pts/hr (annual volume < 2,190)
Frontier	0.25 pts/hr - 0.5 pts/hr (annual volume 2,191 to 4,380)
Small Rural	0.5 pts/hr – 2 pts/hr (annual volume 4,381 to 17,520)
Medium Rural	2 pts/hr – 4 pts/hr (annual volume 17,521 to 35,040)
Large rural	> 4 pts/hr (annual volume > 35,041); and be it further

RESOLVED, That ACEP recognize that ABEM/AOBEM-certified physicians are underrepresented in rural emergency departments and that very low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; and be it further

RESOLVED, That ACEP support rural emergency departments to retain ABEM/AOBEM-certified physicians to serve as emergency department medical directors so there will be physician-led teams in all U.S. EDs; and be it further

RESOLVED, That ACEP support staffing rural hospitals with ED volumes greater than 0.5 patients per hour with dedicated physician coverage; ABEM/AOBEM certified physicians are preferred if available; at volumes greater than 1.0 patients per hour, ABEM/AOBEM certified physician coverage is strongly encouraged; and ACEP will support cost-based reimbursement that covers the cost of 24/7 ABEM/AOBEM certified physician coverage; and be it further

RESOLVED, That ACEP work with the American Academy of Family Physicians, the American Board of Physician Specialties, the American Academy of Emergency Nurse Practitioners, the Society of Emergency Physician Assistants, medical liability insurance carriers, health systems, physician groups, and other stakeholder organizations to develop and support a universal minimum standard for all non-emergency medicine trained physicians, nurse practitioners, and physician assistants practicing in rural emergency departments; and be it further

RESOLVED, That ACEP closely evaluate and approve specific training pathways and onboarding protocols and clinical support systems (e.g., teleEM) for non-emergency medicine trained physicians, physician assistants, and nurse practitioners working solo in extreme low volume facilities; and be it further

RESOLVED, That ACEP support and endorse rural-specific tools including telemedicine initiatives, the development of regional expedited transfer agreements, regional hub and spoke model integration, and rural specific educational tools.

References

1. Moy E, Garcia MC, Bastian B, Rossen LM, Ingram DD, Faul M, Massetti GM, Thomas CC, Hong Y, Yoon PW, Iademarco MF. Leading Causes of Death in Nonmetropolitan and Metropolitan Areas- United States, 1999-2014. MMWR Surveill Summ. 2017 Jan 13;66(1):1-8. doi: 10.15585/mmwr.ss6601a1. Erratum in: MMWR Morb Mortal Wkly Rep. 2017 Jan 27;66(3):93. PMID: 28081058; PMCID: PMC5829895.
2. Singh GK, Siahpush M. Widening rural-urban disparities in all-cause mortality and mortality from major causes of death in the USA, 1969-2009. J Urban Health. 2014 Apr;91(2):272-92. doi: 10.1007/s11524-013-9847-2. PMID: 24366854; PMCID: PMC3978153.
3. (National Healthcare Quality and Disparities Report chartbook on rural health care. Rockville, MD: Agency for Healthcare Research and Quality; October 2017. AHRQ Pub. No. 17(18)-0001-2-EF.)
4. Yiadom MYAB, Baugh CW, Barrett TW, Liu X, Storrow AB, Vogus TJ, Tiwari V, Slovis CM, Russ S, Liu D; ED Operations Study Group 2015. Measuring Emergency Department Acuity. Acad Emerg Med. 2018 Jan;25(1):65-75. doi: 10.1111/acem.13319. PMID: 28940546; PMCID: PMC5764775.
5. Greenwood-Ericksen MB, Kocher K. Trends in Emergency Department Use by Rural and Urban Populations in the United States. JAMA Netw Open. 2019 Apr 5;2(4):e191919. doi: 10.1001/jamanetworkopen.2019.1919. PMID: 30977849; PMCID: PMC6481434.
6. Greenwood-Ericksen MB, Rothenberg C, Mohr N, Andrea SD, Slesinger T, Osborn T, Whittle J, Goyal P, Tarrant N, Schuur JD, Yealy

DM, Venkatesh A. Urban and Rural Emergency Department Performance on National Quality Metrics for Sepsis Care in the United States. J Rural Health. 2019 Sep;35(4):490-497. doi: 10.1111/jrh.12339. Epub 2018 Nov 28. PMID: 30488590.
7. Joynt KE, Harris Y, Orav EJ, Jha AK. Quality of care and patient outcomes in critical access rural hospitals. JAMA. 2011 Jul 6;306(1):45-52. doi: 10.1001/jama.2011.902. PMID: 21730240; PMCID: PMC3337777.
8. (Ivantage Health Analytics 2013 NATIONAL RURAL EMERGENCY DEPARTMENT STUDY)
9. Kaufman BG, Thomas SR, Randolph RK, Perry JR, Thompson KW, Holmes GM, Pink GH. The Rising Rate of Rural Hospital Closures. J Rural Health. 2016 Winter;32(1):35-43. doi: 10.1111/jrh.12128. Epub 2015 Jul 14. PMID: 26171848.
10. Freeman VA, Slifkin RT, Patterson PD. Recruitment and retention in rural and urban EMS: results from a national survey of local EMS directors. J Public Health Manag Pract. 2009 May-Jun;15(3):246-52. doi: 10.1097/PHH.0b013e3181a117fc. PMID: 19363405.
11. Gomez D, Berube M, Xiong W, Ahmed N, Haas B, Schuurman N, Nathens AB. Identifying targets for potential interventions to reduce rural trauma deaths: a population-based analysis. J Trauma. 2010 Sep;69(3):633-9. doi: 10.1097/TA.0b013e3181b8ef81. PMID: 20016384.
12. Heaton J, Kohn MD. EMS Inter-Facility Transport. 2020 Sep 27. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan–. PMID: 32310376.
13. (EMS Workforce for the 21st Century: A National Assessment EMSWorkforceReport_June2008.pdf)
14. (EMS Services in Rural America: Challenges and Opportunities Nikki King, MHSA, Marcus Pigman, MHA, Sarah Huling, BS- ARRT, ARDMS, and Brian Hanson, PhD. Retrieved at 05-11-18-NRHA-Policy-EMS.pdf (ruralhealthweb.org))
15. Zagales I, Bourne M, Sutherland M, Pasarin A, Zagales R, Awan M, McKenney M, Elkbuli A. Regional Population-Based Workforce Shortages in General Surgery by Practicing Surgeon and Resident Trainee. Am Surg. 2021 Jun 26:31348211029870. doi: 10.1177/00031348211029870. Epub ahead of print. PMID: 34176319.
16. (Data taken from the AHA Dataquerry. Pulled 7/14/21)
17. Bennett CL, Sullivan AF, Ginde AA, Rogers J, Espinola JA, Clay CE, Camargo CA Jr. National Study of the Emergency Physician Workforce, 2020. Ann Emerg Med. 2020 Dec;76(6):695-708. doi: 10.1016/j.annemergmed.2020.06.039. Epub 2020 Aug 1. PMID: 32747085.
18. Hansroth J, Findley SW, Quedado KD, Marshall T, Vucelik A, Goode CS. Evaluating West Virginia's Emergency Medicine Workforce: A Longitudinal Observational Study. Cureus. 2021 Mar 1;13(3):e13639. doi: 10.7759/cureus.13639. PMID: 33824792; PMCID: PMC8012015.
19. Reames J, Handel DA, Al-Assaf A, Hedges JR. Rural Emergency Medicine: patient volume and training opportunities. J Emerg Med. 2009 Aug;37(2):172-6. doi: 10.1016/j.jemermed.2007.12.040. Epub 2008 Nov 12. PMID: 19004592.
20. (2018 New Mexico Emergency Department Data Annual Report. https://www.nmhealth.org/data/view/systems/2361/)
21. (Emergency Department Volume and Capacity by Facility - OSHPD)

Background

This resolution addresses many needs of rural hospitals. The multiple resolveds ask that ACEP: 1) Recognize that patients presenting to rural EDs are a vulnerable ED patient population; 2) Support/develop a comprehensive survey of rural EDs to investigate volumes, clinician staffing patterns, and common barriers of care and staffing and for the survey to be based on volume-based stratification; 3) Recognize that ABEM/AOBEM-certified physicians are underrepresented in rural EDs and low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; 4) Support rural EDS to retain ABEM/AOBEM-certified physicians to serve as ED medical directors; 5) Support staffing rural hospitals with ED volumes greater than 0.5 patients/hour with dedicated physician coverage; ABEM/AOBEM certified physicians are preferred if available; at volumes greater than 1.0 patients per hour, ABEM/AOBEM certified physician coverage is strongly encouraged; and will support cost-based reimbursement that covers the cost of 24/7 ABEM/AOBEM certified physician coverage; 6) Work with many other specialty societies, medical liability insurance carriers, health systems, physician groups, and other stakeholder organizations to develop and support a universal minimum standard for all non-emergency medicine trained physicians, NPs, and physician assistants practicing in rural EDs; 7) Evaluate and approve specific training pathways and onboarding protocols and clinical support systems (e.g., teleEM) for non-emergency medicine trained physicians, PAs and NPs working solo in extreme low volume facilities; and 8) Support and endorse rural-specific tools including telemedicine initiatives, development of regional expedited transfer agreements, regional hub and spoke model integration, and rural specific educational tools

Some of the requests in this comprehensive resolution have been addressed in part. ACEP has had several rural health task forces, the most recent of which provided their findings to the ACEP Board of Directors in 2020. All of the rural emergency medicine task forces have, to at least some degree, discussed the vulnerable population that exists in rural America, and the lack of resources including emergency physicians in these areas. However, ACEP does not have a policy statement that states specifically that the rural population is one of the most vulnerable in our country. ACEP's policy statement "Definition of Rural Emergency Medicine" could be revised to include this acknowledgement.

It is well known that ABEM/ABOEM certified physicians are underrepresented in rural EDs. The recent paper by Bennet et al[1] clearly shows this to be a current problem. Specifically ACEP has several papers, but no policy statement that states this fact.

ACEP does not have comprehensive data about rural EDs and has not conducted a rigorous survey as requested in the resolution. In a brief review of the internet and medical literature, no such survey, as specifically outlined, exists. ACEP itself lacks immediate and easy access to this data. It should be noted that ACEP's current database does not contain the names and contact numbers for all ED directors, especially in rural areas and EDs where there are no ACEP members. Many of these smaller, rural hospitals do not have a physician director, and if present few are members of ACEP. Therefore a third party would be required to collect this information in the form required by the resolution.

The resolution also calls for ACEP to support staffing of rural hospitals with low volume. This is in line with the current ED Accreditation Task Force appointed by ACEP President Mark Rosenberg, DO, FACEP. The task force has been charged to create an accreditation program for EDs to ensure that "a person's zip code does not dictate the emergency care they receive." In today's interconnected world, telehealth offers the opportunity for smaller hospitals to have access to emergency physicians (as defined by ACEPs existing policy).[2] ACEP's most recent Rural Emergency Care Task Force Report highlights several successful models for promoting emergency physician-led care in rural areas. Although the criteria for ED accreditation has not yet been determined, we anticipate it will support leadership by an emergency physician and that it will require supervision of non-physicians, with small hospitals with a very low volume (number to be determined) able to utilize dedicated telehealth measures to ensure that all patients are "seen" by an emergency physician. This requirement would incorporate that there be appropriate reimbursement for physician telehealth coverage. This task force is just beginning its work but we anticipate a program launch by October 2022, if not before. The ACEP Board of Directors and the Council Officers will receive frequent updates from the important task force during the next year.

ACEP has supported the efforts of the Emergency Nurses Association (ENA), American Academy of Emergency Nurse Practitioners (AAENP), and the Society of Emergency Medicine Physician Assistants (SEMPA) to improve the skills of their membership. It should be noted that ACEP believes strongly that no additional skill set can substitute for physician training and support of additional training does not support, in any way, independent practice. It should be noted that current training models for nurse practitioners (NPs) and advanced practice nurses (APNs) can be quite variable and general, with the education of APNs primarily focused on patient education/administration/research rather than clinical care. Even the training of physician assistants (PAs) is general in nature. None of these training programs should be assumed to prepare the NP, APN, or PA to practice in an emergency setting. Therefore, ACEP will continue to encourage additional education for NPs, PAs, and especially APNs to practice in a supervised ED setting.

ACEP has for decades supported additional training of RNs as demonstrated by CEN (certified emergency nurse). ACEP has to date supported each organization (AAENP, SEMPA, and ENA specifically for CEN) in creating their own standards. Emergency physicians have been heavily involved in these efforts. Through the ED Accreditation Program outlined above, ACEP could require institutions to require staff to be certified via these pathways, after an initial period of experience in the ED.

This resolution also requests that ACEP work with other organizations to develop minimal standards for NPs and PAs. Today's training programs, particularly for NPs and APNs are, in some cases, largely online. There is concern that the training received in some programs is substandard, even for the generalist education. ACEP could meet with these organizations to help to create a minimum generalist curriculum, however, ACEP lacks the ability to ensure that this action would be followed by specific training programs. We would need to engage with those institutions that oversee such education, such as the American Association of College of Nursing. While accreditation through the Commission on Collegiate Nursing Education has existed for the past 20 years,[3] it does not appear that accreditation is required for an institution to enroll students.

It is important to note that this resolution promotes the use of non-physicians and physicians who do not meet the definition of an emergency physician per ACEP policy. This is contradictory to other resolutions being considered this year by the Council. In addition, it runs counter to our initial advocacy work regarding the implementation of

rural emergency hospitals (REHs). As background, in order to increase access to emergency services in rural areas, Congress included a provision in the Consolidated Appropriations Act (enacted last December) that would allow critical access hospitals and small rural hospitals (those with less to than 50 beds) to convert to REHs starting on January 1, 2023. REHs, once established, will not provide any inpatient services, but must be able to provide emergency services 24 hours a day/7 days a week and have a physician, nurse practitioner, clinical nurse specialist, or physician assistant available at all times. To get REHs up and running by 2023, the Centers for Medicare & Medicaid Services (CMS) must create all the requirements associated with the new facility-type through regulations. ACEP leadership held a meeting in June 2021 with CMS staff who are in charge of creating the new REH Medicare designation to provide our initial feedback. Specifically, we requested that, although REHs can legally be staffed by non-physician practitioners, we strongly believe that all care provided in REHs should be supervised by a board-certified emergency physician, even remotely via telehealth.

Background References

[1]Bennett C:, Sullivan AS, Ginde A, et al. National study of the emergency physician workforce, 2020. *Ann Emerg Med.* 2020;76:695-708.
[2]Definition of an Emergency Physician [policy statement]. Approved April 2017.
[3]Commission on Collegiate Nursing Education CCNE Accreditation (aacnnursing.org)

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
  - Tactic 14. Develop a document defining the scope of practice and supervision requirements for nurse practitioners and physician assistants in the ED.

Fiscal Impact

Unbudgeted expenses of $150,000-200,000 for a comprehensive study and additional expenses of $20,000 – $30,000 for an in-person task force/stakeholder meeting depending on the size of the group.

Prior Council Action

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to work with stakeholders within the College including the Rural Emergency Medicine Section and chapters to provide a regular mechanism to seek input from rural physicians in legislation that impacts rural communities; and seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Affairs Committee to reflect the fact that nearly half of all US EDs are located in rural areas.

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to Board. Directed ACEP to: 1) work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; 2) identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; 3) develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and 4) encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted. Directed ACEP to advocate for the inclusion of EM in the National Health Services Corps scholarship program, explore and advocate for various incentives for emergency medicine residency trained physicians to practice in in rural or underserved areas, explore funding sources for a new workforce study, and work with other emergency medicine organization to encourage the development and promotion of rural emergency medicine clerkships/rotations at medical schools and residency programs.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments

Prior Board Action

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

January 2020, assigned Referred Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine to the Rural Emergency Task Force to review and provide recommendations to the Board to address rural emergency medicine issues.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to work with stakeholders within the College including the Rural Emergency Medicine Section and chapters to provide a regular mechanism to seek input from rural physicians on legislation that impacts rural communities; and to seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Committee.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas;" reaffirmed April 2012 and October 2006; Originally approved in June 2000

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2017, approved the policy statement "Definition of Rural Emergency Medicine."

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

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2014, discussed the proposal from the Rural Emergency Medicine Section to support the Rural Emergency Medicine Education (REME) Program and appointed a Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks.

September 2003, approved the recommendations from the Rural Emergency Medicine Summit

February 2003, approved the development of a Rural Emergency Medicine Summit.

November 2002, approved convening a Rural Workforce Summit to identify specific needs of physicians practicing in rural emergency departments, explore solutions to staffing rural EDs, and make recommendations as to ACEP's role in this effort.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 66(21)

SUBMITTED BY: Howard K. Mell, MD, MPH, CPE, FACEP
Illinois College of Emergency Physicians

SUBJECT: ACEP Promotion of the Role of Emergency Physicians

PURPOSE: 1) Create and disseminate a policy explicitly stating that all patients presenting to an ED deserve to be assessed by an emergency physician and all patients have the right to have an emergency physician directly oversee their care in-person. 2) Reaffirm that ACEP is a professional medical association dedicated to promoting the role of emergency physicians and instruct ACEP staff and officers promote the role of emergency physicians over all other models of care.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, In 1966, the National Academy of Sciences published a white paper entitled "Accidental Death and Disability, the Neglected Disease of Modern Society" that described the poor state of emergency care in the U.S.; and

WHEREAS, In 1968, John Wiegenstein, MD, and John Rupke, MD, and six colleagues formed the American College of Emergency Physicians (ACEP) in Lansing, Michigan; and

WHEREAS, In 1972, the American Medical Association (AMA) recognized emergency medicine as a specialty and created the AMA Section of Interest on emergency medicine; key to this was a recognition that emergency medicine represented a unique body of knowledge that required specialty training to master; and

WHEREAS, The International Federation for Emergency Medicine (IFEM) defines emergency medicine as "a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of episodic undifferentiated physical and behavioral disorders; it further encompasses an understanding of the development of prehospital and in hospital emergency medical systems and the skills necessary for this development"; and

WHEREAS, In 1979, the American Board of Medical Specialties (ABMS) granted the American Board of Emergency Medicine (ABEM) specialty board approval as the 23rd medical specialty in the U.S.; and

WHEREAS, In 1980, the American Osteopathic Association (AOA) Bureau of Osteopathic Specialists authorized the American Osteopathic Board of Emergency Medicine (AOBEM) to begin administering certifying exams in emergency to osteopathic physicians as one of the now 18 medical specialty certifying boards that make up modern osteopathic medicine; and

WHEREAS, In 1986, after lobbying by multiple emergency physicians, the US Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) requiring hospital Emergency Departments that accept payments from Medicare to provide an appropriate medical screening examination (MSE) to anyone seeking treatment for an emergency medical condition, regardless of citizenship, legal status, or ability to pay, in effect declaring that anyone who believed they were suffering from an emergency had the right to an assessment by a physician in the emergency department; and

WHEREAS, In 1988, the ability to accumulate the practice months and hours to take Emergency Medicine Certification Exam without completing a residency (known as the "Grandfather Clause") ended requiring that all

board-certified emergency physicians from that moment on would have to be residency trained in emergency medicine; and

WHEREAS, In 1989, ABEM was granted primary board status allowing the creation of subspecialties in emergency medicine; and

WHEREAS, It is widely accepted that there is a unique body of knowledge and a unique skillset that is required to professionally practice emergency medicine and board certification by ABEM or ABOEM is de facto evidence that an individual has acquired that knowledge and those skills; and

WHEREAS, Over the past decade, more than 15,000 nonphysician providers have been employed in emergency departments (more than 10,000 physician assistants and more than 5,000 nurse practitioners); and

WHEREAS, Nonphysician providers do not meet the requirements for board certification in emergency medicine by ABEM or ABOEM and in most cases are not required to have any specific training in emergency medicine as a requirement of licensure; and

WHEREAS, In many emergency departments, patients are examined and treated by nonphysician providers without direct involvement of a physician; therefore be it

RESOLVED, That ACEP publish and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an emergency physician and have an emergency physician directly oversee their care on an in-person basis; and be it further

RESOLVED, That ACEP reaffirm its role as a professional medical association dedicated to promoting the role of emergency physicians, instructing the ACEP staff and officers to promote the role of emergency physicians over all other models of emergency care.

Background

This resolution asks that ACEP create and disseminate a policy explicitly stating that all patients presenting to an emergency department (ED) deserve to be assessed by an emergency physician. Further, it states that all patients have the right to have an emergency physician directly oversee their care in-person. Finally, it asks that ACEP reaffirm its role as a professional medical association dedicated to promoting the role of emergency physicians and instruct ACEP staff and officers to promote the role of emergency physicians over all other models of care.

ACEP has existing policy defining an emergency physician 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.[1]"*

> *"It should be noted that residents in an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved residency in Emergency Medicine are "Emergency Medicine Resident Physicians.*[1]"

Several other policies exist that promote the role of the emergency physician:

> *"The emergency physician should serve as the leader of the ED team.[2]"*

> *"1. The ED should be emergency physician led and staffed by qualified personnel with knowledge and skills sufficient to evaluate and manage those who seek emergency care. The EDs should be designed*

and equipped to facilitate this work.

"2. Timely emergency care provided by an emergency physician and ED staff should be continuously available 24 hours per day, seven days per week, 365 days per year.[2]"

"The ED should have a designated medical director. The ED medical director†, in collaboration with the director of emergency nursing and with appropriate integration of other ancillary services, should ensure that quality, safety, and appropriateness of emergency care are continuously monitored and evaluated. The ED medical director should have oversight over all aspects of the practice of emergency medicine in the ED.[2]"

"The emergency physician is responsible for the medical care provided in the ED. This includes the medical evaluation, diagnosis, and recommended treatment and disposition of the emergency patient, as well as the direction and coordination of all other care provided to the patient.[2]"

"The ED director should direct the medical care provided in the ED. The medical director of the ED should be certified by the American Board of Emergency Medicine (ABEM), the American Osteopathic Board of Emergency Medicine (AOBEM) or should possess comparable qualifications as established through the privilege delineation policy.[2]"

"ACEP believes that the ED medical director should be responsible for assessing and making recommendations to the hospital's credentialing body related to the qualifications of providers of emergency care with respect to the clinical privileges granted to them. At a minimum, those applying for privileges as emergency physicians should be eligible for ACEP membership. Board certification by ABEM or AOBEM, or pediatric emergency medicine subspecialty certification by the American Board of Pediatrics is an excellent, but not the sole benchmark for decisions regarding an individual's ability to practice emergency medicine.*[3]"

"The gold standard for care in an ED is that performed or supervised by a board-certified/board-eligible emergency physician.[4]"

PAs/NPs should not perform independent unsupervised care in the ED. This holds true regardless of state laws or hospital regulations. In the case of rural and underserved areas, supervision may require telehealth services or real-time off-site emergency physician consultation.
Emergency physicians must have the real-time opportunity to be involved in the care of any patient presenting to the ED and seen by a PA or NP.[4]"

"The American College of Emergency Physicians (ACEP) endorses the 2000 position statement of the Society for Academic Emergency Medicine (SAEM) on the "Qualifications for Unsupervised Emergency Department Care," and believes that the independent practice of emergency medicine is best performed by specialists who have completed American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) certification, or have successfully "completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited emergency medicine residency, and is in the process of completing ABEM or AOBEM examinations.[5]"

"ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care.[5]"

ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists.[5]"

Through these policy statements, ACEP has stated the importance of the emergency physician in emergency care. Additional policy could be created to reaffirm this position and perhaps more clearly state value of an emergency physician. This resolution goes farther and requires that all patients be seen in person by an emergency physician.

Existing ACEP policy permits the supervision of NPs and PAs by either in person or telemedicine, particularly those

seen in rural settings. Therefore, all existing policies that permit supervision of NPs and PAs via telemedicine would need to be revised. Existing policy also permits the emergency physician to discuss a case with an NP/PA and at the discretion of the physician choose to personally see and assess the patient. If the intent of this resolution is for the physician to assess all patients in-person, these policies would need to be revised.

A new policy statement requiring in-person supervision will be difficult for many rural, frontier, and critical access hospitals. Many of these hospitals have difficulty attracting emergency physicians. In a survey of residents graduating in 2019, very few took positions in rural hospitals even though the compensation offered was close to $100,000 more per year, and there was often additional loan forgiveness. Preliminary data from a similar survey of residents graduating in 2021 suggests that trend has not changed.

There are several other resolutions submitted this year regarding the practice of NPs and PAs in the ED and the Council should ensure that these resolutions do not contradict each other.

ACEP's President Mark Rosenberg, DO, FACEP, has appointed an ED Accreditation Task Force to create an accreditation process designed to ensure that "a person's zip code does not define the emergency care they receive." Inherent in that charge is that all patients should be seen virtually or in person by an emergency physician (as defined by ACEP policy) for a facility to be accredited. In addition, the task force must incorporate ACEP policies which, as noted above, clearly call for patients to be seen by an emergency physician. The task force work is underway and plans to submit a final report with identified criteria and a business plan to the Board of Directors in June 2022. If the plan is approved by the Board, staff will begin implementation immediately so that accreditation of emergency departments can start by the end of 2022. Because this initiative is so important, the task force will provide regular updates to the Board, Council Officers, and if requested, to the Council, as well.

Accreditation by ACEP will need to be voluntary. However, through our other hospital-based accreditation programs, we have found significant interest in accreditation by hospitals. Larger institutions often use accreditation to increase market share and differentiate themselves from other institutions. Smaller rural facilities use accreditation to improve community trust and keep patients from traveling to larger facilities. Accreditation appears to be of interest to CEOs and Boards of Trustees as attested to by the plaques in the hallway of any administration wing.

Accreditation can be a more powerful tool than policy statements. We have seen some major changes by facilities to attain accreditation through our Geriatric ED Accreditation Program (GEDA), including the replacement of a non-physician staff by a staff of board-certified emergency physicians. As a bonus, accreditation programs can provide the College with non-dues revenue.

A public opinion poll performed in August 2021 demonstrated that the vast majority of patients (78%) most trust physicians to lead their medical care in an emergency. Additionally, people view 24/7 access to the ED as one of the most essential services the community can provide.[7]

References

[1]Definition of an Emergency Physician [policy statement]. Approved April 2017.
[2]Emergency Department Planning and Resource Guidelines [policy statement]. Approved April 2021.
[3]Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine [policy statement], Approved April 2017.
[4]Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
[5]Providers of Unsupervised Emergency Department Care [policy statement]. Approved January 2019
6Quigley L, Salsberg E, Richwine C. New emergency physicians: who are they, where they are working and their experience in the job market. Results from the survey of Emergency Medicine residents who completed training in 2019. Report to the ACEP Board of Directors
[7]ACEP. Poll: adults view 24/7 access to the ER essential and prefer care lead by physicians in a crisis. https://www.emergencyphysicians.org/

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost effective manner.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to: 1.) Review and update the policy statement " Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Amended Resolution 25(10) Definition of an Emergency Physician referred to the Board of Directors. The resolution asked ACEP to develop a define an emergency physician as someone who has either completed ACGME or AOA residency training in Emergency Medicine or fellowship in Pediatric Emergency Medicine, or is ABEM or AOBEM certified in Emergency Medicine or Pediatric Emergency Medicine, or began practicing emergency medicine in the 20th century and therefore is eligible to be a member of the American College of Emergency Physicians.

Prior Board Action

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, June 2001; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

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

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

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 67(21)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Patient Informed Consent

PURPOSE: 1) Support patients' rights to choose who provides their medical care; 2) reaffirm that it is the gold standard for board-certified emergency physicians to be involved in every patient who presents to an ED; 3) support an informed consent form for patients to indicate their choice of clinician.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Patients should be allowed to make informed consent to their healthcare needs; and

WHEREAS, Patients should always be given the opportunity to see a physician in the emergency department; and

WHEREAS, Patients should be able to choose to see a physician over a non-physician practitioner; therefore be it

RESOLVED, That ACEP support patients' rights to choose who provides their medical care; and be it further

RESOLVED, That ACEP support the gold standard for board-certified emergency physicians to be involved in every patient who presents to an emergency department; and be it further

RESOLVED, That ACEP support an informed consent form to be documented in emergency department patients' charts regarding their choice to: 1) agree to care by non-physician practitioner not supervised by physician; 2) agree to care by a non-physician practitioner only supervised by a physician; or 3) agree to care only by a physician.

Background

This resolution asks ACEP to support patients' rights to choose who provides their medical care, reaffirm that it is the gold standard for board-certified emergency physicians to be involved in every patient who presents to an ED, and support an informed consent form for patients to indicate their choice of clinician.

ACEP' policy statement "Definition of an Emergency Physician" defines an emergency physician 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 strong existing policy to affirm the gold standard in care in the ED is a board-certified emergency physician.[1,2] Our policy statements clearly state that all patient care shall be performed or supervised by a board-certified/board-eligible emergency physician. It further states that NPs/PAs should not perform independent unsupervised care in the ED regardless of state laws or hospital regulations.[2,3] Board certification is defined in another policy.[3]

There is little research on whether patients prefer NPs/PAs or MDs/DOs to care for them in the emergency setting and there is less research suggesting that the public strongly prefers physicians. One article from primary care showed that

55% of patients preferred a physician for their clinician, 21% preferred an NP/PA, and the rest had no preference. Those preferring physicians cited qualifications and technical skills, while those preferring NP/PAs cited bedside manner and convenience. Previous experience with the type of clinician was a major factor in their preference.[4] The Association of American Medical Colleges' Consumer Survey in 2012 showed that 50% of patients preferred to see a physician, but when offered that they could see an NP/PA sooner, most elected to see that type of clinician.[5] A systematic review of 25 articles largely in the US and UK showed that none showed that patient satisfaction with an NP/PA was not significantly different that an MD.[6]

An internet search on the subject yields a wealth of links, generally supplied by nursing, NPs, and PAs supporting the benefits of care from NPs and PAs.

ACEP can produce a model informed consent form but lacks the authority to require it for all institutions. The model consent form could be provided to our Medical Director's Section members and graduates of the ED Director's Academy. Mandating the use of this consent form would require state legislation.

References

1. ACEP. Emergency Department Planning and Resource Guidelines [policy statement]. Approved April 2021.
2. ACEP. Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
3. ACEP. Providers of Unsupervised Emergency Department Care [policy statement]. Approved January 2019.
4. ACEP. ACEP Recognized Certifying Bodies in Emergency Medicine [policy statement]. Approved February 2020.
5. Leach B, Gradison M, Morgan P, Everett C, Dill MJ, de Oliveira JS. Patient preference in primary care provider type. *Healthc (Amst).* 2018;6(1):13-6.
6. Dill MJ, Pankow S, Erikson C, Shipman S. Survey shows consumers open to a greater role for physician assistants and nurse practitioners. *Health Affairs*. 2013;32(6).
7. Hooker RS, Moloney-Johns AJ, McFarland MM. Patient satisfaction with physician assistant/associate care: an international scoping review. *Hum Resource Health*. 2019;17(1):104.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Goal 2 – Enhance Membership Value and Member Engagement

- Objective D – Increase ACEP brand awareness, growth, and impact internationally in a cost effective manner.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to: 1.) Review and update the policy statement " Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Amended Resolution 25(10) Definition of an Emergency Physician referred to the Board of Directors. The resolution asked ACEP to develop a define an emergency physician as someone who has either completed ACGME or AOA residency training in Emergency Medicine or fellowship in Pediatric Emergency Medicine or is ABEM or AOBEM

certified in Emergency Medicine or Pediatric Emergency Medicine or began practicing emergency medicine in the 20th century and therefore is eligible to be a member of the American College of Emergency Physicians.

Prior Board Action

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, June 2001; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

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

February 2020, approved the revised policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine;" revised June 2014; reaffirmed April 2014, October 2008, October 2002; originally approved March 1998.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 68(21)

SUBMITTED BY: Louisiana Chapter
Emergency Telehealth Section

SUBJECT: Patient's Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth)

PURPOSE: Support legislation to require all facilities who have an ED or designate an area as an ED or emergency room to have a board eligible/certified emergency physician onsite or via telehealth at all times (with a limited exception) to market to the public and bill for emergency services; and to impose requirements on facilities to address shortcomings or to limit their ability to name themselves as emergency departments, etc.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, It is the position of the ACEP that board certified emergency physicians are the best suited person to provide emergency care; and

WHEREAS, According to the ACEP, the gold standard for care in an ED is that performed by a board certified/board-eligible emergency physician; and

WHEREAS, It is believed that the optimal scenario is having a board-eligible or board-certified emergency physician (BE/BC) present in-person to provide care to emergency patients but if having a BE/BC physician in person is not possible, having a BE/BC emergency physician available via telehealth is the next best thing for any non-emergency physician or non-physician to have access to a BE/BC EP for discussion of the emergency patient, and for consultation, recommendations, suggestions; and

WHEREAS, It is fair for everyone to have access to a board-certified emergency physician regardless of race, sex, gender, country of national origin, religion, age, profession, the location of the patient, time of day, or other "identifiers" so long as broadband is available; and

WHEREAS, There has been a goal to be able to have every patient who present to an emergency department anywhere in the country be seen by, have their care supervised by, or have the ability to see, a board certified emergency physician; and

WHEREAS, While there are still many areas where broadband is still not available or reliable, there is much greater penetration of broadband throughout the United States in the past few years and technology advancements and improvements in audiovisual telecommunications and equipment that enable reliable and valuable connectivity and communication, between patients and emergency physicians and allow reliable and thorough examinations; therefore be it

RESOLVED, That ACEP support legislation to require all facilities that wish to have an emergency department or designate an area as an emergency department or emergency room, to have a board eligible or board certified emergency physician present onsite preferentially, or via telehealth with an onsite non-emergency physician if on-site availability is not possible, 24 hours a day, 7 days a week to qualify to market to the public and bill for emergency services, with the only exception if broadband does not exist or is impossible to access with legitimate and reasonable efforts to do so, to have such a designation; and be it further

RESOLVED, That ACEP support legislation that if a facility does not currently have an onsite board eligible or board certified emergency physician available to see and treat emergency patients 24 hours a day, 7 days a week,

that facility must submit a plan to the licensing body that regulates them with specific actions the facility is making and will be making to become compliant with having 24/7 coverage by a board eligible or board certified emergency physician within 24 months; and be it further

RESOLVED, That ACEP support legislation to state: if a facility fails to achieve and maintain 24/7 coverage of any emergency facility by board eligible or board certified emergency physicians within 24 months, they must remove all signage and cease all marketing naming them as an ER or emergency department, emergency center, or expressly post in a conspicuous area on the sign in letters in the same font size as large or larger than the largest letters on signage that "THIS FACILITY DOES NOT ALWAYS STAFF OUR FACILITY WITH BOARD CERTIFIED EMERGENCY PHYSICIANS"; and be it further

RESOLVED, That ACEP encourage that facilities that do not have 24/7 coverage with board eligible or board certified emergency physicians cannot bill at the same rates as facilities (emergency departments, emergency centers, emergency rooms, etc.) that do have board eligible or board certified emergency physicians staffing their facilities 24/7.

Background

The resolution has requests ACEP to: 1) support legislation to require all facilities that wish to have an ED or designate an area as an ED or emergency room, to have a board eligible or board certified emergency physician onsite preferentially, or via telehealth with an onsite non-emergency physician if on-site availability is not possible, 24 hours a day, 7 days a week to qualify to market to the public and bill for emergency services, with the only exception if broadband does not exist or is impossible to access with legitimate and reasonable efforts to do so, to have such a designation; 2) support legislation that if a facility does not currently meet such criteria, that facility must submit a plan to the licensing body that regulates them with specific actions the facility is making and will be making to become compliant with having 24/7 coverage by a board eligible or board certified emergency physician within 24 months; 3) support legislation to state: if a facility fails to achieve and maintain 24/7 coverage of any emergency facility by board eligible or board certified emergency physicians within 24 months, they must remove all signage and case all marketing naming them as an ER or emergency department, emergency center, or expressly post in a conspicuous area on the sign in letters in the same font size as large or larger than the largest letters on signage that "THIS FACILITY DOES NOT ALWAYS STAFF OUR FACILITY WITH BOARD CERTIFIED EMERGENCY PHYSICIANS;" and 4) encourage that facilities that do not have 24/7 coverage with board eligible or board certified emergency physicians cannot bill at the same rates as facilities (EDs, emergency centers, emergency rooms, etc.) that do have board eligible or board certified emergency physicians staffing their facilities 24/7.

ACEP's policy statement, "Definition of an Emergency Physician" defines an emergency physician 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."

As outlined in the policy statement, "ACEP Recognized Certifying Bodies in Emergency Medicine," ABEM and AOBEM are recognized as the only primary emergency medicine certifying bodies recognized by the College. The policy also recognizes the American Board of Pediatrics (ABP) as an American Board of Medical Specialties (ABMS) certifying body in pediatrics that provides subspecialty certification for pediatricians in the subspecialty of pediatric emergency medicine. The College has also adopted the policy statement, "The Role of the Legacy Emergency Physician in the 21st Century," which states that "ACEP believes that physicians who begin the practice of emergency medicine in the 21st century must have completed an accredited emergency medicine residency training program and be eligible for certification by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM).

According to the National Study of the Emergency Physician Workforce, 2020, there were 48,835 clinically active emergency physicians in 2020. The most recent ACEP Emergency Medicine Statistical Profile (March 2019) indicates 36,920 emergency physicians are ABEM certified and 2,152 are AOBEM certified. This data suggests that

approximately 80% of all clinically active emergency physicians are board-certified. However, a 2017 analysis found that the supply of board-certified emergency physicians differed greatly by state, with some states fully able to staff an ED while at least 15 states were not able to meet 50% of demand.

The issues of ensuring that EDs are led and staffed by board-certified EPs and adapting emergency physician practice to evolving community needs are also key considerations identified in ACEP's Framework of Workforce Considerations aimed at addressing challenges related to the recent emergency physician workforce study projecting a surplus of emergency physicians over the next decade. Among the suggested actions is the promotion of policies and advocacy for regulations that ensure EDs are led and staffed by a board-certified EP, as well as a proposal to develop a "gold standard" that patients should expect from their emergency department and from those who are providing the care. To this end, ACEP established a task force to research and potentially establish an ED accreditation program that would define nationally recognized standards to provide the highest quality patient care. The task force will offer a proposed direction about pursuing an accreditation program at ACEP21.

Board eligibility or certification requirements may pose unique challenges for rural and underserved communities. The 2020 report issued by the ACEP Rural Emergency Care Task Force highlights particular challenges for rural hospitals, including current understaffing of rural EDs by EPs, that are only likely to worsen given the trend of a net loss of rural EDs and accelerating rural hospital closures. In the report, the Task Force lays out that "the gold standard for the care of ED patients is provision of care by EM residency trained and EM board-certified EPs, with board certification from [ABEM] and [AOBEM]." However, the task force specifically noted that restricting analyses to only emergency medicine trained or board certified EPs would exacerbate an already worrisome forecast of rural facility closures. The report encouraged ACEP to better support emergency physicians working in rural EDs, regardless of their training or board certification status, and to work with rural hospitals to pursue strategies to avoid further rural ED closures. The task force also surveyed emergency medicine residency program directors through CORD-EM, with one of the most commonly cited barriers by respondents were the ACGME requirement that trainees be supervised by EM board eligible/certified physicians in rural EDs.

Recent years have also witnessed the proliferation of delivery models and legislative proposals that would address perceived shortages of available board certified, residency trained emergency physicians by loosening requirements for onsite physician supervision and expanding the scope of practice of APRNs and PAs to permit either independent practice or lower levels of mandated supervision. These trends are not unique to emergency medicine and often reflect either efforts to reduce costs based on the argument that physician training is not always required in a practice environment or to expand the professional roles of non-physician health care practitioners. Additionally, proponents of these trends contend that in rural areas onsite physician care is not always available, meaning that the only choice is between nonphysician care and no care at all.

ACEP's origins are rooted in the establishment of emergency medicine as a medical specialty, and the College's historical development coincides with the rising availability of residency training and board certification for physicians that would hold themselves out as emergency physicians. Whereas the early decades of ACEP are characterized by expansion of the specialty and of specialized care in contrast to non-specialist physicians practicing in emergency departments, challenges are now increasingly arising from nonphysician practitioners arguing that their training suffices for an expanded scope of practice to include unsupervised practice. In contrast to this trend, ACEP policy for freestanding emergency departments, including those operated by hospitals, states that any such emergency department "that presents itself as an ED" should be "staffed by appropriately qualified emergency physicians." Given the array of emergent medical conditions that present at emergency departments, whether remote or rural, at any given time, the training and experience of an emergency physician is crucial for a viable, functioning emergency department team.

As stated in ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department," ACEP opposes the independent practice of emergency medicine by NPs and PAs. ACEP has assisted many state chapters as they confronted legislation that legalized the independent practice by NPs. While independent practice for NPs has passed in several states, efforts by National ACEP and the state chapters helped defeat legislation in many states.

Without question, NPs and PAs are valuable members of the emergency care team and are used effectively in many physician-led care models. However, ACEP has always believed that emergency care should be led by emergency physicians. ACEP has never supported the independent practice by NPs or PAs. In 2018, ACEP created a small workgroup composed of several members of the ACEP Board of Directors to discuss issues around the emergency medicine workforce. From the discussions of that group, two task forces were created: the NP/PA Utilization Task Force and the EM Physician Workforce Task Force.

ACEP's policy statement "Freestanding Emergency Departments" reinforces that any FSED facility that presents itself as an ED should be staffed by appropriately qualified emergency physicians. Additionally, the policy states that "ACEP encourages all states to have regulations regarding FSEDs that are developed in close relationship with the ACEP chapter in that state."

Regarding the last resolved requesting that ACEP encourage lower payments for facilities that do not exclusively staff with board eligible or board-certified emergency physicians, it is important to note that the Medicare statute requires payments for services under the physician fee schedule to be the same regardless of the specialty of the provider delivering the service (Section 1848(C)(6) of the Social Security Act). For example, an emergency physician must be paid the same amount as an orthopedic surgeon reporting the same Current Procedural Terminology (CPT) code. However, non-physician practitioners, such as nurse practitioners and physician assistants, are only reimbursed at 85 percent of the Medicare physician fee rate for a reported code.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

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

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Directed ACEP to review and update the policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department," and to develop tools and strategies to highlight importance of EP staffing of EDs, oppose independent practice by non-physician providers (NPPs), and work to require on-site supervision of NPPs by an emergency physician.

Resolution 27(19) Ensuring Public Transparency and Safety by Protecting the Terms "Emergency Department" and "Emergency Room" as Markers of Physician-Led Care not adopted. Directed ACEP to oppose the use of the terms "emergency" or "ER" by a facility if a physician is not onsite at all times and to draft state and federal legislation mandating that those terms indicate physician led care.

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted. Directed ACEP to explore the feasibility of setting minimum accreditation standards for FEC's.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted. Directed ACEP to study the emergence and proliferation of free-standing EDs and facilities including: applicable federal and state regulatory and accreditation issues; the potential impact on the emergency medicine workforce; the potential fiscal impact on hospital-based EDs; and provide informational resources to the membership.

Amended Resolution 25(10) Definition of an Emergency Physician referred to the Board of Directors. Directed ACEP

to define an "emergency physician" as someone who has either completed ACGME or AOA residency training in Emergency Medicine or fellowship in Pediatric Emergency Medicine, or is ABEM or AOBEM certified in Emergency Medicine or Pediatric Emergency Medicine, or began practicing emergency medicine in the 20th century and therefore is eligible to be a member of the American College of Emergency Physicians.

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted. It directed ACEP to investigate broadening access to ACGME or AOA accredited emergency medicine residency programs to physicians who have previously trained in another specialty.

Resolution 38(98) Recognition of Certifying Bodies adopted. It directed the Board of Directors to review prior actions on recognition of certifying bodies in emergency medicine.

Resolution 51(95) Criteria for Assessment of EPs adopted. The resolution stated: "ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by individual emergency physicians. These include professional credentials such as board certification, objective measurement of care provided, experience, prior training, and evidence of continuing medical education (CME). In general, no single criterion should provide the sole basis for decisions regarding an individual's emergency medicine practice."

Resolution 37(94) Criteria for Certifying Bodies and Recognition of the BCEM not adopted. It called for ACEP to meet with leaders of BCEM to obtain the necessary information to consider recognition of the BCEM and for ACEP to adopt the "Criteria for Recognition of Certifying Bodies" with amendments that would allow ACEP to grant similar recognition and/or acknowledgement of BCEM.

Resolution 35(94) Certifying Boards not adopted. It called for rescinding current ACEP policies regarding certifying boards and that the College reaffirm its ongoing support for ABEM by continuing its role as a parent organization, while acknowledging that other certifying boards exist.

Resolution 33(93) Recognition of Certifying Bodies in Emergency Medicine adopted. It directed ACEP to study the implications and possible criteria for College recognition of certifying bodies in emergency medicine.

Amended Resolution 32(88) Recognition of the American Osteopathic Board of Emergency Medicine adopted. The resolution acknowledged the American Osteopathic Board of Emergency Medicine as a certifying body for osteopathic emergency physicians.

Resolution 39(87) American Osteopathic Board of Emergency Medicine. The resolution acknowledged the American Osteopathic Board of Emergency Medicine as a certifying body for osteopathic emergency physicians. The resolution was not adopted by the Board in November 1987

Substitute Resolution 47(79) Recognize the American Board of Emergency Medicine adopted. It recognized and supported ABEM as the sole certifying body for emergency medicine.

Prior Board Action

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

April 2020, approved revised policy statement "Freestanding Emergency Departments;" originally approved June 2014.

February 2020, approved revised policy statement, "ACEP Recognized Certifying Bodies in Emergency Medicine;" reaffirmed April 2014, October 2008, and October 2002; originally approved March 1998.

April 2019, discussed two options from the task force regarding accreditation of Freestanding Emergency Centers. Approved partnering with the Center of Improvement in Healthcare Quality, which has deeming authority with CMS, to provide accreditation services for FECs.

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

September 28, 2018, discussed the feasibility for ACEP to proceed with implementing an accreditation program for freestanding emergency centers. The Board directed the task force to explore models and develop a business plan.

May 2018, accepted the report of the Freestanding Emergency Centers Accreditation Task Force, which included accreditation standards, and requested additional information about The Joint Commission's accreditation of FECs.

February 2018, approved the policy, "The Role of the Legacy Emergency Physician in the 21st Century;" reaffirmed April 2018 and April 2012; originally approved June 2006.

August 20167, reviewed the Policy Resource & Education Paper (PREP) "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" originally reviewed June 2006. This PREP is an adjunct to the policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine."

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

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

Resolution 9(16) Accreditation Standards for Freestanding Emergency Centers adopted.

November 2015, reviewed the information paper "Freestanding Emergency Departments and Urgent Care Centers."

July 2013, reviewed the revised information paper "Freestanding Emergency Departments;" originally developed in August 2009.

Substitute Resolution 23(12) Free-Standing Emergency Departments adopted.

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

September 2000, rescinded the policy statement "ACEP Criteria for Recognizing Certifying Bodies in Emergency Medicine" and supported development of a new policy acknowledging that ACEP has no criteria for recognizing certifying bodies and will only recognize certifying bodies approved by ABMS or AOA.

Resolution 38(98) Recognition of Certifying Bodies adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted.

September 1994, approved the policy, "Criteria for Recognition of Board Certifying Bodies in Emergency Medicine."

Resolution 33(93) Recognition of Certifying Bodies in Emergency Medicine adopted.

Resolution 32(88) Recognition of the American Osteopathic Board of Emergency Medicine adopted.

Substitute Resolution 47(79) Recognize the American Board of Emergency Medicine adopted.

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

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 69(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Workforce Transparency

PURPOSE: Calls for ACEP to ensure that all providers, clinicians, practitioners, and others who might be perceived as practicing medicine should use exact language to introduce themselves including the phrase "I am not a medical doctor" when appropriate.

FISCAL IMPACT: Budgeted staff resources. Unbudgeted additional unknown costs for state lobbying initiatives. A public education campaign could potentially have costs of $50,000 – 100,000.

WHEREAS, There is more and more confusion amongst the public understanding the education, training, and credentials of the person who may be obtaining their personal and confidential health information, examining them, and treating their medical complaints and conditions; and

WHEREAS, There are many non-physicians in emergency departments and other health settings who may not clearly identify themselves to patients; and

WHEREAS, It is of utmost importance for there to be clarity, honesty, and avoidance of confusion or appearance of deceitfulness in healthcare; therefore be it

RESOLVED, That all physicians, physician assistants, nurse practitioners or any person who might be reasonably be referred to as a provider, clinician, or practitioner, or any person who practices, or could reasonably be interpreted as practicing medicine including the authority to write orders or prescriptions that interacts with a patient, must state their name and then clearly state "I am a medical doctor (MD)," (to include doctors of osteopathic medicine, or the doctor of osteopathic medicine could say "I am a doctor of osteopathic medicine (DO)") or "I am not a medical doctor" depending on the education and training of that individual.

Background

This resolution calls for ACEP to ensure that all providers, clinicians, practitioners, and others who might be perceived as practicing medicine should use exact language to introduce themselves including the phrase "I am not a medical doctor" when appropriate.

ACEP's policy statement "Use of the Title 'Doctor' in the Clinical Setting" states:

"The American College of Emergency Physicians (ACEP) believes that a physician is an individual who has received a "Doctor of Medicine," "Doctor of Osteopathic Medicine," or an equivalent degree (e.g., Bachelor of Medicine, Bachelor of Surgery 'MBBS') following successful completion of a prescribed course of study from a school of allopathic or osteopathic medicine.

ACEP strongly opposes the use of the term "doctor" by other professionals in the clinical setting, including by those with independent practice, where there is strong potential to mislead patients into perceiving they are being treated by a physician.
Therefore, ACEP recommends that anyone in a clinical environment including, but not limited to, a hospital, free-standing emergency department, urgent care, or retail clinic who has direct contact with a

> *patient and presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree*."

Since this existing policy already recommends the introduction referred to in the resolution, staff contacted the primary author to clarify whether additional measures are needed to fulfill this resolution. The author suggested that ACEP advocate for the passage of legislation requiring the use of such an introduction and that ACEP would promote this requirement to the public. The author additionally suggested a reporting mechanism should a provider, clinician, practitioner, or any other person described in this resolution not provide the proper introduction during a medical encounter. The suggested legislative action would need to specify whether it would pertain to all medical encounters or just those in the emergency setting. Federal legislation to address this resolution could be difficult to achieve and it is likely that state legislative would need to be pursued. ACEP could support chapters in the development of model legislation and advocacy efforts for passage of state laws mandating such disclosure. Such laws would need to allow for some exceptions and define the extent to whom such disclosures are mandated.

Creating a reporting mechanism indicates there would be some type of adverse action associated with failure to properly identify oneself – either as a physician or not as a physician. It should be noted that this approach could open up yet another avenue for plaintiff lawyers seeking to show there were "errors" made during a patient visit.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective A – Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.

Fiscal Impact

Budgeted staff resources. Unbudgeted additional unknown costs for state lobbying initiatives. A public education campaign could potentially have costs of $50,000 – 100,000.

Prior Council Action

Substitute Resolution 30(13) Use of the Title "Doctor" in the Clinical Setting adopted. The resolution directed ACEP to affirm the degrees that would define a physician and require those in patient contact in hospital environments who have doctorate degrees but are not physicians to declare themselves a "non-physician" and identify the nature of their doctorate degrees.

Prior Board Action

February 2020, approved the revised policy statement "Use of the Title "Doctor" in the Clinical Setting;" originally approved April 2014

Substitute Council Resolution 30(13) User of the title "Doctor" in the Clinical Setting adopted.

Background Information Prepared by: Sandra Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Harry J. Monroe, Jr.
State Legislation Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 70(21)

SUBMITTED BY: Government Services Chapter

SUBJECT: Creation of Specialized Scope Expansion Advocacy Teams for State Level Advocacy

PURPOSE: 1) Create a toolkit for use at the state level addressing efforts to expand practice scope; 2) create a tracking system for unsupervised practice efforts in each state; 3) create "strike teams" of advocacy experts in EM scope expansion to help states actively engaged on the issue; and 4) partner with the AMA's Scope of Practice Partnership, the Physicians for Patient Protection, and similar groups to address scope expansion efforts nationally.

FISCAL IMPACT: Budgeted committee and staff resources. Any specific actions and/or the use of paid experts would require unbudgeted funds.

WHEREAS, ACEP affirms that nurse practitioners and physician assistants are an important part of a physician led emergency department care team; and

WHEREAS, The American Academy of Nurse Practitioners has made unsupervised practice a top legislative priority; and

WHEREAS, The American Academy of Physician Assistants have recently voted to change their name to dissociate themselves with their supervising physicians and are actively pursuing unsupervised practice in many states; and

WHEREAS, Both of these organizations have well-funded advocacy teams that are working at the state level to advance these initiatives; and

WHEREAS, The American Medical Association (AMA) has developed scope of practice resources that may be used by their members when fighting scope expansion; and

WHEREAS, Emergency physicians have few resources specific to emergency medicine to engage with their state legislators to address these scope expansion efforts; therefore be it

RESOLVED, That ACEP create a toolkit for members to use at the state level to address practice scope expansion efforts that emphasizes the importance of a physician led team for optimal patient safety; and be it further

RESOLVED, That ACEP's advocacy team create a tracking system for unsupervised practice efforts in each state to ensure that the voice of emergency physicians can be heard for this important patient safety topic; and be it further

RESOLVED, That ACEP's advocacy team create a "strike team" of advocacy experts in emergency medicine scope expansion issues that can be tasked to help engage states who are actively involved in scope expansion legislation and support the state chapters and physicians at the local level; and be it further

RESOLVED, That ACEP partner with the American Medical Association Scope of Practice Partnership, Physicians for Patient Protection, and other like-minded groups to address scope expansion efforts on a national basis.

References

1. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=B8843987-1776-EB11-A9C2-995F1D3A2B04
2. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=B387D103-F175-EB11-A9C2-995F1D3A2B04
3. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=C977F9A7-8C72-E911-A9AD-9BD2C184F805
4. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=B0120C61-9572-E911-A9AD-9BD2C184F805
5. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=98FDB3F0-1F81-EB11-A9C2-995F1D3A2B04
6. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=C99E0612-EB93-EB11-A9C2-995F1D3A2B04

Background

The resolution calls for ACEP to: 1) Create a toolkit for use at the state level addressing efforts to expand practice scope; 2) create a tracking system for unsupervised practice efforts in each state; 3) create "strike teams" of advocacy experts in EM scope expansion to help states actively engaged on the issue; and 4) partner with the AMA's Scope of Practice Partnership, the Physicians for Patient Protection, and similar groups to address scope expansion efforts nationally.

Going back to the late 20th Century, nurse practitioners and physician assistants have advocated at the state level for the purpose of expanding their respective scopes of practice and allowing for varying levels of decreased supervision or independent practice. ACEP has assisted many state chapters as they confronted legislation that legalized the independent practice by NPs. While independent practice for NPs has passed in several states, efforts by National ACEP and the state chapters helped defeat legislation in many states.

ACEP has long held out board certification and residency training in emergency medicine as the gold standard for emergency departments. Obviously, those who are not physicians of any sort lack this level of education and training needed for the emergency department.

While the issue has been percolating and growing for many years, the problem was worsened exponentially during the COVID crisis, when governors looking for any and all available resources accepted their staff recommendations to allow independent practice without prior vetting of the issue. This has opened doors for nurse practitioner organizations to argue that such scope expansions should be made permanent.

ACEP's "Code of Ethics for Emergency Physicians" has several provisions related to relationships with non-physician practitioners in the emergency department, including the following:

> "The practice of emergency medicine requires multidisciplinary cooperation and teamwork. Emergency physicians interact closely with a wide variety of other health care professionals, including emergency nurses, emergency medical technicians, and physicians from other specialties. General ethical principles governing these interactions include honesty, respect, appreciation of other professionals' perspectives and needs, and an overriding duty to maximize patient benefit."

ACEP's current policy statement, first created in 2001, "Providers of Unsupervised Emergency Department Care," clearly states that ACEP believes that the independent practice of emergency medicine is best performed by specialists who have completed American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) certification, or have successfully "completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited emergency medicine residency, and is in the process of completing ABEM or AOBEM examinations." Additionally, the policy includes the statement that "ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care" and ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists.

ACEP' s policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the

Emergency Department" provides clear guidance on the scope of practice for PAs and NPs.

In 2018, ACEP invited other national emergency medicine organizations to participate in a task force to examine the future of the emergency medicine work force in the United States. Among the considerations that the task force addressed was to "ensure appropriate use of NPs and PAs to protect the unique role of emergency physicians." The task force report was presented to the ACEP Board in June 2020, which noted that it was a consensus document and it was filed for information. In August 2021 the "Emergency Medicine Physician Workforce: Projections for 2030" was published in *Annals of Emergency Medicine*. In anticipation of that report, ACEP developed a multi-faceted work group to address many of the identified issues. The ACEP website has many resources about the Emergency Medicine Workforce of the Future.

In April 2021, ACEP joined the AMA's Scope of Practice Partnership.

ACEP has developed an array of materials related to scope of expansion and offers them to states in a manner designed to meet state specific needs. The Communications Department is currently at work on a more formal toolkit to assist member.

At the request of ACEP's president elect and senior staff, a "strike team" of advocacy experts is currently in the process of being formed. ACEP's State Legislative/Regulatory Committee is also tasked with furthering this work. In addition, ACEP's State Legislation Director tracks legislation on a variety of subjects of concern to emergency medicine, including scope expansion.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted committee and staff resources. Any specific actions and/or the use of paid experts would require unbudgeted funds.

Prior Council Action

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to: 1) Review and update the policy statement " Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care and survey states and hospitals on where independent practice by NPs is permitted.

Prior Board Action

April 2021. approved joining the AMA's Scope of Practice Partnership at the Steering Committee level.

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

June 2020, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised June 2013 as "Guidelines Regarding the Role of Physician

Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007: originally approved June 2001.

September 2018, accepted the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations to proceed with the NP/PA Utilization Task Force and the Emergency Medicine Workforce Task Force.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers in the emergency department.

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

Background Information Prepared by: Harry Monroe
State Legislation Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 71(21)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Emergency Medicine Workforce by Non-Physician Practitioners

PURPOSE: Support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

FISCAL IMPACT: Budgeted committee and staff resources to develop a new policy statement and/or revise existing policy statements. Unknown additional costs depending on the scope of any action taken beyond policy development.

WHEREAS, The ACEP workforce study has predicted a significant oversupply of board-certified emergency physicians by the year 2030; and

WHEREAS, In the documented workforce study, the non-physician practitioners are estimated to be supplying 20% of emergency care in emergency departments nationwide; and

WHEREAS, Given the oversupply of emergency physicians, non-physician practitioners will not be needed to staff emergency departments; therefore be it

RESOLVED, That ACEP support a reduction in non-physician practitioner emergency department staffing over the next three years to eliminate the use of non-physician practitioners in the ED, unless the supply of emergency physicians for the location is not adequate for the staffing needs.

Background

This resolution calls for ACEP to support a reduction in non-physician practitioners in ED staffing over the next three years and to eliminate the use of non-physician practitioners in the ED unless the supply of emergency physicians for the location is not adequate to staff the facility.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states:

> *"Physician assistants (PAs) and nurse practitioners (NPs) can serve an integral role as members of the emergency care team, but do not replace the medical expertise provided by emergency physicians."*
>
> *"The gold standard for care in an ED is that performed or supervised by a board-certified/board-eligible emergency physician."*
>
> *"PAs/NPs should not perform independent unsupervised care in the ED. This holds true regardless of state laws or hospital regulations. In the case of rural and underserved areas, supervision may require telehealth services or real-time off-site emergency physician consultation."*
>
> *"The use of PAs and NPs in the ED should be determined at the site level by local ED leadership, who are responsible for PA/NP hiring, staffing and supervision.*[1]"

ACEP's policy statement "Providers of Unsupervised Emergency Department Care" states:

> *"ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care."*
>
> *ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists."*[2]

ACEP supports the use of other non-physician staff in the ED, such as emergency pharmacists and social workers.[3,4] It is presumed that the intent of this resolution is limited to nurse practitioners (NPs), advanced practice registered nurses (APRNs), and PAs. The intent of the resolution will need to be clarified in the final language of the resolution if it is adopted.

It should be noted that many policies and articles written by ACEP and others do not distinguish between NPs and APRNs. Indeed, the Emergency Nurses Association (ENA) and the American Nurses Association combine these two groups together when they seek to promote independent practice. However, NPs are only one of four types of APRNs with the others being clinical nurse specialist (largely focused on patient education, administration, and program development), nurse anesthetist, and nurse midwife.[5,6]

In September/October 2020, a survey of ACEP members was performed by Ed Salsberg and associates from the Fitzhugh Mullan Institute for Health Workforce Equity, George Washington University School of Public Health. The respondents represented 8% of our membership and appeared to be representative of the membership as a whole. In that survey, most respondents reported working with PAs (83.5%) and NPs (74.9%). At that time, 66% reported that NPs and PAs had a "moderate" or "strong" positive impact on their productivity (only 11.2% indicted they had a "moderate" or "strong" negative impact - the remainder indicated "no or very little impact"). 57.2% of respondents indicated that NPs and PAs had a positive impact on their job satisfaction (only 16.5% indicated that NPs and PAs had a negative impact). The impact on quality of care were more mixed but was slightly more positive than negative. The respondents were concerned about a negative impact on resident education.[7]

There has been concern regarding the increased use of NPs and PAs in EDs.[8] Productivity by NPs and PAs has been estimated to be about half that of physicians.[9] The volume of services provided by NPs/PAs increased from 4.1% in 1995[9] to 20.2% during 2010-2017.[10] However, physicians continued to be involved with nearly 90% of all ED visits from 2010-2017.[10] Bai's analysis of Medicare claims data showed the proportion of services provided by physicians decreased from 88% in 2012 to 85% in 2015.[11] Patients cared for by NPs and PAs are associated with lower patient acuity[9,11] and therefore lower reimbursement.

Extrapolating from Salsberg's projections, removal of all NPs and PAs from their current positions would increase demand for emergency physicians in 2030 by about 10,000, making supply roughly equal to demand at that time. However, this would assume that graduating residents and those seeking new employment opportunities would be willing to provide the services currently supplied by NPs/PAs. This would include lower acuity patients, and more importantly, services in rural and semi-rural areas. Salsberg's reported that NPs independent billing occurs twice as frequently in rural areas.[12]

The recent workforce study by Bennet showed an increase in emergency physicians in all areas of the country, except for rural, where the number of physicians appeared to decrease. It should be noted that rural emergency physicians are older than those practicing in urban conditions.[13] Salsberg's survey of graduating residents 2019 (pre-pandemic) indicated that very few new graduates took jobs in rural areas, despite a greater salary in rural areas of nearly $100,000 plus, in many cases, loan forgiveness.[12] Preliminary results from this year's survey of graduating residents show that, once again, few entered rural practice, and that the salary difference demonstrated in 2019 remains true today. Despite a tightening job market, higher salaries and loan forgiveness, few graduating residents take jobs in rural areas.

It is not clear from the resolution exactly how ACEP would affect this change in practice. NPs and PAs are integrated into many practices and as studies done during the pandemic indicate, most physicians like practicing with NPs/PAs. In addition, ACEP policy states that decisions on staffing are made by the local emergency department medical

director to "*achieve operational efficiency while maintaining clinical quality and physicians-directed or supervised care.*"[15]

Note: This resolution needs to be considered in context with other 2021 resolutions that seek to retain NPs/PAs in the ED.

Background References

[1]Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
[2]Providers of Unsupervised Emergency Department Care [policy statement]. Approved January 2019.
[3]Clinical Pharmacist Services in the Emergency Department [policy statement]. Approved January 2021.
[4]Social Work and Case Management in the Emergency Department [policy statement]. Approved October 2020.
[5]https://nursinglicensemap.com/advanced-practice-nursing/clinical-nurse-specialist-cns/
6https://www.onlinefnpprograms.com/faqs/clinical-nurse-specialist-versus-nurse-practitioner/
[7]Salsberg E, Masselink L, Westergaard S, Quigley L Richwine C. The Emergency Medicine Physician Workforce: Findings from the 2020 survey of emergency medicine physicians. Report to the ACEP Board of Directors and Workforce Task Force Partners.
[8]Salsberg E, Richwine C, Quigley L, Masselink L, Westergaard S. Projecting the supply and demand for emergency physicians in 2030. Report to the ACEP Board of Directors and Workforce Task Force Partners.
[9]Pines JM, Zocchi MS, Ritsema T, Polansky M, Bedolla J, Venkat A; US Acute Care Solutions Research Group. The Impact of Advanced Practice Provider Staffing on Emergency Department Care: Productivity, Flow, Safety, and Experience. *Acad Emerg Med*. 2020;27(11):1089-99.
[10Wu] F, Darracq MA. Physician assistant and nurse practitioner utilization in U.S. emergency departments, 2010 to 2017. *Am J Emerg Med*. 2020;38(10):2060-4.
[11]Bai G, Kelen GD, Frick KD, Anderson GF. Nurse practitioners and physician assistants in emergency medical services who billed independently, 2012–2016. *Am J Emerg Med*. 2019 May 1;37(5):928-32.
[12]Bennett CL, Sullivan AF, Ginde AA, Rogers J, Espinola JA, Clay CE, Camargo CA Jr. National Study of the Emergency Physician Workforce, 2020. *Ann Emerg Med*. 2020 Dec;76(6):695-708. doi: 10.1016/j.annemergmed.2020.06.039. Epub 2020 Aug 1. PMID: 32747085.
[13]Quigley L, Salsberg E, Richwine C. New Emergency Medicine Physicians: Who They Are, Where They Are Working and Their Experience in the Job Market: Results from the Survey of Emergency Medicine Residents Who Completed Training in 2019. Report to the ACEP Board of Directors and Workforce Task Force Partners.
[14]Bennett CL, Sullivan AF, Ginde AA, Rogers J, Espinola JA, Clay CE, Camargo CA Jr. National Study of the Emergency Physician Workforce, 2020. *Ann Emerg Med*. 2020 Dec;76(6):695-708.
[15]Staffing Models and the Role of the Emergency Department Medical Director.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
  - Tactic 1 – Advocate for ACEP's principles for healthcare reform in current and future legislation that supports the practice of emergency physicians.

- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.
  - Tactic 4 – Assess the needs and explore development of means to improve rural health care. Develop recommendations on opportunities to improve rural emergency care including possible accreditation programs, incentives, and policies. Provide several models of successful rural care practices.

Fiscal Impact

Budgeted committee and staff resources to develop a new policy statement and/or revise existing policy statements. Unknown additional costs depending on the scope of any action taken beyond policy development.

Prior Council Action

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1.) Review and update the policy statement " Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and

educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 44(14) Support for Clinical Pharmacists as Part of the Emergency Medicine Team adopted. It called for ACEP to develop a policy statement in support of clinical pharmacy services in the ED, promote safe and effective medication delivery practices, conduct related clinical research, and foster support for pharmacy residency training in emergency medicine.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Prior Board Action

April 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, approved the revised policy statement "Clinical Pharmacist Services in the Emergency Department;" originally approved June 2015.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

October 2020, approved the revised policy statement "Social Work and Case Management in the Emergency Department;" revised and approved April 2019; reaffirmed June 2013; originally approved October 2007 titled "Patient Support Services."

October 2020, reviewed the "Social Work and Case Management in the Emergency Department" PREP.

June 2020, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

June 2020, filed the final report of the Emergency NP/PA Utilization Task Force.

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007: originally approved June 2001.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers (APP) in the emergency department (ED).

Resolution 44(14) Support for Clinical Pharmacists as Part of the Emergency Medicine Team.

June 2012, reviewed the information paper, "Physician Assistants and Nurse Practitioners in Emergency Medicine."

June 2011, approved the Emergency Medicine Practice Committee's recommendation that ACEP not conduct a survey to determine the state of NP practice in emergency care and to take no further action on Resolution 27(10)

Emergency Department (ED) Staffing by Nurse Practitioners.

May 2001, recommendations of the Staffing Task Force presented to the Board.

September 1999, approved dissemination of survey results from the MLP/EMS Task Force recommendations.

Background Information Prepared by: Sandra Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 72(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Fair Compensation to Emergency Physicians for Collaborative Practice Agreements & Supervision

PURPOSE: Calls for ACEP to: 1) provide a means whereby emergency physicians can have a choice to supervise or collaborate with non-physicians; 2) provide a means for emergency physicians to be fairly compensated to supervise physician assistants and/or collaborate with nurse practitioners; and 3) that this compensation be in addition to the compensation that emergency physicians receive for practicing without supervision and collaborating.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, Many emergency physicians provide supervision of physician assistants; and

WHEREAS, Many emergency physicians have collaborative agreements with nurse practitioners; and

WHEREAS, Non-physician practitioners can offer valuable services as part of an emergency physician led team under the appropriate supervision; and

WHEREAS, This supervision and collaborative agreements require time, effort and energy and often distract from the emergency physician attention; and

WHEREAS, This supervision and collaboration is very valuable to patient care and to employers' ability to staff emergency departments with lesser educated and trained non-physicians; and

WHEREAS, The emergency physician often does not receive compensation for the EP's supervision and collaboration; and

WHEREAS, The supervision and collaboration often interferes in the EP's ability to see patients; and

WHEREAS, The supervision and collaboration often results in significantly more interruptions and a higher risk for medical decision errors and liability to the emergency physician; therefore be it

RESOLVED, That emergency physicians have the choice as to whether to supervise or collaborate with non-physicians; and be it further

RESOLVED, That emergency physicians be fairly compensated to supervise physician assistants and/or collaborate with nurse practitioners; and be it further

RESOLVED, That the fair compensation for supervision and collaborating with non-physicians is in addition to the compensation that the emergency physician receives for practicing emergency medicine without supervision and collaborating.

Background

This resolution asks ACEP to provide a means whereby emergency physicians can have a choice as to whether to

supervise or collaborate with non-physicians. Further it asks that ACEP provide a means by which emergency physicians can be fairly compensated to supervise physician assistants (PAs) and/or collaborate with nurse practitioners (NPs)and that this compensation is in addition to the compensation that emergency physicians receive for practicing without supervision and collaborating.

Currently, the requirement to supervise non-physicians is a contractual matter between the physician and their employee or between the group and their employee. ACEP has several policy statements and a Policy Resource & Education Paper (PREP) regarding compensation arrangements for emergency physicians.[1-7] None of these resources contain language that addresses supervision of non-physicians or additional payment for the supervision of such individuals.

In creating such a policy, it would be necessary to be explicit regarding the terms "supervision" and "non-physicians." In some settings, the physician may be deemed to have some supervision over other team members besides NPs and PAs.

CMS, who covers Medicare and Medicaid, allows the physician to report a split or shared service if a non-physician practitioner (physician assistant or nurse practitioner) and the physician both interact with the patient during a given encounter with the requirement of a documented "substantive portion" chosen by the physician to demonstrate their involvement. Typically, that would be the medical decision making. Alternatively, an appropriate physician attestation statement would suffice to demonstrate the physician participation without the need to duplicate previous documentation by the non-physician provider. The claim would then be paid at 100% of the physician fee schedule rate. If the non-physician provider claim is submitted without being a split or shared service, it is typically paid at 85% of the physician fee schedule amount. There is no separate payment for supervising a non-physician practitioner in the emergency department setting because "incident to" policy does not apply in the facility. There is no provision for a split or shared procedure except under teaching physician rules. A current reimbursement FAQ on this topic is available on the ACEP website.

Unless reimbursement is possible through CMS and/or private insurance, any payment for such services would be from the group or employer.

Background References

[1]Compensation Arrangements for Emergency Physicians. [policy statement]. Approved April 2021.
[2]Fair Payment for Emergency Department Services. [policy statement]. Approved April 2016.
[3]Emergency Physician Compensation Transparency. [policy statement]. Approved October 2020.
[4]Emergency Physician Rights and Responsibilities. [policy statement]. Approved April 2021.
[5]Protecting Emergency Physician Compensation During Contract Transitions. [policy statement]. Approved February 2020.
[6]Emergency Physician Contractual Relationships. [policy resource and education paper]. Approved July 2018.
[7]Emergency Physician Contractual Relationships. [policy statement]. Approved April 2021.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care is silent on this specific issue.
- Objective F – Develop and implement solutions for workforce issues that promote and maintain patient safety.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1.) Review and update the policy statement " Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and

Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. Directed ACEP to work with NP and PA organizations to establish a curriculum and clinically-based ED educational training program and encourage certifying bodies to develop certifying examinations for competencies in emergency care.

Prior Board Action

April 2021, approved the policy statement "Compensation Arrangements for Emergency Physicians;" revised and approved April 2015; Reaffirmed October 2008; revised and approved April 2002, June 1997; reaffirmed April 1992; originally approved June 1988.

April 2021, approved the revised policy statement, "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, August 1993. Originally approved October 1984 titled, "Contractual Relationships between Emergency Physicians and Hospitals."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised and approved October 2015, April 2008, and July 2001; originally approved September 2000.

October 2020, approved the policy statement "Emergency Physician Compensation Transparency."

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

June 2020, filed the final report of the Emergency NP/PA Utilization Task Force.

February 2020, approved the policy statement "Protecting Emergency Physician Compensation During Contract Transitions."

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

September 2018, accepted the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations to proceed with the NP/PA Utilization Task Force and the Emergency Medicine Workforce Task Force.

July 2018, reviewed the "Emergency Physician Contractual Relationships" PREP.

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

June 2011, approved the Emergency Medicine Practice Committee's recommendation that ACEP not conduct a survey to determine the state of NP practice in emergency care and to take no further action on Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners.

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development. In January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine. Resolution 44(19) Independent ED Staffing by Non-Physician Providers Page 6

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. A task force was appointed to review the available information and provide a recommendation to the Board regarding ACEP' s potential involvement in the development of specialized training curricula for PAs and NPs that work in the ED.

May 2001, accepted the report of the Staffing Task Force.

September 1999, approved dissemination of survey results from the MLP/EMS Task Force recommendations.

Background Information Prepared by: Sandra Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

David McKenzie, CAE
Reimbursement Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 73(21)

SUBMITTED BY: Emergency Medicine Residents' Association
Ohio Chapter
Pennsylvania College of Emergency Physicians
Young Physicians Section

SUBJECT: Offsite Supervision of Nurse Practitioners and Physician Assistants

PURPOSE: 1) Revise the policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" to remove "offsite" supervision, including via telephone, telehealth, or video, as a type of indirect supervision of PAs and NPs in the ED. 2) Oppose staffing EDs with PAs and NPs without onsite emergency physician supervision.

FISCAL IMPACT: Budgeted committee and staff resource.

WHEREAS, The American College of Emergency Physicians (ACEP) defines an emergency physician as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM), 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; and

WHEREAS, Emergency physicians and their patients have a right to adequate emergency physician, nurse, and ancillary staffing, resources, and equipment to meet the acuity and volume needs of their patients; and

WHEREAS, The facility management must provide sufficient support to ensure high quality emergency care and patient safety; and

WHEREAS, ACEP has long supported physician-led teams in the emergency department, where emergency nurses (RNs), nurse practitioners (NPs), physician assistants (PAs), pharmacists, and others play an integral role as part of a multidisciplinary team; and

WHEREAS, ACEP has a policy statement, "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" (revised June 2020 with current title; approved June 2013 titled, "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved January 2007 titled, "Guidelines on the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" replacing "Guidelines on the Role of Physician Assistants in Emergency Departments" (2002) and "Guidelines on the Role of Nurse Practitioners in the Emergency Department" (2000)); and

WHEREAS, The 2021 ACEP Emergency Physician Workforce of the Future Report suggested a looming surplus of emergency physicians; therefore be it

RESOLVED, That the ACEP policy statement, "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department," be revised to remove "offsite" supervision, including via telephone, telehealth, or video, as a type of indirect supervision of physician assistants and nurse practitioners in the emergency department; and be it further

RESOLVED, That ACEP oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

References
1. https://www.acep.org/patient-care/policy-statements/emergency-physician-rights-and-responsibilities/
2. https://www.acep.org/who-we-are/ACEPLately/acep-lately-blog-articles/may-2021/
3. https://www.acep.org/contentassets/c3cef041efd54af48b71946c0cb658f0/final---board-report---2020-rural-emergency-care-task-force-oct-2020---provider-002.mcw-final-edits-002.pdf
4. https://www.acep.org/life-as-a-physician/workforce/

Background

This resolution asks ACEP to revise the policy statement, "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department," to remove "offsite" supervision, including via telephone, telehealth, or video, as a type of indirect supervision of physician assistants (PAs) and nurse practitioners (NPs) in the emergency department (ED). Further it asks that ACEP oppose staffing of EDs with PAs and NPs physician without onsite emergency physician supervision.

ACEP has several policies that oppose the independent practice by PAs/NPs:[1,2]

> *"PAs/NPs should not perform independent unsupervised care in the ED. This holds true regardless of state laws or hospital regulations. In the case of rural and underserved areas, supervision may require telehealth services or real-time off-site emergency physician consultation.*[1]"
>
> *"ACEP believes that advanced practice registered nurses or PAs should not provide unsupervised ED care.*
>
> *ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists."*[2]

Many rural hospitals struggle to survive financially. According to the Rural Emergency Medicine Task Force Report, in 2020 a net of 55 rural EDs have closed in the past 17 years. Some rural hospitals struggle to support a board-certified physician practice model. Rural EDs represent 53% of the hospitals in the U.S. but only 24% of the volume.[3,4] Additionally, according to the Rural Emergency Medicine Task Force report, a recent study found that only 8% of all emergency physicians (not necessarily ABEM/ AOBEM certified) work in rural EDs and only about 2% work in very low volume ED's. Even as the job market has tightened for emergency physicians, few graduates choose to staff rural facilities. In a survey of new emergency medicine resident/fellow graduating in 2019, only 8.4% of graduates took positions in semi-rural areas, despite incentives of loan forgiveness and a salary difference of over $100,000 (greater in rural areas).[5] Bennet et al showed that although the total number of clinically active emergency physicians in the U.S. increased by almost 10,000 from 2008-2020, the number of emergency physicians in rural areas actually decreased.[6]

There are several suggestions on ways to provide emergency physician coverage to rural areas. One suggestion, supported by many, is to increase the number of residencies that include a rural rotation. However, an analysis of the Salsberg data suggests there is no difference in the number of residents who chose rural practice after graduation based on whether their residency promotes rural exposure. [7]

It remains to be seen whether a tightening job market and greater concern for a future emergency physician surplus will increase the number of physicians who provide care in a rural area. However, data suggests that graduates do not want to work in a rural area, even if there is a financial incentive to do so. Preliminary results from this year's survey of graduating residents show that, once again, few entered rural practice, and that the salary difference demonstrated in 2019 ($100K + greater in rural areas) remains true today. Despite a tightening job market, higher salaries and loan forgiveness, and residency rural experience, few graduating residents take jobs in rural areas.

Providing care to very rural facilities is already challenging. Several facilities support very rural practices via telehealth today, including the University of Mississippi, University of South Dakota, and the Mayo system in Minnesota. In those models, NPs/PAs staff very small emergency departments but have their care "supervised" remotely by board certified emergency physicians. Were ACEP to oppose offsite supervision via telehealth, either

those facilities would need to be staffed by board certified emergency physicians or those hospitals would likely ignore ACEP policy and staff their facilities with NPs/PAs practicing independently. There are already significant financial incentives for physicians to staff rural hospitals – and they are not working. There are already many residencies that emphasize rural emergency medicine, yet their graduates do not take rural jobs. Removing telemedicine supervision may have the unintended consequence of moving rural jobs permanently into independent NP/PA staffing.

It should be noted that the resolution "Rural Provider Support and a Call for Data" submitted this year specifically calls for support of rural practices with telehealth. There are several other resolutions submitted this year regarding the practice of NPs and PAs in the ED and the Council should ensure that these resolutions do not contradict each other.

Background References

[1]Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
[2]Providers of Unsupervised Emergency Department Care [policy statement]. Approved January 2019.
[3]Ginde AA, Sullivan AF, Camargo CA Jr. National study of the emergency physician workforce, 2008. *Ann Emerg Med*. 2009; 54: 349-359.
[4]Sullivan AF, Richman IB, Ahn CJ, et al. A profile of U.S. emergency departments in 2001. *Ann Emerg Med.* 2006; 48: 694-701.
[5]Leo Quigley, Edward Salsberg, Chelsea Richwine. New Emergency Medicine Physicians: Who They Are, Where They Are Working, and Their Experience in the Job Market: Results from the Survey of Emergency Medicine Residents Who Completed Training in 2019. The Fitzhugh Mullan Institute for Health Workforce Equity. George Washington University School of Public Health. February 2020. Report to the ACEP Board of Directors and Workforce Task Force Partners.
[6]Bennett CL, Sullivan AF, Ginde AA, et al. National study of the emergency physician workforce, 2020. *Ann Emerg Med*. 2020; Published July 31, 2020.
[7]Personal Communication. Ed Salsberg. 2021

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective F – Develop and implement solutions for workforce issues that promote and sustain quality and patient safety.
  - Tactic 4 – Assess the needs and explore development of means to improve rural health care. Develop recommendations on opportunities to improve rural emergency care including possible accreditation programs, incentives, and policies. Provide several models of successful rural care practices.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1.) Review and update the policy statement " Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Prior Board Action

April 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

October 2020, filed the report of the Rural Emergency Medicine Task Force and included recommendations for implementation in ACEP's Strategic Plan.

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers in the emergency department.

May 2001, recommendations of the Staffing Task Force presented to the Board.

September 1999, approved recommendations from the MLP/EMS Task Force to disseminate the results of the surveys.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 74(21)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Regulation by State Medical Boards of All Who Engage in Practice of Medicine

PURPOSE: Support a federal definition of practice of medicine and support that anyone engaged in such practice be regulated by state medical boards that regulate the practice of medicine.

FISCAL IMPACT: Budgeted staff resources.

WHEREAS, The practice of medicine has been defined in the US back to 1907 as the application of medical or surgical agencies for the purpose of preventing, relieving, or curing disease, or aiding natural functions, or modifying or removing the results of physical injury, (Hutchins, Harry B "What is the practice of Medicine?" Mich L. Rev (1906):373-9); and

WHEREAS, In general, a person practices medicine when he or she tries to diagnose or cure an illness or injury, prescribes drugs, performs surgery, or claims he or she is a doctor; and

WHEREAS, States are responsible for providing medical licenses, and each state has a slightly different legal definition for the practice of medicine; therefore be it

RESOLVED, That ACEP support a federal definition of the practice of medicine to include the ordering of tests, diagnosing, prescribing of medications, and/or ordering of treatments on human beings; and be it further

RESOLVED, That ACEP support that anyone, physicians or non-physician practitioners, who engage in the practice of medicine be regulated by the respective state medical boards that regulate the practice of medicine.

Background

The resolution calls for the College to support a federal definition of the practice of medicine and support that anyone engaged in such practice be governed by state medical boards that regulate the practice of medicine. Under the United States Constitution, jurisdiction on various issues is divided between the national government and the individual states. Historically, the practice of medicine as a profession has fallen to the jurisdiction of the states. Similarly, various types of specialties that also are involved in providing health care services to individual people are authorized and regulated at the state level. While various organizations have pursued model laws and related resources that would promote a high degree of uniformity in this patchwork of state regulation, there nonetheless exists a degree of variability in the licensure and regulation of these professions.

Beyond that variation, in recent years changes in terminology, training, and regulation have resulted in increasing ambiguity with regard to what constitutes the practice of medicine as opposed to the practice of providing various sorts of health care services that either do not rise to the level of constituting the practice of medicine or that until recently could only be provided under the supervision of a licensed physician. What constitutes supervision has also varied from state to state. Some organizations representing various health care groups have promoted such ambiguity to argue in favor of unrestricted, or at least less restrictive, practice. Among physicians, this increase in the scope of practice of persons lacking the education and training of physicians has created concerns about patient safety and quality of care.

The Federation of State Medical Boards' workgroup on Team-based Regulation notes that states have adopted a variety of strategies in order to address the regulation of physicians and other practitioners, including the use of joint rulemaking, joint committees, and interagency advisory committees. Coordinated complaint intake and shared investigation data are also used in many states in order to facilitate the handling of complaints. Given that the goals of this resolution would not seem to involve, or at least not require, the elimination of various licensing boards, such coordinating efforts would continue to be required and may become more complex.

ACEP's "Code of Ethics for Emergency Physicians" has several provisions related to relationships with non-physician practitioners in the emergency department, including the following:

> "The practice of emergency medicine requires multidisciplinary cooperation and teamwork. Emergency physicians interact closely with a wide variety of other health care professionals, including emergency nurses, emergency medical technicians, and physicians from other specialties. General ethical principles governing these interactions include honesty, respect, appreciation of other professionals' perspectives and needs, and an overriding duty to maximize patient benefit."

In 2018, ACEP invited other national emergency medicine organizations to participate in a task force to examine the future of the emergency medicine work force in the United States. Among the considerations that the task force addressed was to "ensure appropriate use of NPs and PAs to protect the unique role of emergency physicians." The task force report was presented to the ACEP Board in June 2020, which noted that it was a consensus document and it was filed for information. In August 2021 the "Emergency Medicine Physician Workforce: Projections for 2030" was published in *Annals of Emergency Medicine*. In anticipation of that report, ACEP developed a multi-faceted work group to address many of the identified issues. The ACEP website has many resources about the Emergency Medicine Workforce of the Future.

This resolution would address some of these varied concerns by calling for ACEP to work in favor of a standardized federal definition of the practice of medicine that would then be enforced in a more uniform manner by the states.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective D – Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources.

Prior Council Action

Resolution 24(15) Interstate Medical Licensure Compact Legislation and Opposition to National Medical License referred to the Board of Directors.

Prior Board Action

June 2020, filed the final report of the Emergency PA-NP Utilization Task Force.

June 2020, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department;" originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

April 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

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

October 2016, approved the recommendation of the State Legislative/Regulatory Committee to distribute resources to chapters to address Referred Resolution 24(15) Interstate Medical Licensure Compact Legislation and Opposition to National Medical License.

Background Information Prepared by: Harry Monroe
State Legislation Director

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 75(21)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Required Clinical Experience for Emergency Nurses

PURPOSE: 1) Contact ENA to explore the potential for a joint Emergency Workforce collaboration, with the goal of sharing the task force's identified goals and working together on ensuring consistency in nursing training, supporting practicing nurses to encourage rewarding practice in all communities, and setting the standard for emergency medicine so that every patient has access to an experienced emergency nurse. 2) Collaborate with ENA to advocate for a minimum level of nursing experience prior to working in the ED. 3) Collaborate with ENA in advocating for improved incentives and compensation to further recruit and retain nurses with the skills and experience necessary for the breadth of patients and pathology seen in EDs.

FISCAL IMPACT: Budgeted committee and staff resources. Approximately $20,000 to hold an in person meeting.

WHEREAS, Emergency departments provide care to patients across the spectrum of age, acuity, and both medical and surgical pathology; and

WHEREAS, Emergency medicine involves providing care to undifferentiated patients; and

WHEREAS, ACEP has a history of collaborating with the Emergency Nurses Association (ENA), going back to the early stages of both organizations[1]; and

WHEREAS, ENA passed a resolution as early as 1978 "recommending one year medical/surgical clinical practice and an in-depth orientation including advanced clinical skills to work in the ED"[1] and

WHEREAS, In 1980, the ENA established an emergency nursing core curriculum[1]; and

WHEREAS, The ENA acknowledges that emergency nursing requires "a skill-set well beyond that necessary for nursing licensure"[2]; and

WHEREAS, It has been shown that there is a workforce of experienced nurses potentially available to work in emergency departments in times of surge or disasters[3]; and

WHEREAS, Other national nursing organizations, such as the American Association of Critical-Care Nurses, are taking efforts to combat the noted and growing gap between nursing experience and complexity of patient care[4]; therefore be it

RESOLVED, That ACEP contact the Emergency Nurses Association to explore the potential for a joint Emergency Workforce collaboration, with the goal of sharing the task force's identified goals and working together on ensuring consistency in nursing training, supporting practicing nurses to encourage rewarding practice in all communities, and setting the standard for emergency medicine so that every patient has access to an experienced emergency nurse; and be it further

RESOLVED, That ACEP collaborate with the Emergency Nurses Association to advocate for a minimum level of nursing experience prior to working in the emergency department given the variety of acuity and pathology seen in undifferentiated patients presenting to the ED; and be it further

RESOLVED, That ACEP and the Emergency Nurses Association collaborate in advocating for improved incentives and compensation to further recruit and retain nurses with the skills and experience necessary for the breadth of patients and pathology seen in emergency departments across the country.

References

1. Emergency Nurses Association. ENA 50th Anniversary Timeline. https://rise.articulate.com/share/-3p7YsoNuSI-UWMziOsf-AE33NGHuAiK#/lessons/go2rlSWiE4Gc8w_9gbMcnYJiebGMDOcU
2. Emergency Nurses Association. Position Statement: Emergency Nurse Orientation. https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/emergencynurseorientation
3. Castner J, Bell SA, Castner M, Couig MP. National Estimates of the Reserve Capacity of Registered Nurses Not Currently Employed in Nursing and Emergency Nursing Job Mobility in the United States. *Annals of Emergency Medicine*. Volume 0, Issue 0. Published: June 12, 2021. DOI: https://doi.org/10.1016/j.annemergmed.2021.03.006
4. American Association of Critical-Care Nurses. The Experience-Complexity Gap: The Long and Short of Staffing Numbers. https://www.aacn.org/blog/the-experience-complexity-gap-the-long-and-short-of-staffing-numbers

Background

This resolution asks that ACEP contact the Emergency Nurses Association (ENA) to explore the potential for a joint Emergency Workforce collaboration, with the goal of sharing the task force's identified goals and working together on ensuring consistency in nursing training, supporting practicing nurses to encourage rewarding practice in all communities, and setting the standard for emergency medicine so that every patient has access to an experienced emergency nurse. It further asks ACEP to collaborate with ENA to advocate for a minimum level of nursing experience prior to working in the emergency department (ED) given the variety of acuity and pathology seen in undifferentiated patients presenting to the ED. Finally, it asks that ACEP and ENA collaborate in advocating for improved incentives and compensation to further recruit and retain nurses with the skills and experience necessary for the breadth of patients and pathology seen in EDs across the country.

ACEP has existing policy dating back to 2006 that advocates for ENA's efforts to promote certified emergency nurses (CENs).[1] Additional ACEP policy states:

> *"The American College of Emergency Physicians (ACEP) supports emergency department (ED) nurse staffing systems that provide adequate numbers of registered nurses who are trained and experienced in the practice of emergency nursing.[2]"*

> *"Each nurse working in the ED should provide evidence of adequate previous ED or critical care experience or have completed an emergency care education program. The CEN credential is an excellent benchmark.[3]"*

ENA has a very robust program to support emergency nurses, including an annual conference, an Academy of Emergency Nurses, the Certified Emergency Nurse (CEN) program, a journal, and extensive educational materials. The requirements for a CEN include two years' experience (recommended but not required) and an examination. Study materials have also been developed.

There is currently a severe nursing shortage, made worse by the current pandemic.[4] It is estimated that one million nurses will be required to meet healthcare needs in 2030, even without accounting for any increased attrition due to the pandemic.[5] The average RN in the U.S. is now 50 years old.[6] Much more stringent a requirements for emergency nurses could increase the shortage in EDs as nurses choose alternative careers.

Background References

[1] Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine [policy statement]. Approved February 2018.
[2] Emergency Department Nurse Staffing [policy statement]. Approved October 2016.
[3] Emergency Department Planning and Resource Guidelines [policy statement]. Approved April 2021.
[4] https://www.nytimes.com/2021/08/21/health/covid-nursing-shortage-delta.html
[5] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf
[6] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nssrn-summary-report.pdf

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective C – Promote the value of emergency physicians as essential components of the health care system.
  - Tactic 1 – Develop and promote resources that demonstrate the value of emergency medicine, working with appropriate other entities as needed.

Fiscal Impact

Budgeted committee and staff resources. Approximately $20,000 for an in-person meeting.

Prior Council Action

Substitute Resolution 53(05) Emergency Department Nurse Staffing Model adopted. It directed ACEP to work with ENA and other appropriate organizations to develop and promote an emergency nurse staffing model that lawmakers and hospital administrators could reference.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. Directed the College to continue working with respective specialty organizations of midlevel providers to establish or expand emergency medicine curricula and training programs and to encourage the certifying body of each discipline to develop certification examinations in emergency care.

Prior Board Action

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised and approved April 2014, October 2007, June 2004, June 2001 with the current title; reaffirmed September 1996; revised and approved June 1991; originally approved December 1985 titled "Emergency Care Guidelines."

February 2018, reaffirmed the policy statement "Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine;" reaffirmed April 2012; originally approved October 2006.

October 2016, approved the revised policy statement "Emergency Department Nurse Staffing;" reaffirmed September 2005; originally approved June 1999.

Substitute Resolution 53(05) Emergency Department Nurse Staffing Model adopted.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted.

May 2001, recommendations of the Staffing Task Force presented to the Board.

September 1999, the MLP/EMS Task Force recommendations were presented to the Board. The Board approved dissemination of the results of the surveys.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 76(21)

SUBMITTED BY: District of Columbia Chapter
Maryland Chapter

SUBJECT: Standards for Non-Residency Trained Physicians and Mid-Levels to Work in Emergency Medicine

PURPOSE: Requests ACEP to: 1) object to the practice of any graduate of any unaccredited school be it MD, DO, NP, PA supervised or unsupervised as a medical practitioner at any level in an ED; 2) object to the use of unsupervised assistant physicians as medical practitioners at any level in an ED; 3) create a working group to recommend the minimum qualifications and clinical experience necessary to work in an ED as a supervised advanced practice provider; 4) establish a separate standard for advanced practice providers in states that do not require a collaborative agreement; and 5) establish an objective standard for recertification to continue to practice in emergency medicine for all advanced practice providers.

FISCAL IMPACT: Budgeted committee and staff resources. Unbudgeted expenses of $20,000 – $30,000 for an in-person working group meeting depending on the size of the group.

WHEREAS, Excellent health care outcomes, access to high-quality physician-led emergency care and patient safety are goals of all U.S. Emergency Departments; and

WHEREAS, The medical school and residency paradigm has provided the highest caliber medical practitioners for over a century; and

WHEREAS, Recent trends in education, corporate policy and legislation have created pathways that do not meet an acceptable level of training and experience to justify provision of care outside of physician-led care; and

WHEREAS, State legislation in Missouri has created a practice path called “Assistant Physician” that does not require residency; and

WHEREAS, A substantial proportion of the practitioners in this category are not affiliated with residency trained physicians and demonstrate an unacceptable failure rate on licensing exams (Step 1 with a 30% failure rate, Step 2 with a 58% failure rate for clinical knowledge and 50% fail rate for skills, Step 3 with a 34% failure rate); and

WHEREAS, Nurse practitioners are an increasing percentage of health care professionals rendering care in emergency departments; and

WHEREAS, 23 states now do not require a collaborative agreement with a senior supervising physician; and

WHEREAS, Nurse practitioners once were expected to have thousands of hours of clinical practice prior to starting a nurse practitioner course; and

WHEREAS, There are an increasing number of nurse practitioner schools that do not require any previous clinical experience and there are an increasing number of online and in-person programs with truncated clinical requirements for completion, currently 600 hours (5 blocks of 120 hours each); and

WHEREAS, Unaccredited nurse practitioner programs are growing in number and graduating students who

enter the workforce unimpeded; and

WHEREAS, Nurse practitioner programs will often require their students to set up their own practicums without a robust quality assurance evaluation of those practicums; and

WHEREAS, The nurse practitioner paradigm does not require post-graduate training such as a medical residency; and

WHEREAS, All four certification bodies for nurse practitioners – the American Nurses Credentialing Center (ANCC), Pediatric Nursing Certification Board (PNCB), National Certification Corporation NCC), and the American Academy of Nurse Practitioners Certification Program (AANPCP) – do not require any recertification testing, though they offer it as an option; and

WHEREAS, The three certification bodies that might certify nurse practitioners who could work in an emergency department setting, offer no testing renewal of licensure with ANNC: in a 5-year span – 1,000 hours of clinical practice total with 150 CME; PNCB: in a 7-year span – 30 credits of CME and pediatric updates; and AANPCP: in a 5-year period – 1,000 clinical hours total and 100 CME; therefore be it

RESOLVED, That ACEP object to the practice of any graduate of any unaccredited school be it MD, DO, NP, PA supervised or unsupervised as a medical practitioner at any level in an emergency department; and be it further

RESOLVED, That ACEP object to the use of unsupervised assistant physicians as medical practitioners at any level in an emergency department; and be it further

RESOLVED, That ACEP create a working group to recommend the minimum qualifications and clinical experience necessary to work in an emergency department as a supervised advanced practice provider; and be it further

RESOLVED, That ACEP establish a separate standard for advanced practice providers in states that do not require a collaborative agreement; and be it further

RESOLVED, That ACEP establish an objective standard for recertification to continue to practice in emergency medicine for all advanced practice providers.

Background

The resolution asks ACEP to: 1)object to the practice of any graduate of any unaccredited school be it MD, DO, NP, PA supervised or unsupervised as a medical practitioner at any level in an ED; 2) object to the use of unsupervised assistant physicians as medical practitioners at any level in an ED; 3) create a working group to recommend the minimum qualifications and clinical experience necessary to work in an ED as a supervised advanced practice provider; 4) establish a separate standard for advanced practice providers in states that do not require a collaborative agreement; and 5) establish an objective standard for recertification to continue to practice in emergency medicine for all advanced practice providers

ACEP does not have existing policy covering the medical school graduates from non-accredited schools. Many U.S. students attend medical school outside of the U.S., most often in the Caribbean. Several of these schools have "approval from state agencies, such as the New York State Education Department and the Florida Department of Education, recognition from the Medical Board of California, and accreditations from major accrediting bodies like the Caribbean Accreditation Authority for Education in Medicine and Other Health Professions (CAAM-HP) or the Accreditation Commission on Colleges of Medicine (ACCM)."[1] Other schools may have CAAM-HP/ACCM accreditation but may not have state approval. However, there are several Caribbean schools that are not accredited by CAAM/ACCM.

It is estimated that there are more than 247,000 physicians licensed in the U.S. who graduated from a U.S. medical school.[2] The Liaison Committee on Medical Education currently accredits 155 U.S. schools as well as four in Puerto Rico and 17 in Canada. New medical schools receive preliminary accreditation and are eligible for full accreditation after the graduation of their first class.

There are two organizations that currently accredit graduate nursing programs – the Commission on Collegiate Nursing Education and the Accreditation Commission for Education in Nursing. There is an additional program that accredits nurse midwifery programs. Accreditation is voluntary. Non-accredited programs exist, but graduation from an accredited school is required for certification. Certification is required by all but three states and is required by all major insurers. Graduation from an accredited physician assistant program is required to take the PA certifying examination, so most, if not all schools, are accredited.

Assistant physicians (in some states called associate physicians or graduate registered physicians) are graduates of a medical school but have not completed a residency program. Individuals who work as assistant physicians are composed of unmatched graduates of U.S. medical schools, U.S. citizens who attended international medical school (mostly the Caribbean schools), and foreign medical schools. All assistant physicians are required to pass the United States Medical Examination (USMLE) or COMLEX to obtain an Assistant Physician Medical License. Assistant physician licenses are currently issued in several states but are required to be supervised by a collaborating physician. Depending on the state regulation, assistant physicians are often limited to primary care in medically underserved areas. However, in Arkansas, assistant physicians can work in any setting if permitted by their supervising physician and the policies of the facility.[3] There is currently no ACEP policy that addresses assistant/associate physicians.

ACEP has existing policy about unsupervised care in the ED by NPs and PAs.

> *"PAs/NPs should not perform independent unsupervised care in the ED. This holds true regardless of state laws or hospital regulations. In the case of rural and underserved areas, supervision may require telehealth services or real-time off-site emergency physician consultation."*[4]

> *"Emergency physicians must have the real-time opportunity to be involved in the care of any patient presenting to the ED and seen by a PA or NP. Local physician leadership should create guidelines for the types of supervision required or provided for specific categories of conditions, patients, and clinical scenarios"*[4]

> *"The American College of Emergency Physicians (ACEP) endorses the 2000 position statement of the Society for Academic Emergency Medicine (SAEM) on the "Qualifications for Unsupervised Emergency Department Care," and believes that the independent practice of emergency medicine is best performed by specialists who have completed American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) certification, or have successfully "completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited emergency medicine residency, and is in the process of completing ABEM or AOBEM examinations."*[5]

> *"Residents-in-training or other physicians who do not meet these criteria are less likely to possess the cognitive and technical skill set necessary for rendering unsupervised care for the tremendous breadth and acuity of situations encountered in an ED."*[5]

> *"ACEP believes that advanced practice registered nurses or physician assistants should not provide unsupervised emergency department care."*[5]

> *"ACEP believes that "unsupervised ED practice is best provided by fully trained emergency medicine specialists."* [5]

Several ACEP policies affirm that the staffing of an ED, including the use of NPs and PAs is a decision of the local ED medical director. [4,6,7] A recent task force on the utilization of NPs and PAs in the ED came to the same decision.

There are, as noted in the resolution, several different organizations that offer a certifying exam for NPs who are graduates of accredited institutions. NPs must recertify (usually every five years) and keep the same certifying boards throughout their career. Several of the certifying boards require only CME combined with practice hours OR retaking the examination. It is not clear whether all institutions require current certification. The American Academy of Nurse Practitioners Certification Board has developed the Emergency Nurse Practitioner certification (ENP-C) conjunction with the American Academy of Emergency Nurse Practitioners. At this time, this examination is only open to individuals who are certified as a family nurse practitioner. Recertification is required every five years.

A PA who graduates from a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) can take the Physician Assistant National Certifying Examination (PANCE) for certification administered by the National Commission on Certification of Physician Assistants (NCCPA). All states, the District of Columbia, and Guam require that a candidate pass the PANCE exam for full authorization to practice as a physician assistant. Recertification and proof of 100 hours CME every two years is required. PAs can obtain a Specialty Certificate of Added Qualifications (CAQs) in Emergency Medicine by proof of 3000 hours of practice experience within six years, 150 hours of CME, and passing an examination. "NCCPA's specialty CAQ process is predicated on a strong belief in the value and importance of the physician-PA team, and in support of the procedures and patient case requirement, each applicant must provide attestation from a supervising physician who works in the specialty and is familiar with the PA's practice and experience." [7] Recertification is required every six years.

Background References

1. Three tiers of Caribbean medical schools. https://www.auamed.org/blog/3-tiers-caribbean-medical-schools/
2. Foreign-trained doctors are critical to servicing many US communities. https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf
3. Assistant physicians: a new breed of provider. https://thriveap.com/blog/assistant-physicians-a-new-breed-of-provider.
4. ACEP. Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
5. ACEP. Providers of Unsupervised Emergency Department Care. Approved January 2019.
6. ACEP. Staffing Models and the Role of the Emergency Department Medical Director [policy statement]. Approved April 2020.
7. ACEP. Emergency Department Planning and Resource Guidelines [policy statement]. Approved April 2021.
8. https://www.sempa.org/professional-development/nccpas-caq-in-emergency-medicine/

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

- Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.
  - Tactic 1 – Advocate for ACEP's principles for healthcare reform in current and future legislation that supports the practice of emergency physicians.
- Objective C – Promote the value of emergency medicine and emergency physicians as essential components of the health care system.
  - Tactic 1 – Develop and promote resources that demonstrate the value of emergency medicine, working with appropriate other entities as needed.

Fiscal Impact

Budgeted committee and staff resources. Unbudgeted expenses of $20,000 – $30,000 for an in-person working group meeting depending on the size of the group.

Prior Council Action

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to: 1) Review and update the policy statement " Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative

solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 25(14) CME for Nurse Practitioners and Physician Assistants not adopted. Called for ACEP to develop a policy statement recommending that NPs and PAs working in emergency department or urgent care settings obtain 25 CME credits in emergency care annually

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. Called for the College to work with NP and PA organizations to establish a curriculum and clinically-based ED educational training program and encourage certifying bodies to develop certifying examinations for competencies in emergency care.

Prior Board Action

April 2021, approved revisions to "Emergency Department Planning and Resource Guidelines" policy statement, also revised April 2014, October 2007, June 2004, June 2001. Reaffirmed September 1996, revised June 1991, originally approved December 1985 titled "Emergency Care Guidelines."

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

April 2020, approved policy statement "Staffing Models and the Role of the Emergency Department Medical Director."

January 2019, reaffirmed the policy statement "Providers of Unsupervised Emergency Department Care;" revised and approved June 2013; reaffirmed October 2007; originally approved June 2001.

June 2011, approved taking no further action on referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners. The Emergency Medicine Practice Committee was assigned an objective for the 2011-12 committee year to develop an information paper on the role of advanced practice practitioners in emergency medicine to include scope of practice issues and areas of collaboration with emergency physicians.

September 2006, reviewed the report of the NP/PA Task Force and approved appointing a new task force to focus efforts on development of a curriculum, invite participants from other organizations, and explore funding opportunities for training programs and curriculum development. In January 2007, the National Commission on Certification for Physician Assistants (NCCPA) requested ACEP and SEMPA to participate in a joint task force to further develop the specialty recognition program. An initial meeting of the workgroup was held in May 2007. In June 2007, NCCPA requested ACEP to reappoint its representatives to the NCCPA Workgroup on Specialty Recognition for PAs in Emergency Medicine and advised they would contact the workgroup representatives regarding next steps.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

June 2005, reviewed the work of the Mid-Level Providers Task Force and approved moving forward with a multidisciplinary task force to include mid-level provider organizations to address certification and curriculum issues.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. A task force was appointed to review the available information and provide a

recommendation to the Board regarding ACEP's potential involvement in the development of specialized training curricula for PAs and NPs that work in the ED.

May 2001, accepted the report of the Staffing Task Force.

September 1999, approved recommendations from the MLP/EMS Task Force to disseminate the results of the surveys.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 77(21)

SUBMITTED BY: Louisiana Chapter

SUBJECT: Workforce Fairness

PURPOSE: 1) ACEP hold accountable employers of emergency physicians for the right of any emergency physician practicing at any facility that utilizes non-physicians where the physician is expected to supervise or have a collaborative agreement with any non-physician to raise a concern regarding the care, professional behavior, knowledge, procedural skills or ability of a non-physician that interferes with optimal patient care by a non-physician or the emergency physician's ability to properly oversee the non-physician and assure the best care with the staffing model that the physician does not control; 2) support that emergency physicians should not be forced to supervise or have a collaborative practice agreement with any non-physician which the emergency physicians who practice clinically at the location in question, in the emergency physicians' sole determination, does not feel comfortable doing so i.e., the non-physician poses a risk to patient care, does not receive suggestions or teaching well, failure to follow reasonable patient care related instructions etc.; 3) support that no emergency physician who raises concerns regarding a non-physician's care, professional behavior, knowledge, or procedural skills should receive any negative consequences or retribution by an employer or any entity in any way i.e., financial, vacation time, type or number of shifts, etc. as a result of raising concerns.

FISCAL IMPACT: Budgeted committee and staff resources to develop new policy statements and/or revise existing policy statements. Unknown potential legal costs depending on the number of cases that ACEP would "support."

WHEREAS, Healthcare must be physician led and emergency medicine must be emergency physician led to provide the best trained and educated personnel involved in patent care; and

WHEREAS, It is important to have the input, involvement and leadership of the emergency physicians who are responsible for patient care and the leaders of the patient care teams involved; and

WHEREAS, Emergency physicians are often required to supervise or have collaborative practice agreements with non-physicians i.e. physician assistants, nurse practitioners, etc., that the EP did not train, hire, or have say as to whether that non-physician practices at an acceptable level; therefore be it

RESOLVED, That ACEP support contract management groups, other employers, persons or entities who have employment or independent contract work agreements with emergency physicians be held accountable to any emergency physician who practices at any facility that utilizes non-physicians and is expected to supervise or have a collaborative agreement with any non-physician that raises a concern regarding the care, professional behavior, knowledge, procedural skills or ability of a non-physician that interferes with optimal patient care by a non-physician or the emergency physician's ability to properly oversee the non-physician and assure the best care with the staffing model that the physician does not control; and be it further

RESOLVED, That ACEP support emergency physicians not being forced to supervise or have a collaborative practice agreement with any non-physician which the emergency physicians who practice clinically at the location in question, in the emergency physicians' sole determination, do not feel comfortable doing so i.e., the non-physician poses a risk to patient care, does not receive suggestions or teaching well, failure to follow reasonable patient care related instructions etc.; and be it further

RESOLVED, That ACEP support that no emergency physician who raises concerns regarding a non-physician's care, professional behavior, knowledge, or procedural skills receive any negative consequences or

retribution by an employer or any entity in any way i.e., financial, vacation time, type or number of shifts, etc., as a result of raising concerns.

Background

This resolution asks that ACEP hold accountable employers of emergency physicians for the right of any emergency physician who practices at any facility that utilizes non-physicians where the physician is expected to supervise or have a collaborative agreement with any non-physician to raise a concern regarding the care, professional behavior, knowledge, procedural skills or ability of a non-physician that interferes with optimal patient care by a non-physician or the emergency physician's ability to properly oversee the non-physician and assure the best care with the staffing model that the physician does not control. Further, it asks that ACEP support that emergency physicians should not be forced to supervise or have a collaborative practice agreement with any non-physician which the emergency physicians who practice clinically at the location in question, in the emergency physicians' sole determination, does not feel comfortable doing so i.e., the non-physician poses a risk to patient care, does not receive suggestions or teaching well, failure to follow reasonable patient care related instructions etc. Finally, it asks that ACEP support that no emergency physician who raises concerns regarding a non-physician's care, professional behavior, knowledge, or procedural skills should receive any negative consequences or retribution by an employer or any entity in any way i.e., financial, vacation time, type or number of shifts, etc. as a result of raising concerns.

ACEP has existing policy regarding the use of nurse practitioners (NPs) and physician assistants (PAs) in the emergency department (ED) and is clear that the use of non-physicians and the hiring/firing/staffing of such staff is to be determined by the local ED medical director (required to be an emergency physician as defined by ACEP policy).

> *"The use of PAs and NPs in the ED should be determined at the site level by local ED leadership, who are responsible for PA/NP hiring, staffing and supervision. These physician leaders, along with the PA and/or NP leadership, should be responsible for establishing processes and practice standards that ensure both sufficient physician availability for PA and NP supervision as well as adequate physician opportunity to supervise.[1] "*

ACEPs policy acknowledges the presence of other non-physicians who provide some level of care to the patient in the ED, such as clinical pharmacists and social workers; however, the policies regarding supervision, hiring, firing, and staffing is not addressed for these individuals.

This resolution has multiple parts. First, it asks for protection of the individual physician who, for whatever reason, raises concern regarding the practice by a non-physician at their facility. ACEPs current policy states"

> *"Emergency physician autonomy in clinical decision making should be respected and should not be restricted other than through reasonable rules, regulations, and bylaws of his or her medical staff or practice group."*
>
> *"Emergency physician autonomy should not be unduly restricted by value based or other cost-saving guidelines, contracts, rules, or protocols. The physicians must have the ability to do what they believe in good faith is in the patient's best interest."*
>
> *"Emergency physicians shall not be subject to adverse action for bringing to the attention, in a reasonable manner, of responsible parties, deficiencies in necessary staffing, resources, and equipment."*
>
> *"Emergency physicians are entitled to due process before any adverse final action with respect to employment or contract status, the effect of which would be the loss or limitation of medical staff privileges or their ability to see patients. Emergency physicians' medical and/or clinical staff privileges should not be reduced, terminated, or otherwise restricted except for grounds related to their competency, health status, limits placed by professional practice boards or state law.[2]"*

This resolution does not indicate specific action ACEP would take to support a physician engaged in a dispute over supervision of a non-physician. ACEP recognizes that there are multiple staffing models and ACEP policy states that the local medical director should determine which model to utilize. It is not clear how ACEP would adjudicate between an ED medical director and an individual physician who had concerns about the model utilized in a given facility.

The second resolved asks that an emergency physician should not be "forced" to work with a non-physician about whom they have concerns. ACEP policy again states that staffing of a department should be at the discretion of the local ED medical director. Creating an arbitration system or providing assistance for any possible litigation could be time-consuming and costly for ACEP.

The third resolved asks that ACEP ensure that no physician who raises concerns regarding a non-physician should be adversely affected. ACEP could develop a policy statement to address this issue and this information could be added to the checklist that ACEP has developed for physicians seeking employment.[3]

Background References

[1]Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved June 2020.
[2]Emergency Physician Rights and Responsibilities [policy statement]. Approved April 2021.
[3]https://www.acep.org/life-as-a-physician/career-center/negotiating-the-best-employment-contract/

ACEP Strategic Plan Reference

Goal 2 – Enhance Membership Value and Member Engagement

- Objective A – Improve the practice environment and member well-being.

Fiscal Impact

Budgeted committee and staff resources to develop new policy statements and/or revise existing policy statements. Unknown potential legal costs depending on the number of cases that ACEP would "support."

Prior Council Action

Resolution 44(19) Independent ED Staffing by Non-Physician Providers referred to the Board of Directors. Called for ACEP to 1.) Review and update the policy statement " Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department." 2) Develop tools and strategies to identify and educate communities and government on the importance of emergency physician staffing of EDs. 3) Oppose the independent practice of emergency medicine by non-physician providers. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Prior Board Action

April 2021, discussed the emergency medicine workforce data that was presented at the Emergency Medicine Workforce Summit held earlier that day.

January 2021, discussed the preliminary report of the emergency medicine workforce data from the Emergency Physician Workforce Task Force.

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities;" revised and approved October 2015, April 2008, and July 2001; originally approved September 2000.

June 2020, approved revisions to "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement, revised June 2013 as "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department", originally approved as "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" January 2007 by replacing two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

October 2019, reviewed an interim report from the Emergency NP/PA Utilization Task Force.

August 2018, approved the final report from the ACEP Board Emergency Medicine Workforce Workgroup and initiated the recommendations therein to appoint a task force to consider the evolution of the role and scope of practice of advanced practice providers (APP) in the emergency department (ED).

June 2011, approved the Emergency Medicine Practice Committee's recommendation that ACEP not conduct a survey to determine the state of NP practice in emergency care and to take no further action on Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners.

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Gary Katz, MD, MBA, FACEP, Speaker
Kelly Gray-Eurom, MD, MMM, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2021 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: 78(21)

SUBMITTED BY: Florida College of Emergency Physicians
Diversity, Inclusion, & Health Equity Section

SUBJECT: In Memory of Leon L. Haley, Jr., MD, MHSA, CPE, FACEP, FACHE

WHEREAS, Leon L. Haley, Jr., MD, MHSA, CPE, FACEP, FACHE, was an active member of the American College of Emergency Physicians and an outstanding servant leader who provided high quality and compassionate care throughout his career; and

WHEREAS, Dr. Haley was a past Executive Associate Dean for Clinical Services and Chief Medical Officer for Emory Medical Care Foundation; and

WHEREAS, Dr. Haley rose to the position of Senior Vice President for Medical Affairs and Chief of Emergency Medicine Affairs at Emory University-Grady Hospital; and

WHEREAS, Dr. Haley was the first African American Dean and Vice-President of Health Affairs for the University of Florida College of Medicine-Jacksonville; and

WHEREAS, Dr. Haley was the first African American appointed CEO of UF Health Jacksonville, a major academic health science center; and

WHEREAS, Dr. Haley served as a board member of the Accreditation Council of Graduate Medical Education, the American Board of Emergency Medicine, and the Society of Academic Emergency Medicine; and

WHEREAS, Dr. Haley served on the Institute of Medicine Committee on Health Insurance Status; and

WHEREAS, Dr. Haley was a member of the American College of Healthcare Executives, the American College of Physician Executives, and the National Association of Health Services Executives; and

WHEREAS, Dr. Haley served in leadership/volunteer positions for a number of professional, business, national, and local organizations during his career and received several honors and awards; and

WHEREAS, Dr. Haley served as an outstanding role model for under-represented minorities in emergency medicine and an advocate for serving the most vulnerable and promoting diversity, equity, and inclusion throughout his career; and

WHEREAS, Dr. Haley was a skilled bridge-builder who transformed people, organizations, and communities by creating a vision that inspired all who interacted with him; and

WHEREAS, Dr. Haley was a dedicated and devoted father, colleague, and friend who inspired all of those who knew him; therefore be it

RESOLVED, That the American College of Emergency Physicians remembers with honor and appreciation the accomplishments and contributions of a gifted emergency physician, Leon L. Haley, Jr., MD, MHSA, CPE, FACEP, FACHE, and extends condolences and gratitude to his parents Leon and Elizabeth Ann, his children Grant, Wesley, and Nichelle, his sister Lisa, family, friends, and colleagues for his remarkable service to the specialty of emergency medicine, patient care, and the communities he served so well.