American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

INTRODUCTION

2022 Annual Council Meeting
Wednesday Evening, September 28, 2022 through Friday, September 30, 2022
Hilton San Francisco Union Square

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.

Only the RESOLVED sections of the resolutions are considered by the Council. The WHEREAS statements and background sections are informational or explanatory. Only the resolutions adopted by the Council and ratified by the Board of Directors become official. Council Standing rules become official on adoption by Council.

Asynchronous testimony will open on August 29 for all resolutions assigned to a Reference Committee. An announcement with the link to the 2022 resolutions will be posted on the Council engagED when asynchronous testimony is open. 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

The asynchronous testimony platform is open to all members. When commenting please include the following:

1. Whether you are commenting on behalf of yourself or your component body
    a. chapter, section, AACEM, CORD, EMRA, or SAEM
2. Whether you are commenting in support, opposition or suggesting an amendment to the resolution
3. Any additional information to support your position.

The asynchronous platform is the only method to introduce testimony until the live Reference Committee meetings in San Francisco. Opinions posted elsewhere (including Council engagED) will not be considered in the Reference Committee deliberations. Like in-person testimony, all comments should be addressed to the Reference Committee Chair or the Speaker. **Please do not direct any communications to another member, including those who have posted before you, with whom you may or may not agree.** And like the in-person Council meeting, proper decorum is expected within the asynchronous testimony platform.

Comments should be 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 Monday, September 19. Comments from the online testimony will be used to develop the preliminary Reference Committee reports. The preliminary reports will be distributed to the Council on Friday, September 23 and will be the starting point for the live Reference Committee debate during the Council meeting in San Francisco on Thursday, September 29.

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

Board of Directors candidates, and the resolutions. Additional documents may be added over the next several days, so please check back if what you need is not currently available.

We are looking forward to seeing everyone in San Francisco!

Your Council Officers,

Kelly Gray-Eurom, MD, MMM, FACEP
Speaker

Melissa W. Costello, MD, FACEP
Vice Speaker

American College of Emergency Physicians®
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DEFINITION OF COUNCIL ACTIONS

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

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

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

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

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2022 Council Meeting
Reference Committees

Reference Committee A – Governance & Membership
Resolutions 10-23

Nicole A. Veitinger, DO, FACEP (OH), Chair
Deborah D. Fletcher, MD, FACEP (LA)
John M. Gallagher, MD, FACEP (HI)
Kurtis A. Mayz, JD, MD, MBA, FACEP (OK)
Alexandra N. Thran, MD, FACEP (VT)
Brad L. Walters, MD, FACEP (MI)

Maude Surprenant Hancock, CAE
Laura Lang, JD

Reference Committee B – Advocacy & Public Policy
Resolutions 24-40

Abhi Mehrotra, MD, MBA, FACEP (NC) Chair
Erik Blutinger, MD, MSc (NY)
Angela P. Cornelius, MD, FACEP (TX)
Hilary E. Fairbrother, MD, FACEP (TX)
Puneet Gupta, MD, FACEP (CA)
Diana Nordlund, DO, JD, FACEP (MI)

Jeff Davis
Ryan McBride, MPP

Reference Committee C – Emergency Medicine Practice
Resolutions 41-58

Dan Freess, MD, FACEP (CT) Chair
Andrea Austin, MD, FACEP (CA)
Lisa M. Bundy, MD, FACEP (MS)
Antony P. Hsu, MD, FACEP (MI)
James D. Maloy, MD, MPH (DC)
David Nestler, MD, MS, FACEP (MN)

Jonathan Fisher, MD, FACEP
Travis Schulz, MLS, AHIP

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2022 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Michael L. Callaham, MD, FACEP *Richelle J. Cooper, MD, MSHS, FACEP* *Richard C. Dart, MD, PhD, FACEP* *Steven M. Green, MD, FACEP* *David L. Schriger, MD, MPH, FACEP* *Donald M. Yealy, MD, FACEP*	
2	Commendation for Virginia Kennedy Palys, JD *Illinois College of Emergency Physicians*	
3	Commendation for Paul Pomeroy, MD, FACEP *Michigan College of Emergency Physicians* *Sara S Chakel, MD, FACEP* *Douglas M Char MD, FACEP* *Melanie Heniff, MD, JD, FAAP, FACEP* *Kurtis A Mayz, JD, MD, MBA, FACEP* *Diana Nordlund, DO, JD, FACEP* *Suzie Park, DO* *Scott H Pasichow, MD, MPH* *David T Overton, MD, MBA, FACEP* *Michael D Repplinger, MD, PhD, FACEP* *Todd L Slesinger, MD, FACEP, FCCM, FCCP* *Annalise Sorrentino, MD, FACEP* *James D Thompson, MD, FACEP* *Larisa M Traill, MD, FACEP* *Bradford L Walters, MD, FACEP*	
4	Commendation for Loren Rives, MNA *Chad Kessler, MD, FACEP* *Alexander Limkakeng, MD, FACEP* *Bruce Lo, MD, FACEP* *Laura Oh, MD, FACEP* *Virginia College of Emergency Physicians* *Section of Medical Directors*	
5	Commendation for Mark S. Rosenberg, DO, MBA, FACEP *New Jersey Chapter*	
6	In Memory of Carey D. Chisholm, MD *Indiana Chapter*	
7	In Memory of Loren A. Crown, MD, FACEP *Tennessee College of Emergency Physicians*	
8	In Memory of Sherrill Mullenix *Delaware Chapter*	

9	In Memory of Adetolu "Tolu" Odufuye, MD *Diversity, Inclusion, & Health Equity Section* *Young Physicians Section* *Emergency Medicine Residents' Association* *Arizona Chapter* *Florida College of Emergency Physicians* *Georgia College of Emergency Physicians* *Maine Chapter*	
10	Candidate Members in the ACEP Council - Bylaws Amendment *Emergency Medicine Residents' Association*	A
11	Establishing a Young Physician Position on the ACEP Nominating Committee - Bylaws Amendment *Council Steering Committee*	A
12	Council Approval of Board Actions on Referred Resolutions – Bylaws Amendment *Brad Dreifuss, MD, FACEP* *Robert McNamara, MD* *Charles Pattavina, MD, FACEP*	A
13	Past Leader Participation in Council Meetings – Bylaws Amendment *Maine Chapter*	A
14	Past Leader Participation in Council Meetings – Council Standing Rules Amendment *Maine Chapter*	A
15	Electronic Voting During the Council Meeting – Council Standing Rules Amendment *Council Steering Committee*	A
16	Required Candidate Campaign Materials from Floor Candidates – Council Standing Rules Amendment *Council Steering Committee*	A
17	Criteria for the Location of Future National ACEP Events *Michael Bresler, MD, FACEP* *Valerie Norton, MD, FACEP* *California Chapter*	A
18	Disclosure of Clinical Emergency Data Registry Revenue Sources *Brad Dreifuss, MD, FACEP* *Robert McNamara, MD, FACEP*	A
19	Due Process and Interaction with ACEP *Brad Dreifuss, MD, FACEP* *Robert McNamara, MD* *Charles Pattavina, MD, FACEP*	A
20	Expert Consultation for Employee Contracts *Deborah Fletcher, MD, FACEP* *Jamie Hoitien Do Kuo, MD*	A
21	Financial Support of Litigation Involving the Corporate Practice of Medicine in California *Brad Dreifuss, MD, FACEP* *Robert McNamara, MD, FACEP* *Charles Pattavina, MD, FACEP*	A

22	State Chapter Funding *Jamie Hoitien Do Kuo, MD* *Deborah Fletcher, MD, FACEP*	A
23	Study of Councillor Term Limits *Young Physicians Section*	A
24	Access to Reproductive Health Care Services *Michael Bresler, MD, FACEP* *Valerie Norton, MD, FACEP* *Lori Winston, MD, FACEP* *California Chapter* *Massachusetts College of Emergency Physicians*	B
25	Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care *Aislinn Black, DO, MPH, FACEP* *James Blum, MD* *Scott Pasichow, MD MPH* *Karina Sanchez, MD* *Nikkole Turgeon, MD* *Daniel Udrea, MD* *Jennifer Walker, MD FACEP* *American Association of Women Emergency Physicians Section* *Social Emergency Medicine Section* *Young Physicians Section* *Emergency Medicine Residents' Association*	B
26	Promoting Safe Reproductive Health Care for Patients *Peter Acker, MD, MPH, FACEP* *Youyou Duanmu, MD, MPH* *Monica Saxena, MD, JD* *Kelly Quinley, MD* *American Association of Women Emergency Physicians Section* *Pediatric Emergency Medicine Section* *Social Emergency Medicine Section* **see resolution for additional individual cosponsors*	B
27	Equitable Access to Emergency Contraception in the ED *James Blum, MD* *Diana Halloran, MD* *Pranav Kaul, MD* *Nicholas Melucci, MPH* *Nikkole Turgeon, MD* *Jennifer Walker, MD, FACEP* *American Association of Women Emergency Physicians Section* *Social Emergency Medicine Section*	B
28	Billing and Collections Transparency and Interaction with ACEP *Brad Dreifuss, MD, FACEP* *Robert McNamara, MD* *Charles Pattavina, MD, FACEP*	B
29	Buprenorphine is an Essential Medicine and Should be Stocked in Every ED Pain *Management & Addiction Medicine Section* *Donald Stader, MD, FACEP* *John Spartz, MD* *Nathan Novotny*	B

30	Compassionate Access to Medical Cannabis Act – "Ryan's Law" *Larry Bedard, MD, FACEP* *Dan Morhaim, MD, FACEP*	B
31	Decriminalization of All Illicit Drugs *Larry Bedard, MD, FACEP* *Dan Morhaim, MD, FACEP*	B
32	Supervised Consumption Facilities/Safe Injection Sites *Larry Bedard, MD, FACEP* *Dan Morhaim, MD, FACEP*	B
33	Telehealth Bridge Model for the Treatment of Opioid Use Disorder *Pennsylvania College of Emergency Physicians*	B
34	Emergency Department Safety *New York Chapter*	B
35	Workplace Violence Towards Health Care Workers *Massachusetts College of Emergency Physicians*	B
36	Emergency Medical Services Are Essential Services *New York Chapter* *EMS-Prehospital Care Section*	B
37	Enhance Patient Safety and Physician Wellness *New York Chapter*	B
38	Focus on Emergency Department Patient Boarding as a Health Equity Issue *Illinois College of Emergency Physicians*	B
39	Signage at Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient EDs Without Onsite Physicians *Pennsylvania College of Emergency Physicians*	B
40	Support for Medicaid Expansion *Andrew Bern, MD, FACEP* *James Blum, MD* *Neal Cohen, MD* *Cedric Dark, MD, MPH, FACEP* *Herbert Duber, MD, MPH FACEP* *Steven Hardy, MD, MS* *Dennis Hsieh, MD, JD* *James Maloy, MD, MPH* *Lisa Maurer, MD, FACEP* *Sar Medoff, MD, MPP, FACEP* *James Mitchiner, MD, MPH, FACEP* *Utsav Nandi, MD, MSCI, FACEP* *Ashley Ryles Nicholson, MD, MPH, FACEP* *D.W. "Chip" Pettigrew, MD, FACEP* *Kirstin Woody Scott, MD, MPhil, PhD* *Thomas J Sugarman, MD, FACEP* *Nikkole Turgeon, MD* *Brad Uren, MD, FACEP* *Mississippi Chapter* *Tennessee College of Emergency Physicians* *Michigan College of Emergency Physicians* *Wisconsin Chapter* *Diversity, Inclusion, & Health Equity Section* *Social Emergency Medicine Section* *Young Physicians Section*	B

41	Addressing Stigma in the Emergency Department *Pain Management & Addiction Medicine Section*	C
42	ED/Emergency Medicine Experience for Residents from Other Specialties *Arkansas Chapter*	C
43	Endorsing ED Resident Competency in Buprenorphine Initiation *Pain Management & Addiction Medicine Section*	C
44	Competencies of Independent Emergency Medicine Providers *Amit Arwindekar, MD, FACEP* *Howie Mell, MD, FACEP*	C
45	Offsite Supervision of Nurse Practitioners and Physician Assistants *Pennsylvania College of Emergency Physicians*	C
46	Safe Staffing for Nurse Practitioners and Physician Assistants Supervision *Illinois College of Emergency Physicians*	C
47	Unbiased Outside Agency Report for Nurse Practitioner Schools *Emergency Medicine Workforce Section*	C
48	ED Staffing at Critical Access Hospitals, Rural Emergency Hospitals, Outpatient EDs Pennsylvania College of Emergency Physicians	C
49	Enhancing Rural Emergency Medicine Patient Care *Rural Emergency Medicine Section*	C
50	Supporting Emergency Physicians to Work Rural *Rural Emergency Medicine Section*	C
51	Implementation of Social Determinants of Health Screening in the ED *Dennis Hsieh, MD, JD* *Laura Janneck, MD, FACEP* *Nikkole Turgeon, MD* *Social Emergency Medicine Section*	C
52	Minimum Standards of Care for Health-Related Social Needs in the ED *Social Emergency Medicine Section*	C
53	Law Enforcement and Intoxicated Patients in the ED *Pennsylvania College of Emergency Physicians*	C
54	Moral Injury Reporting and Tracking *Emergency Medicine Workforce Section*	C
55	Patients Leaving the ED Prior to Completion of Care Against Medical Advice *Jennifer Conn, MD, FACEP* *Kevin Conn, MD, FACEP* *Rachel Levitan, MD* *Anne Jennifer Richter, MD, FACEP*	C
56	Policy Statement on the Corporate Practice of Medicine *Brad Dreifuss, MD, FACEP* *Robert McNamara, MD* *Charles Pattavina, MD, FACEP*	C
57	Recognized Bodies for Emergency Physician Board Certification *Michigan College of Emergency Physicians*	C

58	Removing Unnecessary and Invasive Medical Exams and Questionnaires from Employment Contracts *Emergency Medicine Residents' Association*	C

Late Resolutions

59	In Memory of Brian Robb, DO, MBA, FACEP *Missouri College of Emergency Physicians*
60	In Memory of James R. Roberts, MD, FACEP *Pennsylvania College of Emergency Physicians*
61	In Memory of Douglas D. Rockacy, MD, FACEP *Pennsylvania College of Emergency Physicians*
62	In Memory of Robert J. Teichman, MD, PhD *Hawaii Chapter*
63	In Memory of Jason M. White, MD, FACEP *Michigan College of Emergency Physicians*

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 1(22)

SUBMITTED BY: Richelle J. Cooper, MD, MSHS, FACEP
Richard C. Dart, MD, PhD, FACEP
Steven M. Green, MD, FACEP
David L. Schriger, MD, MPH, FACEP
Donald M. Yealy, MD, FACEP

SUBJECT: Commendation for Michael L. Callaham, MD, FACEP

WHEREAS, Michael L. Callaham, MD, FACEP, served the College and the specialty with skill and dedication as a member of the editorial board of *Annals of Emergency Medicine* for more than 40 years, including 20 years as Editor in Chief; and

WHEREAS, During his time at *Annals* he ensured an ever-rising level of a valid, scientifically rigorous peer-review that has resulted in the publication of manuscripts impactful to the practice of emergency medicine in the U.S. and across the globe; and

WHEREAS, Under his leadership the journal thrived in all ways including an increase in monthly circulation to more than 40,000 subscribers, providing journal access to low- and middle-income country physicians, and more than 2.2 million article downloads in 2020; and

WHEREAS, Under his leadership yearly manuscript submissions have increased to more than 2,200; the scientific impact factor of the journal has increased to 5.721, the highest of any emergency medicine journal; and the journal and the specialty of emergency medicine has had increasing press coverage, with more than 1,100 media mentions of *Annals* articles in 2021; and

WHEREAS, Dr. Callaham has been a staunch advocate for the investigator-authors, and readers of the journal, with routine surveys and critical review and revision of journal processes to meet the end-user needs; and

WHEREAS, During his tenure with the journal he developed innovations and initiatives to increase the value of the journal to the readership; and

WHEREAS, His development and mentorship of the *Annals of Emergency Medicine* resident editor fellowship provided a platform to launch the careers of many future editors and leaders in emergency medicine; and

WHEREAS, Dr. Callaham elevated the presence of emergency medicine, the journal, and the College as president of World Association of Medical Editors (WAME) and as a member of the National Academy of Medicine; and

WHEREAS, Dr. Callaham became the leading world-wide expert in the study and science of peer-review, and represented the College and journal with distinction with numerous contributions to the International Congress on Peer Review and Scientific Publication Peer Review Congress; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting impact of the contributions of Michael L. Callaham, MD, FACEP, to the advancement of science and success of *Annals of Emergency Medicine*; and be it further

RESOLVED, That the American College of Emergency Physicians commends Michael L. Callaham, MD, FACEP, for his outstanding service, leadership, and commitment to the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 2(22)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Commendation for Virginia Kennedy Palys, JD

WHEREAS, Virginia (Ginny) Kennedy Palys, JD, has served as the Executive Director of the Illinois College of Emergency Physicians (ICEP) for 38 years; and

WHEREAS, Ms. Kennedy Palys has been dedicated to the growth and development of emergency medicine across the country leading the chapter through unparalleled growth to 1,400 members in 2022; and

WHEREAS, The unwavering support and leadership of Ms. Kennedy Palys steered ICEP through financial challenges while becoming a role model for large chapter executives; and

WHEREAS, Ms. Kennedy Palys strengthened the stability through a partnership with the International Trauma Life Support (ITLS), serving as their Executive Director; and

WHEREAAS, ITLS is a 501(c) (3) educational foundation dedicated to reducing death and disability from trauma through training and ITLS trains annually more than 35,000 emergency and pre-hospital professionals in more than 80 countries and ITLS remains the only prehospital trauma education program endorsed by ACEP; and

WHEREAS, Ms. Kennedy Palys has developed four decades of emergency medicine leadership across the country serving as confidant, counselor, advisor, and friend; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Virginia (Ginny) Kennedy Palys, JD, for her career of dedicated service, outstanding leadership, commitment to the College, the emergency physicians of Illinois, the specialty of emergency medicine, and the patients that we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 3(22)

SUBMITTED BY: Michigan College of Emergency Physicians
Sara S Chakel, MD, FACEP
Douglas M Char MD, FACEP
Melanie Heniff, MD, JD, FAAP, FACEP
Kurtis A Mayz, JD, MD, MBA, FACEP
Diana Nordlund, DO, JD, FACEP
Suzie Park, DO
Scott H Pasichow, MD, MPH
David T Overton, MD, MBA, FACEP
Michael D Repplinger, MD, PhD, FACEP
Todd L Slesinger, MD, FACEP, FCCM, FCCP
Annalise Sorrentino, MD, FACEP
James D Thompson, MD, FACEP
Larisa M Traill, MD, FACEP
Bradford L Walters, MD, FACEP

SUBJECT: Commendation for Paul R Pomeroy, Jr., MD, FACEP

WHEREAS, Paul R Pomeroy, Jr., MD, FACEP, has served the specialty of emergency medicine and the College with complete dedication over seven decades, from the 1960s through the 2020s; and

WHEREAS, Dr. Pomeroy assisted Dr. Eugene Nagel in trials of EKG telemetry while serving in the US Coast Guard during the Vietnam War, with this technology later being implemented for use by Miami, Florida, Emergency Medical Services (EMS); and

WHEREAS, Dr. Pomeroy began working in Emergency Medicine in 1970 as a moonlighting resident at Wyandotte Hospital in Michigan, and, over his career, subsequently served as the Director of the Emergency Departments of several Michigan hospitals, including Wyandotte Hospital, Pontiac St. Joseph Mercy Hospital, and Livonia St. Mary Mercy Hospital; and

WHEREAS, Dr. Pomeroy, in his leadership roles at the hospitals he served, was instrumental in beginning the process to staff the emergency departments he directed with full-time emergency physicians; and

WHEREAS, Dr. Pomeroy served as EMS Medical Director for Oakland County and Western Wayne County in Michigan, and introduced many innovations and improvements to the systems he served over his career, including elevating the training of Bloomfield Township Fire Department response personnel to paramedic status, teaching Livonia Fire Department basic EMTs to utilize defibrillators in a first for the state of Michigan, and introducing Combitubes as an intermediate airway device in a successful pilot study with the Livonia Fire Department, which led to his directorship of a state-wide Michigan course to train EMS personnel in the usage of Combitubes; and

WHEREAS, Dr. Pomeroy also served as a cruise ship physician prior to his retirement from the clinical practice of medicine after 39 years; and

WHEREAS, Dr. Pomeroy contributed to the education of emergency physicians through his authorship of the chapter on Hypertension in the first two McGraw-Hill editions of Tintinalli's "A Study Guide in Emergency Medicine," first published by ACEP in 1978; and

WHEREAS, Dr. Pomeroy has served the Michigan College of Emergency Physicians with distinction, starting with his election to the Michigan Chapter Board of Directors in 1977, including a term as President of the Chapter from 1982-83, and also leading the Chapter's first long-term planning meeting, directing the Chapter's first board preparation course, authoring a history of the Chapter for its 30th anniversary, and remaining actively engaged in the Chapter for over 45 years; and

WHEREAS, Dr. Pomeroy has received recognition of his service from the Michigan Chapter as a recipient of the Ronald L Krome Meritorious Service Award (1985); and

WHEREAS, Dr. Pomeroy holds the distinction of longest continuous service as ACEP Councillor, having served as a Councillor for 45 consecutive years, from 1977 through 2021, including service at the only Special Council meeting in the history of the College in 1978, and has also authored numerous Council resolutions throughout his tenure; and

WHEREAS, Dr. Pomeroy served the College Bylaws Committee from 1994 through 2021, including service as chair of the committee; and

WHEREAS, Dr. Pomeroy has received numerous awards for his involvement with the College, including the Council Meritorious Service Award (1992), the Honorary Membership Award (1998), and the John A Rupke Legacy Award (2013); and

WHEREAS, Dr. Pomeroy's numerous accomplishments over a long and dedicated career have helped to promulgate and grow the specialty of Emergency Medicine; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Paul R Pomeroy, Jr., 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 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 4(22)

SUBMITTED BY: Chad Kessler, MD, FACEP
Alexander Limkakeng, Jr., MD, FACEP
Bruce Lo, MD, FACEP
Laura Oh, MD, FACEP
Virginia College of Emergency Physicians
Medical Directors Section

SUBJECT: Commendation for Loren Rives, MNA

WHEREAS, Loren Rives, MNA, began her employment with ACEP in 2015 as a grants manager and quickly transitioned to the Senior Manager for Academic Affairs; and

WHEREAS, Ms. Rives has been an exceptional staff liaison to the Academic Affairs Committee; Research Committee; and Research, Scholarly Activity, and Innovation Section by supporting their efforts and assuring their tasks were completed to the highest standards; and

WHEREAS, Ms. Rives provided staff support for the Teaching Fellowship, overseeing its co-branding with the Council of Residency Directors in Emergency Medicine and creating the Resident Teaching Fellowship; and

WHEREAS, Ms. Rives provided staff support for the Emergency Medicine Basic Research Skills (EMBRS) Course, transitioning it to virtual during the COVID pandemic and then back to an in-person meeting; and

WHEREAS, Ms. Rives took on additional duties as the staff liaison for the Coalition on Psychiatric Emergencies, coordinating this group and moving it into a productive group that has improved the care of patients with mental health disorders; and

WHEREAS, Ms. Rives also acquired additional duties as the staff liaison for the Emergency Department Sickle Cell Care Coalition providing support for their meetings and creating resources for emergency physicians to better care for patients with sickle cell; and

WHEREAS, Ms. Rives has overseen the Research Forum, improving the meeting, transitioning it from in-person, to virtual, to hybrid, and back to in-person during the COVID pandemic and created a special separate Research Forum for COVID to ensure that research on COVID was released as early as possible, thereby saving the lives of patients; and

WHEREAS, Ms. Rives was an invaluable asset in the creation of the highly successful Virtual Grand Rounds program; and

WHEREAS, Ms. Rives was a valued member of the ACEP staff, not only for her work but also for how she performed it and with her quiet, confident manner and incredible work ethic she accomplished all of this and much more to support emergency physicians and the patients they treat; therefore be it

RESOLVED, That the American College of Emergency Physicians commends Loren Rives, MNA, for her outstanding service and commitment to the College and the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 5(22)

SUBMITTED BY: New Jersey Chapter

SUBJECT: Commendation for Mark S. Rosenberg, DO, MBA, FACEP

WHEREAS, Mark S. Rosenberg, DO, MBA, FACEP, has been an extraordinary and dedicated leader while serving on the Board of Directors 2015-22, and in his roles as President-Elect 2019-20, President 2020-21, and Immediate Past President 2021-22; and

WHEREAS, Dr. Rosenberg led ACEP during the COVID-19 pandemic and championed the creation of innovative approaches to patient outreach and vaccine programs in addition to advocating for the safety and well-being of emergency physicians; and

WHEREAS, Dr. Rosenberg, during his tenure on the ACEP Board of Directors, developed The Alternatives to Opioids (ALTO) program to address the issue of variation and over prescribing, which was used to develop The Alternatives to Opioids (ALTO) in the Emergency Department Act (H.R. 5197/S.2516) that was enacted in June 2018; and

WHEREAS, During his term as President, Dr. Rosenberg was committed to ACEP addressing health care disparities/health equity and COVID/future pandemics; and

WHEREAS, Dr. Rosenberg has been an articulate spokesperson for ACEP's agenda, advocating for the removal of the X-Waiver, and highlighting the barrier to treating overdose patients; and

WHEREAS, Dr. Rosenberg has been a staunch advocate for preserving reimbursement for emergency physicians and ensuring that the "No Surprises Act" protects both patients and physicians from surprise billing; and

WHEREAS, Dr. Rosenberg has exemplified his commitment to ACEP and its members by meeting virtually with every chapter during his presidency; and

WHEREAS, Dr. Rosenberg has served as a member, chair, and Board liaison to various ACEP committees, task forces, and sections and was a founding member and chair of ACEP's Geriatric Emergency Medicine Section and the Palliative Medicine Section; and

WHEREAS, Dr. Rosenberg was instrumental in the development of ACEP's Geriatric Emergency Department Accreditation Program and the Pain & Addiction Care in the ED Accreditation Program; and

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

WHEREAS, Dr. Rosenberg served on the Board of Trustees of the Emergency Medicine Foundation and continues to support his commitment to emergency medicine research through his contributions; and

WHEREAS, Dr. Rosenberg demonstrated leadership through chapter involvement and served on the New Jersey Chapter Board of Directors 2010-17, and as President 2015-16; and

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

WHEREAS, Dr. Rosenberg 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 Mark S. Rosenberg, DO, MBA, 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 2022 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(22)

SUBMITTED BY: Indiana Chapter

SUBJECT: In Memory of Carey D. Chisholm, MD

WHEREAS, Emergency medicine lost a beloved leader of our specialty in the passing of Carey D. Chisholm, MD, who died July 7, 2021; and

WHEREAS, Dr. Chisholm earned his medical degree from the Medical College of Virginia in 1980 and completed his residency training in emergency medicine at Madigan Army Medical Center; and

WHEREAS, Dr. Chisholm became the emergency medicine residency program director at Brooke Army Medical Center in 1985 and in 1989 he came to Indiana University, where he ultimately served as emergency medicine residency program director for over 23 years; and

WHEREAS, During his greater than 20-year tenure at the Indiana University Emergency Medicine residency program, with his exceptional dedication to physician education and leadership development, he shaped the careers of hundreds of physicians; and

WHEREAS, Dr. Chisholm was also a recognized leader in the field of emergency medicine on a national level having served as president of the Society for Academic Emergency Medicine and received numerous prestigious awards, including the American College of Emergency Physicians Hero of Emergency Medicine award in 2008, and the American Academy of Emergency Medicine Lifetime Achievement Award in 2014; and

WHEREAS, Dr. Chisholm's passion for teaching had no limit and he was known as much for his bedside clinical teaching as the rigorous emergency medicine residency curriculum that produced more than 500 highly-trained emergency physicians during his tenure as program director, and beyond resident education, he also taught evidence-based medicine, bioethics, and professionalism to medical students; and

WHEREAS, Dr. Chisholm's dedication to residents' professional and personal development extended far beyond the walls of the hospital and he frequently hosted educational and social events at his home, or retreats at resident-chosen locations across Indiana and during these gatherings he prepared superb meals for residents and their families, in addition to teaching about clinical and non-clinical topics pertinent to emergency medicine; and

WHEREAS, Dr. Chisholm created a sense of family for the Indiana University emergency medicine community and the relationships, both professional and personal, that developed out of these activities lasted long past residents' years of training; and

WHEREAS, Even after his retirement as residency program director, Dr. Chisholm continued to serve as an educator and mentor to residents and faculty members and following the tragic death of his long-time friend and colleague, Kevin Rodgers, MD, he, Robin Chisholm, and Ruth Rodgers also created the Chisholm-Rodgers Legacy Fund to support clinical education and leadership development for years to come; and

WHEREAS, Dr. Chisholm's legacy will be carried out across the globe by the hundreds of physicians he trained, who themselves have gone on to teach other students and care for countless patients; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Carey D. Chisholm, MD, to the specialty of emergency medicine, especially as an educator, and extends the College's condolences to his wife of almost 40 years, Robin Chisholm, as well as to their daughters, Kelsey and Taylor.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 7(22)

SUBMITTED BY: Tennessee College of Emergency Physicians

SUBJECT: In Memory of Loren A. Crown, MD, FACEP

WHEREAS, With the untimely death of Loren A. Crown, MD, FACEP, on May 29, 2022, ACEP lost a gifted communicator, a tireless emergency medicine advocate, and a founder of the Tennessee ACEP Chapter; and

WHEREAS, Dr. Crown received his medical degree from Washington University School of Medicine in St. Louis and completed his medicine residency at the University of Illinois in Chicago; and

WHEREAS, Dr. Crown was board certified in family and sports medicine and practiced emergency medicine at St. Francis (where he established the first chest pain center in West Tennessee and a Level II Trauma Center) and St. Joseph Hospitals and served as medical director of the emergency department; and

WHEREAS, Dr. Crown joined the faculty of the University of Tennessee (UT) Health Sciences Center and moved to Tipton County in 1991 to establish the UT-Tipton Family Practice Program and an Emergency Medicine Fellowship program in Covington to prepare doctors for family and emergency practice in rural communities; and

WHEREAS, At UT, Dr. Crown achieved tenure and the rank of full clinical professor and during the next quarter century, he trained many dozens of fellows, residents, and medical students in family and emergency medicine; and

WHEREAS, Dr. Crown gave lectures both throughout the country and internationally, published more than 100 journal articles, wrote textbook chapters, served as editor of medical journals, presided over conferences, and moderated a medically oriented television program; and

WHEREAS, Dr. Crown was the Medical Advisor for the Southwest Tennessee and Dyersburg State College Paramedic programs; and

WHEREAS, Dr. Crown received many accolades and was elected by the American Academy of Emergency Medicine peers as Physician of the Year, by the Tennessee Rural Health Association as Practitioner of the Year and by his hospital as Doctor of the Year; and

WHEREAS, Active in professional societies, he was Chair of the Board of Certification of Emergency Medicine, President of the Tennessee College of Emergency Physicians, and President of the Memphis Academy of Family Physicians; and

WHEREAS, In community affairs, he served as President of the Memphis branch of the American Heart Association, as Vice President of the Alumni of Leadership Memphis. He also sat on the boards of United Way, the Memphis chapter of the American Red Cross, Art Today, Dyersburg State College Foundation, The Tipton Arts Council, and the Boys and Girls Clubs of Hatchie River; and

WHEREAS, Dr. Crown had a long and distinguished service as a member of ACEP and the Tennessee ACEP Chapter for more than 30 years; and

WHEREAS, Dr. Crown served the Tennessee Chapter as councillor, alternate councillor, and as a member of

the chapter Board of Directors; and

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

WHEREAS, Dr. Crown served his community for 30 years as an emergency physician and tirelessly worked to support and advocate for emergency medicine; and

WHEREAS, Dr. Crown additionally practiced Emergency Medicine at the University of Tennessee Health Sciences Center where he touched many lives with his kindness, compassion, and desire to truly help mankind; and

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

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

RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the accomplishments and contributions of a gifted emergency physician, Loren A. Crown, MD, FACEP, and extends condolences and gratitude to his wife, Elaine Kathleen Ellis, family, and friends for his service to the specialty of emergency medicine and to patient care.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 8(22)

SUBMITTED BY: Delaware Chapter

SUBJECT: In Memory of Sherrill Mullenix

WHEREAS, Sherrill Mullenix contributed immensely to the Emergency Medicine Community in Delaware in her role as the Delaware Chapter Executive for 18 years; and

WHEREAS, Ms. Mullenix shepherded hundreds of residents training in Emergency Medicine and dual-training in Emergency Medicine & Internal Medicine through that training and into practice over 25 years as the EM/IM residency coordinator at ChristianaCare, impacting not only these physicians but by extension the entirety of the Emergency Medicine community and countless patients; and

WHEREAS, Ms. Mullenix further contributed to the education of future Emergency Medicine physicians through her long-standing roles with EMRA; and

WHEREAS, Emergency Medicine in Delaware lost a friend, a colleague, and her constant immeasurable support this year when Ms Mullenix passed away; therefore be it

RESOLVED, That the American College of Emergency Physicians, the Delaware Chapter, and the friends and colleagues of Sherrill Mullenix recognizes her longstanding dedication and incredible contributions to the current state and the future of emergency medicine and acknowledges that she is irreplaceable and is missed.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 9(22)

SUBMITTED BY: Diversity, Inclusion, & Health Equity Section
Young Physicians Section
Emergency Medicine Residents' Association
Arizona Chapter
Florida College of Emergency Physicians
Georgia College of Emergency Physicians
Maine Chapter

SUBJECT: In Memory of Adetolu "Tolu" Odufuye, MD

WHEREAS, Emergency medicine lost a staunch advocate for the specialty in Adetolu "Tolu" Odufuye, MD, a dedicated mentor, organizational leader, and dear friend, who passed away on June 7, 2022, and left behind family, friends, residents, medical students, and colleagues; and

WHEREAS, Dr. Odufuye graduated from the University of Minnesota-Twin Cities and the Mayo Clinic College of Medicine, completing her emergency medicine residency at the Department of Emergency Medicine, Regions Hospital/HealthPartners and served in emergency departments in Atlantic Beach, Florida, , Emory University, Georgia, the Mayo Clinic in Jacksonville, Florida, and ThedaCare Medical Center in Waupaca, WI; and

WHEREAS, Dr. Odufuye served on national committees and Taskforces for the American College of Emergency Physicians including the State Legislative and Regulatory Committee, Strategic Planning Action Team for career fulfillment, and the Diversity, Inclusion and Health Equity (DIHE) Section Executive Leadership Committee; and

WHEREAS, Dr. Odufuye served as an alternate councilor for the DIHE Section, newsletter editor and its founding secretary; and

WHEREAS, Dr. Odufuye was elected Chair of the Diversity, Inclusion & Health Equity Section of which she was an inaugural member; and

WHEREAS, Dr. Odufuye was a passionate voice for equity and for change; and

WHEREAS, Dr. Odufuye touched the lives of countless individuals as a role model, colleague, consultant, friend; therefore be it

RESOLVED, That ACEP and the Diversity, Inclusion and Health Equity Section hereby acknowledges the many contributions made by Adetolu "Tolu" Odufuye, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of Adetolu "Tolu" Odufuye MD, FACEP, her friends, and her colleagues our condolences and gratitude for her tremendous service to the specialty of emergency medicine and to the patients and physicians of Florida and the United States.

2022 Council Meeting
Reference Committee Members

Reference Committee A – Governance & Membership
Resolutions 10-23

Nicole A. Veitinger, DO, FACEP (OH), Chair
Deborah D. Fletcher, MD, FACEP (LA)
John M. Gallagher, MD, FACEP (HI)
Kurtis A. Mayz, JD, MD, MBA, FACEP (OK)
Alexandra N. Thran, MD, FACEP (VT)
Brad L. Walters, MD, FACEP (MI)

Maude Surprenant Hancock, CAE
Laura Lang, JD

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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(22)

SUBMITTED BY: Emergency Medicine Residents' Association

SUBJECT: Candidate Members in the ACEP Council

PURPOSE: Bylaws amendment to allow medical students to serve as councillors.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws and implement the amendment.

WHEREAS, Medical student members make up approximately 23% of EMRA membership and 11% of total ACEP membership, and as all EMRA members are ACEP candidate members and there are currently 4,332 medical student members of both EMRA and ACEP as of May 2022; and

WHEREAS, Article VIII – Council, Section 1 – Composition of the Council, paragraph three of the ACEP Bylaws state: "EMRA shall be entitled to eight councilors, each of whom shall be a candidate or regular member of the College, as representative of all of the members of EMRA;" and

WHEREAS, Currently there are no medical students serving as ACEP councillors within the College to represent their voice and membership in EMRA, thus not representative of "all of the members of EMRA;" and

WHEREAS, ACEP candidate members comprising medical students decreased roughly 20% from 2021-2022 with further anticipated reductions in 2022-2023; and

WHEREAS, The 2022 Electronic Residency Application Service Match had the highest number of unfilled positions in emergency medicine programs in the last decade with 7.5% of all emergency medicine programs unfilled following the match[1]; and

WHEREAS, Medical student members represent the future of the emergency medicine profession and may offer a perspective not already represented in the ACEP Council as it currently presides; and

WHEREAS, Medical students already serve in vital roles within EMRA by introducing meaningful resolutions, debating the utility of proposed resolutions as amendments to EMRA policy, and furthering the mission and vision of the organization; and

WHEREAS, In the interest of attracting and retaining medical students into the field of emergency medicine, workplace studies have connected employees' experience of having their voices heard and represented led to more positive work experiences and higher retention[2,3]; and

WHEREAS, The American Medical Association (AMA) has an important engagement with medical students at all levels of their organization, notably the Medical Student Section (MSS), that often guides broad organizational policy matters and instituting important changes in the field of medicine[1]; therefore be it

RESOLVED, That the ACEP Bylaws Article IV – Membership, Section 2.3 – Candidate Members, paragraph two be amended to read:

"The rights of candidate members at the chapter level are as specified in their chapter's bylaws. At the national level, candidate members shall not be entitled to hold office, but ~~physician members~~ may serve on the

Council. Candidate members appointed to national committees shall be entitled to vote in committees on which they serve."; and be if further

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

"Each chartered chapter shall have a minimum of one councillor as representative of all of the members of such chartered chapter. There shall be allowed one additional councillor for each 100 members of the College in that chapter as shown by the membership rolls of the College on December 31 of the preceding year. However, a member holding memberships simultaneously in multiple chapters may be counted for purposes of councillor allotment in only one chapter. Councillors shall be elected or appointed from regular and candidate ~~physician~~ members in accordance with the governance documents or policies of their respective sponsoring bodies."

References:

1. *Joint statement on the 2022 emergency medicine residency match*. ACEP . https://www.acep.org/news/acep-newsroom-articles/joint-statement-match-2022/
2. *Smith Senior News Writer TM*. How medical students help shape AMA policy-and medicine's future. American Medical Association. https://www.ama-assn.org/member-groups-sections/medical-students/how-medical-students-help-shape-ama-policy-and-medicine-s Published May 24, 2022. Accessed June 30, 2022.
3. *IBM Smarter Workforce Institute; 2017*. https://www.ibm.com/downloads/cas/JDMXPMBM. Khalid K, Nawab S. Employee participation and employee retention in view of compensation. SAGE Open. 2018;8(4):215824401881006. doi:10.1177/2158244018810067

Background

This Bylaws amendment seeks to allow medical students to serve as councillors. ACEP has a long history of medical student participation, beginning in 1975 when the Bylaws were amended to allow medical students to become candidate members of ACEP. Candidate members cannot vote or hold office, except candidate physician members (residents and fellows) can serve as councillors/alternate councillors. Medical students appointed to national ACEP committees are entitled to vote as committee members.

The medical student voice in the Council is intended, under existing policy, is through EMRA as well as their state chapter and section councillors. Although interested in emergency medicine while in medical school, a medical student may not have determined their future medical specialty and there is no guarantee that a medical student will pursue emergency medicine as a career.

The Council has previously debated the ability for medical students to serve as voting members of the Council. Resolution 13(14) Medical Student Voice in the ACEP Council requested the Council Steering Committee to evaluate the Council's ability to address candidate students' membership needs, explore ways in which candidate student members can contribute to the Council, explore the possibility of candidate student members serving as alternate councillors, or an appropriate alternative and report the finding and recommendations to the Board of Directors. The Council adopted an amended resolution that removed exploring the ability for medical students to serve as alternate councillors since alternate councillors have the same rights and responsibilities as councillors and many disagreed with medical students serving as councillors with full voting privileges.

The Steering Committee discussed the amended resolution at their meeting on January 20, 2015, and the vice chair of EMRA's Medical Student Council participated in the discussion. The Steering Committee expressed strong support for welcoming medical student attendance at the Council meeting and addressing their needs to the extent possible within ACEP's existing structure. The Steering Committee supported continuing to look for ways to involve medical students in the Council meeting, but did not support developing or cosponsoring a resolution to allow medical students to serve as councillors or alternate councillors. The Council meeting is open to all members of ACEP, including medical students. Medical students can attend and participate in the Reference Committee hearings. Suggestions from the Steering Committee for additional medical student participation included:

1. "Shadowing" a councillor or alternate councillor.
2. Attending the Reference Committee hearings and reporting on the discussions to their delegation members who may not be able to attend that Reference Committee hearing or during the discussion on a particular resolution.
3. Active participation in social media communications during the Council meeting.

A report from the Steering Committee's discussions and the response to EMRA was provided to the Board in June 2015.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Budgeted staff resources to update the Bylaws and implement the amendment.

Prior Council Action

June 2015, reviewed the report from the Steering Committee regarding Amended Resolution 13(14) Medical Student Voice in the ACEP Council.

Amended Resolution 13(14) Medical Student Voice in the ACEP Council adopted. The resolution directed the Council Steering Committee to evaluate the Council's ability to address candidate students' membership needs, explore ways in which candidate student members can contribute to the Council, and report the finding and recommendations to the Board of Directors.

Resolution 10(13) Medical Student Members not adopted. The resolution was a Bylaws amendment specifying that councillor allocation be based on physician members of the College and would not include medical students.

Resolution 10(07) Complimentary Members in Section Councillor Allocation adopted. This Bylaws amendment clarified that complimentary section memberships for candidate members are to be included when determining section eligibility for a councillor.

Substitute Resolution 5(75) Medical Student Participation in ACEP adopted. Amended the Bylaws to allow medical students to become candidate members of ACEP, but not entitled to vote or hold office.

Prior Board Action

Amended Resolution 13(14) Medical Student Voice in the ACEP Council adopted.

Resolution 10(07) Complimentary Members in Section Councillor Allocation adopted.

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

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

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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(22)

SUBMITTED BY: Council Steering Committee

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

PURPOSE: Bylaws amendment establishing a young physician to the Nominating Committee.

FISCAL IMPACT: Budgeted resources expenses for the Nominating Committee.

WHEREAS, Resolution 14(21) Establishing a Young Physician Position on the Nominating Committee was adopted by the Council and directed the Council Steering Committee to submit a Bylaws amendment to the Council in 2022 to support the establishment of a young physician position on the Nominating Committee; therefore be it

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 7 – Nominating Committee be amended to read:

A Nominating Committee for positions elected by the Council shall be appointed annually and chaired by the speaker. The speaker shall appoint five members**, at least one of which will be a young physician, defined as a member under the age of 40 or within the first ten years of practice,** 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.

Background

This Bylaws amendment establishes a young physician position on the Nominating Committee

The current Bylaws language do not exclude a young physician from being appointed by the Council Speaker to serve on the Nominating Committee and for the past several years a young physician member has been appointed to serve on the committee.

Resolution 14(21) Establishing a Young Physician on the ACEP Nominating Committee was adopted by the Council. It directed the Council Steering Committee to submit a Bylaws resolution to the Council in 2022 to establish a young physician position on the Nominating Committee. Although a young physician member had been appointed to the Nominating Committee as standard practice, members requested it be codified in the Bylaws.

The Council Steering Committee discussed the resolution at their January 24, 2022, meeting and assigned it to a subcommittee to develop a Bylaws amendment. The subcommittee believed it was important to include ACEP's definition of a young physician in the resolution. The draft resolution was reviewed by the Council Steering Committee at their May 1, 2022, meeting and it was approved for submission to the 2022 Council.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Budgeted resources for the Nominating Committee.

Prior Council Action

Resolution 14(21) Establishing a Young Physician on the ACEP Nominating Committee adopted. The resolution directed the Council Steering Committee to submit a Bylaws resolution to the Council in 2022 to establish a young physician position on the Nominating Committee.

Prior Board Action

Resolution 14(21) Establishing a Young Physician on the ACEP Nominating Committee adopted.

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

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 12(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD
Charles Pattavina, MD, FACEP

SUBJECT: Council Approval of Board Actions on Referred Resolutions

PURPOSE: Seeks to amend the Bylaws to: 1) require a report on each resolution referred to the Board will become a matter of business at the subsequent Council meeting; 2) the report will include a summary of the Board's discussion and their recommendations regarding the referred resolution; and 3) the Board's recommendations on referred resolutions will be subject to approval by the Council.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws. Budgeted Council Steering Committee and staff resources to develop processes to address the amendment.

WHEREAS, The Council is the true representative body of the American College of Emergency Physicians (ACEP) made up of members from all states, sections, and associated organizations, e.g., the Emergency Medicine Residents' Association (EMRA), Association of Academic Chairs of Emergency Medicine (AACEM); and

WHEREAS, The Board of Directors, being a smaller body, is not representative of the full membership of ACEP; and

WHEREAS, The ACEP should be governed by the will of its general dues-paying membership and not a select few; and

WHEREAS, In other major physician organizations with representative bodies such as the American Medical Association (AMA) and state medical societies, resolutions referred to the Board are reported back to the representative body with recommendations that are subject to review and action by that body; and

WHEREAS, Currently, in ACEP, referred resolutions can be subject to final action by the Board with no further Council input, thereby taking material decision making and participatory power away from the Council; therefore be it

RESOLVED, That the ACEP Bylaws Article VIII – Council, Section 8 – Board of Directors Actions 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 45 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 quarterly intervals until these communications demonstrate that no further Board action is required according to the Bylaws listed previously in this section.

A Board report on each resolution referred, in whole or part, by the Council to the Board of Directors, will be prepared and become business of the subsequent Council meeting. The Board report will include a summary of the discussion and the Board's recommendations regarding the referred matter. As business of the Council, the Board's recommendations will be subject to Council approval. The Council will review, discuss, and act on the Board report. This may include approval, rejection, amendment, or referral of the recommendations.

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

Reference
https://www.acep.org/globalassets/sites/acep/media/about-acep/pdfs/bylaws-oct-2021.pdf

Background

This resolution seeks to amend the Bylaws to require a report on each resolution referred to the Board to become a matter of business at the subsequent Council meeting. The report to the Council will include a summary of the Board's discussion and their recommendations regarding the referred resolution and will be subject to approval by the Council.

The options available to the Council regarding resolutions are adopt, adopt as amended, not adopt, or refer. Resolutions are referral to the Board of Directors, the Council Steering Committee, or the Bylaws Interpretation Committee (for certain provisions of the Bylaws). A resolution may be referred to the Board of Directors for a variety of reasons, including but not limited to:

- additional information is needed to inform a decision
- additional expertise, study, or data collection is required
- additional discussion is needed to consider potential unintended consequences regarding controversial or complex issues
- consider the impact of the resolution to the organization
- obtain a legal opinion
- a significant financial investment may be required that is not available in the current budget
- further analysis of fiscal impact is needed (this is particularly true regarding late or emergency resolutions when background information has not been prepared)
- the resolution asks the College to consider a decision that is contrary to current policy or creates new policy
- pending legislative or regulatory matters
- the Council was not able to reach consensus

As mentioned in the Whereas statements, some physician organizations with representative bodies, such as the American Medical Association, have processes in place whereby resolutions referred to the Board of Directors may be reported to the representative body with recommendations subject to review and action by that body. The AMA House of Delegates may vote to "refer" or "refer for decision;" "refer" means the resolution or report is sent to the Board (or through the Board to the appropriate council or committee) for report back to the house, while "refer for decision" means the resolution or report is sent to the Board for disposition and the house is notified of the outcome at its next meeting.

ACEP's Board of Directors has the authority to take action on referred resolutions as they deem appropriate. The ACEP president, on behalf of the Board of Directors, may assign the referred resolution to a committee, task force, section, workgroup of the Board, or staff to review the referred resolution and provide recommendations to the Board regarding proposed action on the resolution.

The Board of Directors is currently required, per the Bylaws Article VIII – Council, Section 8 – Board of Directors Actions on Resolutions, to provide "written and comprehensive communication regarding the actions taken and status of each adopted and referred resolution" including "a summary of the Board of Directors' intent, discussion, and decision for each referred resolution." Reports on the prior year's resolutions, as well as reports from the two previous years, are provided in the Council meeting materials. Additionally, information on the disposition of each resolution is available on the ACEP website, Actions on Council Resolutions. The resolutions are listed by year and title and include the original resolution, background information, testimony in the Reference Committee, Council action, Board action, and implementation action. The search function includes a global search across all resolutions and a search capability within each year. All resolutions since 1993 are now available. Staff are continuing to work on adding all resolutions since 1972.

Each year the Council Steering Committee reviews the implementation actions on adopted and referred resolutions to ensure that the will of the Council is followed in implementing the resolutions. Their review includes actions on all resolutions adopted and referred from the most recent Council meeting and the resolutions from the two prior years. This requirement is codified in the Council Standing Rules, "Policy Review" section:

> "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."

The Steering Committee has the authority to represent the Council between annual meetings as defined in the Bylaws Article XI – Committees, Section 3 – Steering Committee:

> A Steering Committee of the Council shall be appointed by the speaker of the Council. The committee shall consist of at least 15 members, each appointed annually for a one-year term. It shall be the function of the committee to represent the Council between Council meetings. The committee shall be required to meet at least two times annually, and all action taken by the committee shall be subject to final approval by the Council at the next regularly scheduled session. The speaker of the Council shall be the chair of the Steering Committee.
>
> The Steering Committee cannot overrule resolutions, actions, or appropriations enacted by the Council. The Steering Committee may amend such instructions of the Council, or approve amendments proposed by the Board of Directors, provided that such amendment shall not change the intent or basic content of the instructions. Such actions to amend, or approve amendment, can only be by a three-quarters vote of all the members of the Steering Committee and must include the position and vote of each member of the Steering Committee. Notice by mail or official publication shall be given to the membership regarding such amendment, or approval of amendment, of the Council's instructions. Such notice shall contain the position and vote of each member of the Steering Committee regarding amendment of or approval of amendment.

The proposed Bylaws amendment directs that referred resolutions to the Board will become a matter of business at the subsequent Council meeting. The Board typically takes action on a referred resolution within the first year, however, some resolutions may require additional time for a decision and implementation. For example, a referred resolution may require funding that is not available in the current fiscal year budget or it may take additional time for data

collection, etc. Adoption of the resolution as proposed would require the follow year's Council to approve the Board of Director's recommendations on how to implement the resolution. This would delay action on the referred resolution until the implementation recommendations were approved by the Council. This has the potential to impede the ability of ACEP to take action on the referred resolution.

If this resolution is adopted, it will be necessary to change the format of the Council meeting agenda. It is unclear from the resolution as written whether the intent is for the Board's implementation recommendations to be assigned to a Reference Committee for deliberation or if the intent is for the Council to deliberate directly on the implementation recommendations. Adoption of this language creates the potential for re-debate/re-vote/re-referral for each referred resolution from the prior year's Council meeting and could expand the Council agenda significantly.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership

Fiscal Impact

Budgeted staff resources to update the Bylaws. Budgeted Council Steering Committee and staff resources to develop processes to address the amendment.

Prior Council Action

None that is specific to action taken by the Board on referred resolutions being subject to approval by the Council.

Amended Resolution 10(21) Board of Directors Action on Council Resolutions adopted. Amended 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.

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 10(21) Board of Directors Action on Council Resolutions adopted.

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: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 13(22)

SUBMITTED BY: Maine Chapter

SUBJECT: Past Leader Participation in Council Meetings

PURPOSE: Amends the Bylaws to allow all past members of the Board of Directors who are not serving as councillors or alternate councillors to participate in the Council meeting in a non-voting capacity similar to past presidents, past speakers, and past chairs of the Board.

FISCAL IMPACT: Increased hotel or convention center labor costs for onsite set-up of the Council meeting to include the extra seating requirements by expanding the Council meeting floor. Additional staff labor hours will be needed to contact past members of the Board of Directors to confirm their attendance at the Council meeting and make adjustments to the Council meeting floor plan to accommodate the additional seating. Budgeted staff resources to update the Bylaws.

WHEREAS, Past leaders are resources for knowledge, expertise and institutional memory and those roles provide unique career fulfillment opportunities to mentor emergency physician leaders on issues of great import and consequence; and

WHEREAS, Past leaders are key to leadership development, especially in smaller chapters; and

WHEREAS, In addition to past speakers, many past directors, including past presidents and past chairs of the Board, wish to participate and help with leadership development; and

WHEREAS, Prior to the establishment of the office of Chair of the Board, past Board chairs were most often known as past directors; therefore be it

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

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

Background

This is a companion resolution to Resolution 14(22) Past Leader Seating in Council Meetings – Council Standing Rules Amendment.

This Bylaws amendment would allow all past members of the Board of Directors who are not serving as councillors or alternate councillors to participate in the Council meeting in a non-voting capacity similar to past presidents, past speakers, and past chairs of the Board.

Past presidents and past speakers have been allowed to sit with their Council delegations and participate in a non-voting capacity since 1989. Resolutions were adopted in 2017 allowing past chairs of the Board to sit with their Council delegations and participate in a non-voting capacity.

Past members of the Board of Directors have an opportunity to serve as councillors or alternate councillors within their component bodies. Any member, not just councillors or alternate councillors, are allowed to testify in Reference Committees. Any member, including past members of the Board, currently may be recognized at the microphone to speak during the Council meeting.

There are currently 73 past members of the Board of Directors and of those 37 are past presidents, 6 are past speakers, and 10 are past chairs of the Board. Adoption of this resolution will potentially add 20 seats to the Council floor in 2023. Additional seats will need to be added in future years as Board members complete their term.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Increased hotel or convention center labor costs for onsite set-up of the Council meeting to include the extra seating requirements by expanding the Council meeting floor. Additional staff labor hours will be needed to contact past members of the Board of Directors to confirm their attendance at the Council meeting and make adjustments to the Council meeting floor plan to accommodate the additional seating. Budgeted staff resources to update the Bylaws.

Prior Council Action

Resolution 13(17) Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment adopted. The resolution amended the Council Standing Rules to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment adopted. The resolution amended the Bylaws to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted. This resolution allowed for past presidents and past speakers to sit with their Council delegations as non-voting participants.

Prior Board Action

Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment adopted.

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

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

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Council Standing Rules Amendment

RESOLUTION: 14(22)

SUBMITTED BY: Maine Chapter

SUBJECT: Past Leader Seating in Council Meetings

PURPOSE: Amends the Council Standing Rules to allow all past members of the Board of Directors who are not serving as councillors or alternate councillors to participate in the Council meeting in a non-voting capacity similar to past presidents, past speakers, and past chairs of the Board.

FISCAL IMPACT: Increased hotel or convention center labor costs for onsite set-up of the Council meeting to include the extra seating requirements by expanding the Council meeting floor. Additional staff labor hours will be needed to contact past members of the Board of Directors to confirm their attendance at the Council meeting and make adjustments to the Council meeting floor plan to accommodate the additional seating. Budgeted staff resources to update the Council Standing Rules.

WHEREAS, Past leaders are resources for knowledge, expertise and institutional memory and those roles provide unique career fulfillment opportunities to mentor emergency physician leaders on issues of great import and consequence; and

WHEREAS, Past leaders are key to leadership development, especially in smaller chapters; and

WHEREAS, In addition to past speakers, many past directors, including past presidents and past chairs of the Board, wish to participate and help with leadership development; and

WHEREAS, Prior to the establishment of the office of Chair of the Board, past Board chairs were most often known as past directors; therefore be it

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

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

RESOLVED, That the Council Standing Rules "Past Presidents, Past Speakers, and Past Chairs of the Board Seating" section be amended to read as follows with the proviso that the changes will become effective after the 2022 Council meeting and only upon adoption of the companion Bylaws amendment titled "Past Leader Participation in Council Meetings":

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

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

PROVISO: The provisions of this resolution shall not go into effect unless Resolution 13(22) Past Leader Participation in Council Meetings – Bylaws Amendment is adopted by the Council and the Board of Directors.

Background

This is a companion resolution to Resolution 13(22) Past Leader Participation in Council Meetings – Bylaws Amendment.

This Council Standing Rules amendment would allow all past members of the Board of Directors who are not serving as councillors or alternate councillors to participate in the Council meeting in a non-voting capacity similar to past presidents, past speakers, and past chairs of the Board.

Past presidents and past speakers have been allowed to sit with their Council delegations and participate in a non-voting capacity since 1989. Resolutions were adopted in 2017 allowing past chairs of the Board to sit with their Council delegations and participate in a non-voting capacity.

Past members of the Board of Directors have an opportunity to serve as councillors or alternate councillors within their component bodies. Any member, not just councillors or alternate councillors, are allowed to testify in Reference Committees. Any member, including past members of the Board, currently may be recognized at the microphone to speak during the Council meeting.

There are currently 73 past members of the Board of Directors and of those 37 are past presidents, 6 are past speakers, and 10 are past chairs of the Board. Adoption of this resolution will potentially add 20 seats to the Council floor in 2023. Additional seats will need to be added in future years as Board members complete their term.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Increased hotel or convention center labor costs for onsite set-up of the Council meeting to include the extra seating requirements by expanding the Council meeting floor. Additional staff labor hours will be needed to contact past members of the Board of Directors to confirm their attendance at the Council meeting and make adjustments to the Council meeting floor plan to accommodate the additional seating. Budgeted staff resources to update the Council Standing Rules.

Prior Council Action

Resolution 13(17) Seating of Past Chairs of the Board in the ACEP Council – Council Standing Rules Amendment adopted. The resolution amended the Council Standing Rules to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment adopted. The resolution amended the Bylaws to permit past chairs of the Board, who are not otherwise serving as councillors or alternate councillors, to participate in the Council in a non-voting capacity similar to past presidents and past speakers of the Council.

Amended Resolution 52(88) Seating of Past Presidents and Past Speakers of ACEP adopted. This resolution allowed for past presidents and past speakers to sit with their Council delegations as non-voting participants.

Prior Board Action

Resolution 12(17) Seating of Past Chairs of the Board in the ACEP Council – Bylaws Amendment adopted.

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

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

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 15(22)

SUBMITTED BY: Council Steering Committee

SUBJECT: Electronic Voting During the Council Meeting

PURPOSE: Amends Council Standing Rules to specify that voting electronically includes remote communication and voting technology; stipulates that individual connectivity issues or individual disruption of remote communication technology will not be the basis for a point of order or other challenge to any voting; and that the chair of the Tellers, Credentials, & Elections Committee will monitor the voting to ensure there are no large discrepancies between votes.

FISCAL IMPACT: Budgeted staff resources to update the Council Standing Rules. Cost savings of approximately $4,000 to utilize remote voting technology instead of physical keypads.

WHEREAS, In 2020 and in 2021, the Council utilized remote electronic voting technology; and

WHEREAS, The Council adopted temporary Standing Rules in 2021 that contained a provision specifying that "Individual connectivity issues will not be the basis of a Point of Order or a challenge to any votes."; and

WHEREAS, The Council may use remote communication and voting technology in the future and the Council Standing Rules should codify that individual connectivity issues will not be the basis of a Point of Order or a challenge to any votes; therefore be it

RESOLVED, That the ACEP Council Standing Rules, "Election Procedures" section, paragraph one, and the "Voting on Resolutions and Motions" section be amended to read:

Election Procedures

Elections of the president-elect, Board of Directors, and Council officers shall be by a majority vote of councillors voting. Voting shall be by written or electronic ballot**, which may include remote communication and voting technology**. There shall be no write-in voting. **Individual connectivity issues or individual disruption of remote communication technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the Speaker.**

Voting on Resolutions and Motions

Voting may be accomplished by an electronic voting system, **including remote communication technology,** voting cards, standing, or voice vote at the discretion of the speaker. Numerical results of electronic votes and standing votes on resolutions and motions will be presented before proceeding to the next issue. **Individual connectivity issues or individual disruption of remote communication and voting technology shall not be the basis for a point of order and/or other challenge to any voting utilizing such technology. The Chair of the Tellers, Credentials, & Elections Committee will monitor the voting for large discrepancies between votes and notify the Speaker.**

Background

This resolution amends the Council Standing Rules to specify that voting electronically includes remote

communication and voting technology; stipulates that individual connectivity issues or individual disruption of remote communication technology will not be the basis for a point of order or other challenge to any voting; and that the chair of the Tellers, Credentials, & Elections Committee will monitor the voting to ensure there are no large discrepancies between votes.

During their January 24, 2022, meeting, the Council Steering Committee discussed the Council's use of remote voting technology for the past two years and potential changes that may be needed in the Council Standing Rules if the Council meeting is held virtually or as a hybrid meeting in future years. The Council adopted Temporary Standing Rules to conduct business as a virtual meeting in 2020 and as a hybrid meeting in 2021. All other provisions of the Council Standing Rules remained in effect except as enumerated in the Temporary Standing Rules. Since a hybrid meeting was conducted in 2021, the orange voting cards and keypads could not be used by councillors attending the meeting virtually.

The Steering Committee supported continuing to use an online voting system instead of the keypads so that the same system would be used whether the Council meeting is held in person, hybrid, or fully virtual. The committee agreed that the current provisions in the Council Standing Rules that allow voting by using an electronic voting system includes the ability to use online voting software since it is a form of electronic voting. A subcommittee was assigned to develop a Council Standing Rules amendment. The subcommittee recommended including language that specifies voting by electronic ballot may include remote communication and voting technology and voting by an electronic voting system includes remote communication technology. The subcommittee discussed potential problems individuals may have with connecting to the electronic voting system or problems with their personal internet provider and recommended including language that individual connectivity issues or individual disruption of internet service will not be the basis for a point of order or other challenge to any voting. The subcommittee acknowledged that there have been a few problems during some past Council meetings with electronic voting related to Wi-Fi capacity or disruption of internet service that had to be addressed before resuming any electronic voting. The voting patterns were monitored by the chair of the Tellers, Credentials, & Elections Committee and reported to the Council Speaker when problems were identified. The subcommittee believed it was important to include this information in the amendment. The draft resolution was reviewed by the Council Steering Committee at their May 1, 2022, meeting and it was approved for submission to the 2022 Council.

The cost for the electronic voting platform that was used during the 2021 meeting was $884. This is considerably less than the cost for the annual software licensing fee of $4,950, and the additional costs to maintain and replace keypads. Keypads are issued to each credentialed councillor and alternate councillors substituting for councillors use the keypad issued to the councillor. Similarly, when the orange voting cards are used for voting, the alternate councillor uses the voting card issued to the councillor. It is possible to generate an invalid ballot during elections when using the keypads if a councillor votes for less than four candidates for the Board of Directors. However, there is a provision within the Council Standing Rules "Election Procedures" section stipulating that a vote must be retaken if the number of invalid ballots is sufficient to affect the outcome of the vote. The keypad software has been programmed to calculate this scenario. Online voting systems are accessed by a secure web address and are programmed so that no invalid ballots can be generated. Usually, any electronic device (cell phone, computer, tablet) can be used with online voting systems. Online voting systems are programmed in advance with the names and credentials of the councillors who will be voting during the Council meeting. Alternate councillors substituting for councillors must use the login credentials of the credentialed councillor, which is similar in function to using the orange voting card or keypad of the councillor.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Budgeted staff resources to update the Council Standing Rules. Cost savings of approximately $4,000 to utilize remote voting technology instead of physical keypads.

Prior Council Action

October 2021, adopted Temporary Council Standing Rules to accommodate a hybrid meeting for in-person and virtual participation, including using an online voting platform.

October 2020, adopted Temporary Council Standing Rules to accommodate the virtual meeting, including utilizing it for electronic voting.

Prior Board Action

None

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

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 16(22)

SUBMITTED BY: Council Steering Committee

SUBJECT: Required Candidate Campaign Materials from Floor Candidates

PURPOSE: Council Standing Rules amendment specifying the required candidate campaign materials for floor candidates and the deadline for submission.

FISCAL IMPACT: Budgeted staff resources for collection of candidate campaign materials and distribution to the Council.

WHEREAS, The Council Standing Rules do not specify the candidate campaign materials that are required to be submitted by floor candidates or the deadline to submit campaign materials; therefore be it

RESOLVED, That the ACEP Council Standing Rules, "Nominations" section, be amended to read:

Nominations

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

Members not nominated by the Nominating Committee may **self-nominate by** declar~~e~~**ing** themselves "floor candidates" at any time after the release of the Nominating Committee report and before the speaker closes nominations during the Council meeting. All floor candidates must notify the Council speaker in writing. Upon receipt of this notification, the candidate becomes a "declared floor candidate," has all the rights and responsibilities of candidates otherwise nominated by the Nominating Committee, and must comply with all rules and requirements of the candidates. **All required candidate materials (including but not limited to professional photo, CV, Candidate Campaign Rules Attestation, responses to written questions, candidate data sheet, conflict of interest disclosure statement) must be available immediately at the time of floor nomination – either completed by the due date for all nominees or at the time of notification to the Speaker of intent to seek nomination, whichever date is later.** ***See also Election Procedures.***

Background

This Council Standing Rules amendment specifies the required candidate campaign materials that must be submitted by floor candidates and the deadline for submission.

The Council Standing Rules do not currently specify the campaign materials that must be submitted by floor candidates or when those materials must be submitted. Usually, anyone planning to seek nomination from the Council floor makes this intent known well in advance of the Council meeting. The "declared floor candidate" is then included in any communications to candidates about the required (and optional) campaign materials and the deadlines to submit them. However, there is the possibility that someone will decide to seek nomination from the floor after those deadlines. The Council Steering Committee discussed the requirements of floor candidates at their January 24, 2022, meeting and tasked the Candidate Forum Subcommittee with developing a Council Standing Rules amendment to further support a transparent and equitable election process for all candidates. The Steering Committee also discussed

potential revisions to the Candidate Campaign Rules, including revisions to the "Floor Nominations" section. Similar language regarding the required candidate materials was added to the Candidate Campaign Rules. The revisions were approved by the Council Steering at their May 1, 2022, meeting and were effective immediately. The updated Candidate Campaign Rules were then distributed to the candidates. The draft resolution, which further codifies the language that was added to the Candidate Campaign Rules, was also reviewed by the Council Steering Committee on May 1 and was approved for submission to the 2022 Council.

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Budgeted staff resources for collection of candidate campaign materials and distribution to the Council.

Prior Council Action

None

Prior Board Action

None

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

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 17(22)

SUBMITTED BY: Michael Bresler, MD, FACEP
Valerie Norton, MD, FACEP
California Chapter

SUBJECT: Criteria for the Location of Future National ACEP Events

PURPOSE: 1) Study the feasibility of moving previously scheduled national-level ACEP events away from states that do not offer a full range of reproductive health care options; 2) Refrain from scheduling future national ACEP events in states that do not offer a full range of reproductive health care options; and 3) the prohibition of scheduling meetings in these states applies only to national ACEP events.

FISCAL IMPACT: Combined fiscal impact of cancelling all current meeting contracted in these states is approximately $1,760,000. Budgeted staff resources necessary to investigate, negotiate cancellations, and finalize contracting process with the new venues. Unbudgeted staff resources for sourcing and supervision of expert meeting and convention planning independent contractors to assist with securing new contracts with an estimated expense of $25,000.

WHEREAS, The American College of Emergency Physicians (ACEP) supports access to health care for all patients; and

WHEREAS, It is recognized that various members of ACEP may hold divergent views on the issue of access to abortion services; and

WHEREAS, Current law in several states restricts access to certain types of reproductive health care, including abortion services; and

WHEREAS, These laws create inequities in access to safe and timely care that are disproportionately borne by patients of lower socio-economic status, minorities, and those in rural areas; and

WHEREAS, Patients may experience complications and adverse outcomes due to the inability to access these types of care in a safe and timely manner, resulting in increased emergency department visits due to complications; and,

WHEREAS, ACEP has an interest in reducing preventable complications for all patients, including pregnant people who travel to attend the ACEP Council meeting or another ACEP event; therefore be it

RESOLVED, That ACEP study the feasibility of moving previously scheduled national-level ACEP events away from states that do not offer access to a full range of reproductive health care options; and be it further

RESOLVED, That ACEP not schedule future national-level ACEP events in states that do not offer access to a full range of reproductive health care options; and be it further

RESOLVED, That with recognition of the necessity for both the College and its chapters to continue to function in states that limit access to a full range of reproductive health care options, the prohibition of scheduling meetings in these states shall apply to national-level ACEP events only, and shall not apply to individual chapters of the College.

References

1. Nash E et al. Impact of Texas' abortion ban: a 14-fold increase in driving distance to get an abortion. Gutmacher Institute policy analysis, 2021. https://www.guttmacher.org/article/2021/08/impact-texas-abortion-ban-14-fold-increase-driving-distance-get-abortion
2. Bearak J, Popinchalk A, Ganatra B, Moller A-B, Tunçalp Ö, Beavin C et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. Lancet Glob Health. 2020 Sep; 8(9):e1152-e1161. doi: 10.1016/S2214-109X(20)30315-6.
3. Ganatra B, Gerdts C, Rossier C, Johnson Jr B R, Tuncalp Ö, Assifi A et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. The Lancet. 2017 Sep.
4. Stevenson AJ, The Pregnancy-related mortality impact of a total abortion ban in the United States. Demography 2021 (6); 2019-28. https://doi.org/10.1215/00703370-9585908
5. Harris LH, Grossman D. Complications of unsafe and self-managed abortion. N Engl J Med 2020;382:1029-40.
6. Tasset J, Harris LH. Harm reduction for abortion in the United States. Obstet Gynecol 2018;131:621-4.
7. Paltrow LM, Flavin J. Arrests of and forced interventions on pregnant women in the United States, 1973–2005: implications for women's legal status and public health. J Health Polit Policy Law 2013;38:299-343.
8. Myers C, Jones R, Upadhyay U. Predicted changes in abortion access and incidence in a post-Roe world. Contraception 2019;100: 367-73.

Background

This resolution asks ACEP to study the feasibility of moving previously scheduled national-level ACEP events away from states that do not offer a full range of reproductive health care options[1], refrain from scheduling future national ACEP events in states that do not offer a full range reproductive health care options, and specifies that the prohibition of scheduling meetings in states without such options applies only to national ACEP events

ACEP has contracted for *Scientific Assembly* in the following states with a full range of reproductive health care:

- Philadelphia, PA – 2023 and 2029 (2029 can be cancelled without penalty based upon the level of success in 2023)
- Las Vegas, NV – 2024 and 2028
- Chicago, IL – 2026 and 2031
- Boston, MA – 2027 (and potentially 2032 if approved by the Board at their 9/28/22 meeting)
- San Francisco, CA – 2030

Currently, the only state without a full range of reproductive health care contracted for *Scientific Assembly* is Texas when the meeting will be held in Dallas in 2025.

There are several non-*Scientific Assembly* meetings contracted in 2023 in states without a full range of reproductive health care that are honoring ACEP's contractual commitment for cancelled meetings in 2022 because of COVID. These include:

<u>New Orleans, LA</u>
- Reimbursement: Trends and Strategies in Emergency Medicine and Advanced Procedure Coding for Emergency Medicine
- Teaching Fellowship for Residents and Teaching Fellowship

<u>Dallas, TX</u>
- Emergency Department Directors Academy Phase I Spring and Fall, Phase II, and Phase III
- Teaching Fellowship

[1] ACEP recognizes that references to "a full range of reproductive health care" may be interpreted differently by the reader; however, in order to retain consistency with language used by the authors of the resolution, this verbiage is incorporated into the Background section of the document.

Other non-*Scientific Assembly* meetings contracted for 2023 a full range of reproductive health care are:

- New York, NY – Advanced Pediatric Emergency Medicine Assembly
- Washington, DC – Leadership and Advocacy Conference.

Annual meeting venues/cities are determined based on member data of desirable cities, history of prior experiences hosting the annual meeting, airline costs, hotel and convention center function space and guest room capabilities, cost factors, walkability, restaurants, nightlife, and a variety of other factors. ACEP25 in Dallas, TX honors a contractual commitment for ACEP20 that was cancelled because of COVID prior to the city's shut down. Sourcing a city at this point would be impossible based on the limited number of cities that can accommodate a meeting this size over the optimal dates for our members. Typical sourcing of a meeting this size must occur 10+ years out. Cancellation penalties would be in excess of $1.1 million dollars for ACEP25 and does not include the cost of staff labor to research and negotiate this citywide event in other locations.

The cities chosen to host non-SA meetings are determined based on the target audience and their preferences as well as the type of meeting and the time allotted for social and networking events. Meetings contracted in Dallas allow ACEP to remove all costs associated with staff travel and to net a higher ROI. Moving these meetings from Dallas increases the expenses by approximately $7,500 for three staff to manage each event. Cancelling these meetings would exceed $660,000 in cancellation penalties. Meetings contracted for the next 18 months must not be cancelled as education planning has begun and CME approval and marketing will occur this fall to ensure their success.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels including federal, state, and local

Fiscal Impact

The combined fiscal impact of canceling all current meeting contracts in these states is approximately $1,760,000. Budgeted staff resources necessary to investigate, negotiate cancellations, and finalize contracting process with the new venues. Unbudgeted staff resources for sourcing and supervision of expert meeting and convention planning independent contractors to assist with securing new contracts with an estimated expense of $25,000.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Debbie Smithey, CMP, CAE
Managing Director, Education Development

Toni McElhinney, CMP
Conventions & Meetings Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 18(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD

SUBJECT: Disclosure of Clinical Emergency Data Registry Revenue Sources

PURPOSE: Requests ACEP to provide information on the sources and amount of revenue for CEDR in the Treasurer's Report to the Council.

FISCAL IMPACT: None

WHEREAS, The membership of ACEP has a very negative view of the corporatization of emergency medicine based on the results of the 2021 ACEP Workforce Task Force survey and the collected experiences recently reported to the Department of Justice and the Federal Trade Commission by ACEP (letter to Lina Khan and Jonathan Kanter, April 20, 2022); and

WHEREAS, According to the 2021 Treasurer's report to the Council, ACEP receives significant revenue from "CEDR and Quality" ($4 million/12% of revenue); and

WHEREAS, The reputation and membership of the AMA has suffered greatly because of its high amount of non-dues income; and

WHEREAS, The membership of ACEP may view it as a conflict of interest for ACEP to be receiving significant income from private equity owned or backed ED staffing companies; therefore be it

RESOLVED, That information on the sources and amount of revenue for the Clinical Emergency Data Registry be disclosed in the Treasurer's report to the Council and to the membership.

Background:

This resolution requests ACEP to provide information on the sources and amount of revenue for the Clinical Emergency Data Registry (CEDR) in the Treasurer's Report to the Council

ACEP's Quality Department was started in 2013 to address emerging policy issues and threats to physician reimbursement based on pay-for-performance and value-based purchasing programs, such as, Medicare and CHIP Reauthorization Act (MACRA) of 2014. CEDR was launched in 2015 to support ACEP members and other emergency physicians fulfill data needs for reporting Merit-based Incentive Payment System (MIPS) to CMS, as well as Improvement in Medical Practice (IMP) attestations to ABEM. In 2020, 56% of CEDR physician participants were ACEP members, representing approximately 28% of ACEP members eligible to participate. Even in the face of challenges to the MIPS program due to COVID-19, such as federal waivers and the lean bonus potential, 75% of ED clinicians received a large enough bonus to cover their fees for participation in the CEDR program, and 45% did so well that the bonus also covered their cost of ACEP membership. Moreover, 19% scored a perfect MIPS score of 100 points, resulting in an estimated $1,686 bonus for each physician.

The Board of Directors has approved significant investments in the development of quality programs and products, such as CEDR, quality measures, and quality improvement initiatives, such as the Emergency Quality Network (E-QUAL). ACEP's Quality Division has strived to be fiscally self-sustaining through generation of revenue to recover part of the ongoing costs. The program, however, has required an ongoing infusion of capital investment, largely

because of the complexity of extracting data from systems often beyond the control of the independent physician group, such as the collection of clinical data from the hospital's electronic health record.

Over the past 7 years, the maturation of the Quality Division has led to the successful procurement of quality improvement program grants through support from both government and private foundations. A significant portion of $4 million in revenue is obtained through grants and the remaining portion comes from CEDR operational revenue. CEDR is primarily focused on small and medium independent democratic groups and rural and critical access hospital based emergency departments. Most of the large groups, including those backed by private equity, have their own Qualified Clinical Data Registry (QCDR) or QualiFIED Registry (QR) or Data Warehouse and have shied away from subscribing to CEDR.

Every CEDR customer executes a Participation Agreement, as well as a Business Associate and Data Use Agreement, which contains confidentiality provisions requiring the parties request and receive written permission from the other prior to disclosing details of the contract, including the name of the customer and fees paid to the Registry. This is a standard contract provision and protects each party from unauthorized use of their name, likeness, and private financial information. As such, ACEP would need to obtain authorization from each customer before publishing any information about its participation in CEDR, including, but not limited to, announcements regarding usage of the Registry and amounts paid by the group.

ACEP Strategic Plan Reference

Resources and Accountability – ACEP commits to financially disciplined and modern processes and a culture that aligns sufficient and transparent stewardship of resources to strategic priorities most relevant to members and essential for the future of emergency medicine.

- Develop alternative/non-traditional revenue and in-kind sources and opportunities to achieve our strategic priorities.

Fiscal Impact

None

Prior Council Action

None

Prior Board Action

None that is specific to releasing CEDR revenue sources to the Council.

Background Information Prepared by: Pawan Goyal, MD, MHA, PMP, CBA, CPHIMS, CHIP, FAMIA, FHIMSS, FAHIMA, Fellow NLM
Senior Vice President, Quality

Leslie Patterson Moore, JD
Senior Vice President, General Counsel

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 19(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD
Charles Pattavina, MD, FACEP

SUBJECT: Due Process and Interaction with ACEP

PURPOSE: 1) 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 or waivers of due process for emergency physicians; and 2) create a method for members to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying such that are of concern, and to investigate the matter allowing the entity an opportunity to respond or modify its policy prior to exclusion for violation of this policy.

FISCAL IMPACT: Unbudgeted and unknown costs to create a method to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying due process, and investigate allegations. Costs could be considerable depending on the scope. Potential significant legal expenses to respond to lawsuits against ACEP for such actions. Should a plaintiff prevail in such litigation, they would be eligible for treble damages, cost of suit and attorney's fees. Potential significant reduction in advertising, exhibit and sponsorship revenue for all ACEP activities and programs.

WHEREAS, It has been demonstrated in the American College of Emergency Physicians ("ACEP") report to the Federal Trade Commission ("FTC") and U.S. Department of Justice ("DOJ") regarding mergers dated April 20, 2022 that, despite an ACEP policy in favor of due process, many ACEP members are denied due process as it pertains to their ability to see patients in the emergency department ("ED"); and

WHEREAS, The voluntary database created in response to the 2020 Resolutions on Due Process, intended to allow members to understand which entities offer due process, has been of no practical use to the members in this area; and

WHEREAS, The denial of due process is often achieved by requiring a physician, for example, by contractual agreement, to automatically give up their rights to a fair hearing outlined in the Medical Staff Bylaws when terminated by the entity holding the exclusive contract for emergency services at a relevant facility; and

WHEREAS, Hospital administrators can request or pressure the entity holding the exclusive contract for emergency services to terminate an emergency physician thus avoiding the existing Joint Commission and other hospital accrediting bodies' prohibitions on such administrative interference with the Medical Staff Bylaws and responsibilities, and

WHEREAS, Due process is considered a fundamental right that is essential to allow the physician to act in the best interest of the patient; and

WHEREAS, The literature, ACEP's member input in the aforementioned report to the FTC/DOJ, and recent anecdotal examples during the pandemic confirm that emergency physicians can be terminated for speaking up regarding the quality of care and patient safety; and

WHEREAS, The FTC in 2004 (see 8/30/04 letter of Jeffery W. Brennan to Alvin Dunn, Esq.) stated in response to antitrust concerns raised by ACEP, that ACEP could respond to "behavior of market participants that it believes are detrimental to its members or the public;" and

WHEREAS, The denial of due process is detrimental to ACEP members and the public; therefore, be it

RESOLVED, That ACEP adopt this policy: "Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support, or otherwise be associated with the ACEP, as of January 1, 2023, shall remove all contractual restrictions on or waivers of due process for emergency physicians. Physicians cannot be asked to waive this right as it can be detrimental to the quality and safety of patient care. The entities affected include but are not limited to physician group practices, hospitals and staffing companies."; and be it further

RESOLVED, That ACEP create a method for members to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying such that are of concern, and to investigate the matter allowing the entity an opportunity to respond or modify its policy prior to exclusion for violation of this policy.

References

1. Weiss LD. AAEM White Paper on Due Process Rights for Physicians. J Emerg Med 2007; 33:439-40.
2. McNamara RM, Beier K, Blumstein H, Weiss LD, Wood J. A survey of emergency physicians regarding due process, financial pressures and the ability to advocate for patients. J Emerg Med 2013; 45: 111-116
3. ACEP comments to FTC/DOJ: https://www.acep.org/globalassets/acep-response-to-ftc-and-doj-rfi-on-merger-guidelines-04.20.22.pdf
4. Seattle Times article on Dr. Ming Lin https://www.seattletimes.com/seattle-news/health/er-doctor-who-criticized-bellingham-hospitals-coronavirus-protections-has-been-fired/

Background

This resolution requests ACEP to 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 or waivers of due process for emergency physicians; and create a method for members to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying such that are of concern, and to investigate the matter allowing the entity an opportunity to respond or modify its policy prior to exclusion for violation of this policy.

There is not one universally accepted standard for what constitutes due process. If the resolution is adopted, a detailed definition will need to be developed and advertised to fully inform the membership and stakeholder organizations about the new obligations, and ultimately to determine compliance.

It should be noted that The Joint Commission (TJC) standard on due process is limited to a requirement that the hospital makes the practitioner aware of available due process for adverse privileging decisions. There are no TJC requirements related to due process specific to employment. Specifically, Section 10.01.01 of its Medical Staff Standards dictates that "There are mechanisms, including a fair hearing and appeal process, for addressing adverse decisions regarding reappointment, denial, reduction, suspension or revocation of privileges that may relate to quality of care, treatment, and services issues." Additionally, the Health Care Quality Improvement Act of 1986 includes a provision that members of a professional review body are not shielded from liability for their professional review actions if they do not ensure due process for the physician facing that action.

The first resolved of this resolution is almost the exact language of the last resolved of Referred Amended Resolution 44(20) Due Process in Emergency Medicine. In response to the 2020 referred resolution, ACEP Board members have been reaching out to members and offering their time and resources to better understand and guide ACEP's actions to fully address the intent of the referred resolution. Throughout the year, members of the Board spoke with numerous individuals who had been fired, taken off the schedule, transferred to other sites, or otherwise impacted by terms of their contracts. These conversations confirmed these actions were happening across all employment models, from large corporate groups to small democratic groups and academic groups. There were also situations where due process protections were in place with an employer and physicians still lost hospital privileges and were removed from the schedule at the request of the hospital CEO.

ACEP's General Counsel engaged Powers, Pyles, Sutter & Veville, P.C. (a legal firm with specialized expertise in healthcare and representation of nonprofit organizations) as outside counsel to review Referred Amended Resolution 44(20) and provide a third-party outside legal opinion on the anti-trust risk to ACEP to carry out the resolution as written. The opinion was presented to the Board of Directors in June 2021 with available case law and previous legal opinions shared on this matter. It was the recommendation of outside counsel that the findings of all four available legal opinions were consistent and clearly demonstrated a substantial risk to carrying out the resolution as written. However, suggestions were made by general and outside counsel that meet the intent of the resolution. Specifically, ACEP could seek to obtain non-competitive information from all emergency physician-employing entities who are exhibitors, advertisers, and sponsors of ACEP meetings and products with the intent to increase transparency and demonstrate an employer's adherence to key ACEP policy statements.

ACEP leadership and staff developed contracting and employment resources on the ACEP website to assist members and develop requirements for increasing transparency among members and entities that employ emergency physicians regarding adherence to ACEP policy statements. There are dozens of pages of resources on the ACEP website dedicated to the topics of Employment Contracts and other practice and legal issues, as well as a growing set of resources from ACEP's Democratic Group Practice section. In an effort to better support all members as they face unprecedented challenges in hiring, ACEP staff embarked on a process to update, curate and develop educational and other assets into a complete set of resources designed to educate and empower physicians, at any point in their career, to more knowledgeably evaluate contract terms and pushback on unfair business practices, regardless of employment model or practice type. To supplement this, the Medical-Legal Committee developed a new contract resource, a checklist of "Key Considerations in an Emergency Medicine Employment Contract." The checklist is available on the EMRA website and the ACEP website in the Medical-Legal Resources. Additionally, for just $15 per year, all ACEP members currently have access to legal and financial support assistance through an affinity program with Mines & Associates, our wellness and counseling partner. This service includes a 30-minute in-person consultation for each individual legal matter, a 30-minute telephone consultation per financial matter, and 25% discount on select legal and financial services all with MINES network of legal and financial professionals. Under the category of Business Legal Services, this includes advice, consultation and representation regarding contracts, incorporation, partnerships, and other commercial activities.

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."

Despite efforts to ensure physicians are accorded due process related to actions that may negatively impact their medical staff privileges, physicians are not always assured due process in actual practice. The aforementioned PREP notes that "frequently emergency physicians have been forced to waive due process rights." Hospitals may ask physicians to waive their due process rights as part of the employment agreement or award staffing contracts only to groups that require their physicians to waive their rights to due process.

ACEP's policy statement "Emergency Physician Rights and Responsibilities" addresses the due process issue, stating in part:

7. Emergency physicians should be provided access to timely quality and other performance metrics.
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. 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.

For several years, ACEP has informed, helped draft, and advocated for legislation to support due process for emergency physicians. In fact, due process protections were one of ACEP's three key issues at the 2022 Leadership & Advocacy Conference (LAC) in Washington, DC, with advocates going to Capitol Hill to promote the concept and urge reintroduction of the revised "ER Hero and Patient Safety Act," legislation previously introduced in the 116th Congress by Representative (now Senator) Roger Marshall, MD (R-KS) and Raul Ruiz, MD (D-CA). Due process protections remain a key federal legislative priority for the College, and ACEP continues working with legislators in both the House and Senate to secure bipartisan sponsors prior to introduction of the bill for the current 117th Congress. Additionally, ACEP has urged the Senate Health, Education, Labor, and Pensions (HELP) Committee to include Sen. Marshall's due process legislation in the committee's mental health package, given the relationship of due process rights to emergency physician job satisfaction and stress and burnout, and continues working to identify any opportunities to include this provision in a larger legislative package.

As part of the recent workforce initiative, ACEP leadership began meeting with the leadership of large employer groups to have open conversations about the state of the workforce and share feedback from our members. ACEP is sharing data on member perceptions of career satisfaction, which includes concerns about billing transparency, and encouraging groups to discuss these concerns with their physicians. As a direct result of one of these conversation, an employer group agreed to change a policy in order to adhere to ACEP's recommended standards.

Like many professional associations, ACEP provides venues for competitors to communicate with its members such as exhibiting at meetings, sponsoring events, and advertising in publications. While some court decisions allow associations to offer or deny access to these venues on arbitrary grounds, there is also case law holding that a denial of essential means of competition may be made the basis for antitrust challenges against associations. Since ACEP is the oldest and largest association of emergency physicians and its *Scientific Assembly* is the largest emergency medicine meeting in the world, excluding certain competitors from these venues could have a significant, adverse impact on those competitors' ability to compete and could result in antitrust litigation filed against ACEP.

ACEP's "Antitrust" policy statement states: "The College is not organized to and may not play any role in the competitive decisions of its member 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 policy further specifies:

- There will be no discussions discouraging or withholding patronage or services from, or encouraging exclusive dealing with any health care provider or group of health care providers…
- There will be no discussions about restricting, limiting, prohibiting, or sanctioning advertising or solicitation that is not false, misleading, deceptive, or directly competitive with College products or services.
- There will be no discussions about discouraging entry into or competition in any segment of the health care market.

- There will be no discussions about whether the practices of any member, actual or potential competitor, or other person are unethical or anti-competitive, unless the discussions or complaints follow the prescribed due process provisions of the College's Bylaws.

As referenced in the Whereas statement, in 2004, ACEP sought and received an Advisory Opinion from the Federal Trade Commission (FTC) regarding issues raised in two Council resolutions referred to the Board in 2003. The resolutions were 17(03) Certificate of Compliance and 18(03) Intention to Bid for a Group Contract. Resolution 17(03) desired to require emergency medicine staffing groups to sign a certificate and comply with its terms as a prerequisite for their participation as an exhibitor or sponsor of any College activity. One of the terms included was that groups must confirm that "with the provision period not to exceed one year, our physician group provides our emergency physicians access to predefined due process." Other provisions of the certificate included certification that groups provide their physicians a predefined and reasonable pathway to full partnership, that they do not impose post-contractual restrictive covenants, and that the group is wholly owned by practicing physicians. While the FTC Advisory Opinion noted that ACEP could respond to "behavior of market participants that it believes are detrimental to its members or the public," it raised a number of potential antitrust concerns about actions contemplated by both resolutions. Regarding Resolution 17(03), the Advisory Opinion stated that "an agreement among ACEP members to affiliate only with entities that adopted all of the business practices listed in the proposed Resolution would be highly suspect." It also stated that "agreements among ACEP members not to do business except on the terms contained in the Resolution, or a direct ACEP prohibition of its members' accepting employment on non-conforming terms, would raise serious antitrust concerns." The Advisory Opinion also stated that "ACEP may not unreasonably restrict competition among its members in order to force all contractual relationships between emergency physicians and holders of contracts to provide emergency services to hospitals into its preferred model."

Approximately 19% of all corporate support ACEP received in FY 2021-22 was derived from physician groups, staffing companies, and hospitals/clinics. Combined, they contributed $541,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities. Further, ACEP uses advertising to promote employment opportunities, affinity partnerships, member benefits and resources in various channels, including our job board www.emcareers.org, our monthly publication *ACEP Now*, digital advertising in our e-newsletters and more. Prohibiting these types of agreements would eliminate funding used to offset the cost of key member benefits, including the *Annals of Emergency Medicine*, *ACEP Now,* and member counseling services and limit member access to employment opportunities and resources.

The second resolved would require ACEP to create and implement a means of investigating individual alleged offenses, responding to complaints of noncompliance, gathering evidence, and conducting fair and impartial hearings to provide due process to the accused entity. The College would also be required to impose a similar process to determine whether it should refuse or accept advertising, sponsorship, or offer to exhibit from an individual or group. It is possible that the filing of charges against a corporate entity and the potential sanction required by this process could be used as a tool by the company's competitors to discredit or limit the effectiveness of their competition.

Taking enforcement action to deny an entity's ability to exhibit, sponsor, or advertise with ACEP may create additional potential liability risk for ACEP. Excluding an entity from being able to advertise in or sponsor any ACEP activity could subject the College to a claim of restraint of trade or business defamation. Should a court decide that the procompetitive justifications for these actions do not justify the potential anti-competitive effects and therefore conclude that the actions violate Federal law (specifically the Sherman Act, 15 U.S.C. §§1,2) governmental sanctions may result in civil penalties of up to $100 million for businesses or $1 million for individuals, and criminal penalties of up to ten years. The government can also seek injunctive relief to stop an organization from engaging in a potentially unlawful activity. Should ACEP face a lawsuit from an entity that believes it has been unfairly excluded from a College activity, should they prevail, they may be eligible to recover treble damages (three times the amount of actual financial damages as proven by the plaintiff), costs of suit, as well as attorneys' fees. Such challenges can be mitigated by developing and adhering to strict processes.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing

their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local

Fiscal Impact

Unbudgeted and unknown costs to create a method to report incidents of denial of due process, review member-submitted contractual clauses or other methods of denying due process, and investigate allegations. Costs could be significant depending on the scope. Potential significant legal expenses to respond to complaints against ACEP for such actions. Potential significant reduction in outside funding support.

Prior Council Action

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors.

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. 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 the American Hospital Association, the American College of Health Care Executives and other entities.

Resolution 18(03) Intention to Bid for Group Contracts referred to the Board of Directors. The resolution called for ACEP to require member to abide by a policy regarding "Duty to Inform Other ACEP Members of Intention to Bid for Their ED Group Contract."

Resolution 17(03) Certificate of Compliance referred to the Board of Directors. 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."

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.

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 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 38(90) Due Process Rights of Hospital Based Physicians not adopted. The resolution called for ACEP to work with The Joint Commission on the Accreditation of Hospital Organizations (now The Joint Commission) to develop standards to protect due process rights of hospital-based physicians.

Prior Board Action

June 2021, discussed with outside legal counsel the implications of Referred Amended Resolution 44(20) Due Process in Emergency Medicine.

April 2021, approved the revied 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 2021, April 2008 and July 2001; originally approved September 2000

January 2021, directed the Emergency Medicine Practice Committee and the Medical-Legal Committee, with support from ACEP's General Counsel, to review and provide a recommendation regarding further action on the resolution.

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.

January 2019, reaffirmed the policy statement "Antitrust;" reaffirmed June 2013 and October 2007; revised and approved October 2001; originally approved June 1996 replacing a policy statement with the same title that was approved in April 1994.

September 2018, approved the policy statement "Due Process for Physician Medical Directors of Emergency Medical Services."

July 2018, reviewed the PREP "Emergency Physician Contractual Relationships" as an adjunct to the policy statement "Emergency Physician Contractual Relationships."

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.

September 2003, approved the submission of the request for an FTC Advisory Opinion

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: Mollie Pillman, MBA, CAE
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Leslie Moore, JD
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Jana Nelson
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Laura Wooster, MPH
Senior Vice President, Advocacy & Practice Affairs

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 20(22)

SUBMITTED BY: Deborah Fletcher, MD, FACEP
Jamie Hoitien Do Kuo, MD

SUBJECT: Expert Consultation for Employee Contracts

PURPOSE: Provide legal education, expert consultation, and document review for new graduates who are actively negotiating employment contracts.

FISCAL IMPACT: Possibilities range from partnership with third party services or establishing a volunteer pool (low/no cost), to contracting with attorney services and paying the fee for individual contract review directly or through an established grant fund (up to $3.5 million).

WHEREAS, All physician jobs require contracts with hospitals or contract medical groups; and

WHEREAS, Physicians receive little to no education or training in contract negotiations; and

WHEREAS, Physicians may misunderstand contract details; and

WHEREAS, Physicians may enter undesirable contracts including wages below fair market value, non-compete clauses, requirements to supervise non-physician providers, and so on; and

WHEREAS, Physicians would benefit from expert consultation; therefore be it

RESOLVED, That ACEP provide, as a member benefit at no charge, legal education, expert consultation, and document review for new graduates who are actively negotiating employment contracts.

Background

This resolution calls for ACEP to provide, as a member benefit at no charge, legal education, expert consultation, and document review for new graduates who are actively negotiating employment contracts.

ACEP recognizes the importance of equipping all emergency medicine physicians, especially those new to practice, with the resources and tools needed to ensure that any potential contracts they consider include fair compensation and benefits, and protection for themselves and their patients during the course of medical practice. There is a growing number of resources available on the ACEP website dedicated to the topics of employment contracts and other practice and legal issues, including a checklist to negotiate the best contract and an on-demand course on standard contract precautions. The site also includes a list of local attorneys available to review contracts and assist with other legal matters.

In an effort to better support all members as they face unprecedented challenges in hiring, ACEP Membership and Practice Affairs staff embarked on a process to update, curate, and develop educational and other assets into a complete set of resources designed to educate and empower physicians, at any point in their career, to more knowledgeably evaluate contract terms and pushback on unfair business practices, regardless of employment model or practice type. To supplement this, the Medical-Legal Committee developed a new contract resource, a checklist of "Key Considerations in an Emergency Medicine Employment Contract." The checklist is available on the ACEP website in the Medical-Legal Resources area.

ACEP's General Counsel and other College staff cannot directly offer legal advice to chapters or individual members. Action of this type could create an attorney-client relationship, which could create both a conflict of interest and potential liability issues, as well as endangering ACEP's insurance coverage. Currently, all ACEP members have access to legal and financial support assistance through an affinity program with Mines & Associates, our wellness and counseling partner. This service includes unlimited 30-minute in-person consultation for each individual legal matter, a 30-minute telephone consultation per financial matter, and 25% discount on select legal and financial services all with MINES network legal and financial professionals. Under the category of Business Legal Services, this includes advice, consultation and representation regarding contracts, incorporation, partnerships, and other commercial activities. These services cost members $15.00 annually.

ACEP staff have been investigating options to provide additional contract review and consultation for ACEP members as they transition into practice and throughout their careers. The College has not made any determinations regarding the viability of the options; however, some under consideration, which are not mutually exclusive, include:

1. Partnering with a specialized third-party service to provide ACEP members with discounts on physician contract review services and compensation data;
2. ACEP partnership with an individual or network of recommended attorneys who could review member contracts in a limited format upon request;
3. Establishing a team of experienced ACEP member volunteers/mentors willing to assist early career and other job-seeking physicians with reviewing and negotiating contract terms, provided sufficient parameters are in place to manage risk, protect the College and its volunteers; or
4. Establishing a grant program or fund providing an avenue for ACEP members to apply for financial support which could be used for early-career contract review or for specific emergent legal needs as they arise throughout the member's career.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Implement practical solutions to provide mental wellness and resiliency support for members to manage legal, emotional, and physical challenges.
- Create and disseminate the standards, best practices and policies impacting career fulfillment required to have sustainable, well workplaces for emergency physicians.
- Place ACEP in the center of providing career fulfillment and wellness, revising recruitment or retention tools to emphasize "What will ACEP do for me?"

Fiscal Impact

The fiscal impact of each of the options outlined is approximated below.

Program Option	**Estimated Fiscal Impact**
Partnering with a specialized third-party service to provide ACEP members with discounts	Negotiations would result in 10-20% discount to ACEP members in exchange for promotion through ACEP channels. There would be minimal cost to ACEP for promoting this opportunity.
Contracting with an individual or network of recommended attorneys to pay the fees for contract review upon request	Estimated attorney fees for review and advisement on a single employment contract run from $1,000 to $1,500 (legal representation of the physician to the employer would be at additional cost). If each graduating resident (2,436 total) were to utilize this service individually during the fiscal year, the cost to ACEP would likely be between $2.5 million and $3.5 million. ACEP would likely be able to negotiate a discounted rate, but this would still constitute a substantial expense to the College.

Establishing a community of experienced ACEP member volunteers/mentors	This option would be low financial cost to ACEP but would require the valuable time of a strong network of volunteers and sufficient legal precautions to protect all parties.
Establishing a grant program or fund which would allow ACEP members to apply for financial support for career legal services	The cost to establish a fund would be determined by the number and amount of grants that ACEP planned to provide.

Prior Council Action

Resolution 17(21) Fair Emergency Physician Employment Contract Template not adopted. The resolution requested that ACEP develop sample contracts for employees and independent contractors to ensure members are effective and educated self-advocates when considering potential employment opportunities.

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.

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

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.

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 Clauses and 54(94) Due Process.

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

Background Information Prepared by: Mollie Pillman, MS, MBA, CAE
Senior Vice President, Member Engagement

Leslie Moore, JD
Senior Vice President, General Counsel

Jana Nelson
Senior Vice President, Communications

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 21(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD
Charles Pattavina, MD, FACEP

SUBJECT: Financial Support of Litigation Involving the Corporate Practice of Medicine in California

PURPOSE: Requests ACEP to donate $1 million from members' equity to the American Academy of Emergency Medicine Foundation to support the American Academy of Emergency Medicine – Physician Group litigation versus Envision.

FISCAL IMPACT: $1,000,000

WHEREAS, A significant number of the nation's emergency departments ("EDs") are controlled by one or more staffing companies with private equity backing or ownership; and

WHEREAS, Optum, a subsidiary of the United Healthcare, an insurer, through Sound Physicians, has significant ownership of emergency medicine practices; and

WHEREAS, The Corporate Practice of Medicine (CPOM) doctrine exists in many states intended to keep the business interest out of the physician-patient relationship; and

WHEREAS, The CPOM doctrine has as its main purpose the protection of patients and the avoidance of the commercialization of the practice of medicine; and

WHEREAS, On March 25, 2022, ACEP filed an amicus brief in support of the American Academy of Emergency Medicine – Physician Group (AAEM-PG) litigation against Envision that addresses CPOM in California; and

WHEREAS, A favorable ruling was issued by the United States District Court for the Northern District of California Federal Court on May 27, 2022, that denied the Motion to Dismiss in the litigation and allowed the claims made by the AAEM-PG regarding CPOM to proceed further; and

WHEREAS, The membership of ACEP has a very negative view of the corporatization of EM based on the results of the 2021 ACEP Workforce Task Force survey and the collected experiences recently reported to the DOJ and FTC by ACEP (letter to Lina Khan and Jonathan Kanter, 4/20/2022); and

WHEREAS, ACEP has detailed the grave threats to emergency medicine posed by private equity and corporate involvement in its April 18, 2022, Statement on Private Equity and Corporate Investment in Emergency Medicine; and

WHEREAS, The members of ACEP in California and likely other states would reap significant benefit if the AAEM-PG is successful in this litigation; and

WHEREAS, The legal costs for this litigation are expected to be in excess of $2 million; and

WHEREAS, ACEP has a substantial amount of funds as members' equity; therefore be it

RESOLVED, That ACEP directly support the American Academy of Emergency Medicine – Physician Group litigation versus Envision by a donation of $1 million of the members' equity to the American Academy of Emergency Medicine Foundation.

References

1. Denial of Motion to Dismiss: https://www.aaem.org/UserFiles/file/USDCDoc47.pdf
2. https://www.acep.org/globalassets/sites/acep/media/acep-newsroom-images/2022.03.25-filed-acep-amicus-brief.pdf
3. https://www.acep.org/globalassets/acep-response-to-ftc-and-doj-rfi-on-merger-guidelines-04.20.22.pdf
4. https://www.acep.org/administration/physician-autonomy/acep-statement-on-private-equity-and-corporate-investment-in-emergency-medicine/

Background

This resolution requests ACEP to donate $1 million from members' equity to the American Academy of Emergency Medicine Foundation to support the American Academy of Emergency Medicine Physician Group's (AAEMPG) lawsuit against Envision Healthcare, Inc.

AAEM-PG filed suit against Envision on December 2021 and shortly thereafter, ACEP published a statement supporting AAEM-PG's stance on physician autonomy as demonstrated by the lawsuit. ACEP then filed an amicus brief in the case on March 25, 2022. The brief sought to educate the Court on the critical importance of upholding the sanctity of physicians' duties to their patients and the significance of allowing them to practice medicine without undue pressure from outside forces. As the largest and most influential medical society in emergency medicine, ACEP represented our more than 38,000 members in this effort to assert the physician's right to autonomy in medical decision-making. EMRA also filed a Declaration of Interest in support of the ACEP position.

Although the plaintiff raised several issues in its complaint, the ACEP brief focused on the corporate practice of medicine doctrine and asserted:

> *The principle of putting patients over profits is the bedrock of our nation's healthcare system. This principle is preserved by ensuring clinical treatment decisions are made exclusively by physicians. ACEP recognizes the potential efficiencies associated with larger practice sizes and counts among its members many physicians practicing in large groups, including some backed by private equity investment. However, ACEP also recognizes that unregulated corporate involvement in medicine may threaten physician autonomy and adversely impact quality of care. ACEP strongly believes that, regardless of structure, physicians must focus primarily on patient care and never prioritize profits over patients.*

The brief further asserted:

> *The foundational principle of CPOM is that medical decisions should be made by physicians and any structure that prevents this should be prohibited. Should the Court decide to hear this case, the Court's decision should be guided by this foundational principle.*

The Board of Directors also approved the ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine on April 6, 2022, reaffirming ACEP's core values and emphasizing the physician-patient relationship as the moral center of medicine.

The ACEP Legal Activity Guidelines (Guidelines) provides the criteria in determining issues that merit ACEP's legal involvement. The Guidelines (Attachment A) specifically require that legal expenditures "will be authorized by the Board of Directors, or, in time sensitive matters, by ACEP's president, with notification to the Board of Directors. A member or chapter seeking approval for activities or expenditures must make a written request to the Board of Directors, setting forth in detail the reasons for and significance of the matter to the specialty of emergency medicine, and the action or activity desired. The executive director of the College, in consultation with the general counsel, will

review and evaluate the request in accordance with this policy, and make a recommendation to the Board of Directors or president, as appropriate." The Guidelines further set forth questions that should be analyzed by the individual or chapter in their written request to the Board.

It should be noted that AAEM has not requested ACEP's participation in the lawsuit as a co-plaintiff. As ACEP is not a party to the lawsuit, it has no authority to make critical decisions in the case or contribute to strategic discussions. AAEM's request also does not provide an estimated budget for the litigation but rather only asks that funds be donated to its foundation.

ACEP member equity is the cumulative net earnings of the organization since its inception and is reported on ACEP's financial balance sheet. Liquid reserve, a subset of equity, is the amount of equity (available in cash and investments) that is available for contingencies after the provision for investment in fixed and other assets plus working capital. The ACEP Financial Compendium states that the member equity balance shall be no less than 30% of the total annual operating expense budget and that the liquid reserve balance shall be no less than 15% of the total annual operating expense budget. Based on the FY 2022-23 operating budget, the minimum required balance is approximately $12 million for equity and $6 million to ensure there are adequate funds in reserve to maintain operations in the event of unforeseen circumstances. The current unrestricted member equity balance is $22.1 million and includes $1.8 million of unrealized gains/losses.

Several mechanisms exist for the spending of unrestricted member equity. The Finance Committee may recommend a deficit budget or budget modification in response to the long-term directives and strategic plan established for ACEP. ACEP recently launched a new strategic plan that requires investing a portion of member equity in infrastructure and technology to support a more personalized, proactive, and exceptional experience for members. In the current fiscal year, ACEP is using $1.2 million of member equity to implement the first year of the strategic plan. Over the next five years, this financial investment will result in a measurable decrease in the member equity balance. Reserves of up to $500,000 per year may be utilized to support the financial startup and creation of new and innovative opportunities that allow ACEP to grow and advance its mission but that may be cost prohibitive within the ACEP operational budget. The guidelines for the Strategic Project Initiatives (SPI) program are contained in the Compendium of Financial Policies and Operational Guidelines. Initiatives that were approved for funding from member equity through the SPI program include the development of the Acute Unscheduled Care Model, redesign of the PEER program, development and launch of the Pain & Addiction Care in the ED (PACED) accreditation program, and quality measures development and depreciation. Additionally, in early 2022, the Board approved a $3.4 million investment from equity over the next three years to establish the Emergency Medicine Data Institute (EMDI).

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

$1,000,000

Prior Council Action

Amended Resolution 52(20) The Corporate Practice of Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) prepare a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine and fee splitting in each state and the results of this review will be compiled into a resource and announced to members as an available electronic download; 2) adopt as policy: "ACEP, in concert with its relevant component state chapter, in those states where there are existing prohibitions on the corporate practice of medicine,

will provide assistance to physician owned groups who are threatened with contract loss to a corporate entity or to hospital employed physicians whose site will be taken over by a corporate entity by providing, upon request, a written review of the legality of the corporation obtaining the contract for emergency services."; 3) in those states that are found to have existing prohibitions on the corporate practice of medicine, along with the relevant state chapter, petition the appropriate authorities in that state to examine the corporate practice of emergency medicine if such is believed to occur within that state and ACEP will reach out to the state professional societies to solicit the support of the state medical society; and 4) work with the American Medical Association to convene a meeting with representatives of physician professional associations representing specialties and other stakeholders affected by the corporate practice of medicine, to ensure the autonomy of physician owned groups or hospital employed physicians contracting with corporately-owned management service organizations.

Prior Board Action

April 2022, approved the "ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine."

January 2022, approved filing a brief in the AAEM-PG vs. Envision lawsuit.

September 2021, approved actions regarding Referred Amended Resolution 52(20) The Corporate Practice of Medicine.

April 2009, approved the revised "Legal Activity Guidelines," reaffirmed May 1997; originally approved November 1987.

Background Information Prepared by: Leslie Patterson Moore, JD
Senior Vice President, General Counsel

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

American College of Emergency Physicians®
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LEGAL ACTIVITY GUIDELINES

The American College of Emergency Physicians (ACEP) may elect, at the request of a chapter or a member or on its own initiative, to participate in a legal matter, including litigation, which promotes the common business interests of the members of the College and is directed toward the improvement of the profession of emergency medicine. In the course of any such activity, the College will not perform particular services for individual persons.

Participation by the College may take the form of monitoring potential or actual legal actions, providing legal advice or legal counsel, appearing as *amicus curiae*, intervening in or initiating litigation or other legal activity as may be appropriate.

College activities or expenditures pursuant to this policy will be authorized by the Board of Directors or, in time sensitive matters, by ACEP's president, with notification to the Board of Directors. A member or chapter seeking approval for activities or expenditures must make a written request to the Board of Directors, setting forth in detail the reasons for and significance of the matter to the specialty of emergency medicine, and the action or activity desired. The executive director of the College, in consultation with the general counsel, will review and evaluate the request in accordance with this policy, and make a recommendation to the Board of Directors or president, as appropriate.

An individual or chapter requesting action under this policy may be required to participate financially with the College. Approval for ACEP's participation will be for prospective activities and expenditures only, and will not be given for reimbursement of fees or expenses already incurred.

Criteria

The following criteria will serve as a guide in determining what issues merit legal involvement from ACEP:

1. Applicability of the issue to ACEP members
   - Is the issue national, regional, or local?
   - Does the issue affect all members?
   - Does the issue affect a segment of ACEP members with a significant role in emergency medicine (e.g., residency faculty, emergency department directors, EMS medical directors, etc.)?

2. Impact of this issue on emergency medicine practice or quality of care
   - How significant is the issue?
   - Is the issue long-term or ephemeral?

3. Uniqueness of ACEP's role
   - Is ACEP in a unique position to affect the outcome of this issue?
   - Will the issue be partially addressed by others, but ACEP is needed for the best outcome?
   - Are there other reliable, appropriate sources of influence?
   - Will the issue be resolved satisfactorily by others, if ACEP does not participate?

4. Support of ACEP priorities and purpose
   - Does the issue address one of the priority achievement strategies, desired states of emergency medicine, or purposes as outlined in ACEP's Bylaws?

5. Likelihood of positive outcome
   - How likely is it that ACEP's involvement will affect the issue in a positive way?

6. Consequences of negative outcome
   - If the outcome is negative, what are the consequences arising from ACEP's involvement?

Individuals or chapters requesting participation from ACEP in a legal matter should provide an analysis of how this issue addresses the questions posed above.

Amicus Curiae

The criteria stated above shall be applied to requests for ACEP's participation in *amicus curiae*. In addition to such requests from ACEP members and chapters, ACEP may also initiate the submission of an *amicus curiae* or consider requests from other entities to participate in *amicus curiae* that impact emergency medicine. All requests from other entities will be screened by the executive director and general counsel for the applicability of the criteria. If the executive director determines that the scope of the *amicus curiae* substantially meets the criteria, the general counsel will forward the request to the president for review with a recommendation that the request be assigned to the Medical-Legal Committee.

Upon the president's approval, the request will be forwarded to the Medical-Legal Committee for review and recommendation. Upon receipt of such recommendation, the president is authorized to determine whether or not ACEP files an *amicus curiae* and will report such submission to the Board. However, ACEP Board review and approval is required for any *amicus curiae* that is submitted on ACEP's behalf to the U.S. Supreme Court.

Revised and approved April 2009; reaffirmed May 1997; originally approved November 1987.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 22(22)

SUBMITTED BY: Jamie Hoitien Do Kuo, MD
Deborah Fletcher, MD, FACEP

SUBJECT: State Chapter Funding

PURPOSE: Requests national ACEP to return 10% of national dues to each chapter calculated by 0.1 x number of state dues-paying members every year.

FISCAL IMPACT: The high-level fiscal impact of returning 10% of national dues revenue to state chapters for advocacy would be $1,218,567.87. This number would change annually as dues revenue fluctuates. Additional unbudgeted staff resources would be required to administer a formal grant program or oversee accountability of spending the funds toward their dedicated purpose, as well as accounting for calculation and payment of the funds on a monthly or annual basis.

WHEREAS, Numerous topics that affect emergency medicine are regulated at the state level, including but not limited to scope of practice legislation and Medicaid funding and non-compete clauses; and

WHEREAS, States, especially smaller states, have limited funding from state ACEP fees to contribute to political action including lobbying, political action committees, fundraisers, and representation in state medical societies; and

WHEREAS, National ACEP supplies no funding to state chapters for state level legislation; and

WHEREAS, States would benefit from national level financial support so that states can more effectively represent emergency medicine; and

WHEREAS, ACEP's 2022 Strategic plan lists 5 themes including #1: Expand and strengthen the role and impact of state-level advocacy; and

WHEREAS, ACEP's 2022 Strategic plan lists 5 themes including #2: Standardize advocacy strategies and approach at the federal, state, and workplace level; and

WHEREAS, ACEP's 2022 Strategic plan lists 5 themes including #4: Identify, test, and adopt new fundraising strategies to support advocacy initiatives; and

WHEREAS, National ACEP financial support for state chapters for advocacy would demonstrate ACEP's commitment to its strategic plan; therefore be it

RESOLVED, That ACEP return 10% of national dues to each chapter calculated by 0.1 x number of state dues-paying members every year.

Background

This resolution requests national ACEP to return 10% of national dues to each chapter calculated by 0.1 x number of state dues-paying members every year

Late in 2021, ACEP's state government affairs function was moved from the Clinical Affairs line of service to the

Public Affairs line of service to ensure better alignment and coordination across ACEP's federal and state advocacy initiatives. Past state and federal advocacy efforts had, at times, been siloed and fragmented, leading to missed opportunities for stronger advocacy impact and victories.

Emergency physicians are increasingly impacted by issues (including scope of practice, Medicaid payment reforms, etc,) that are governed and regulated at the state level. A key focus of the advocacy pillar of ACEP's new Strategic Plan is devoted to strengthening and expanding the role and impact of state-level advocacy for the College.

Acknowledging the importance of these strategic changes in focus, and to ensure these changes translate into real-world advocacy impact and improvements for emergency medicine, ACEP has almost tripled funding in the budget allocated to state government affairs in this fiscal year as compared to last year. In addition to this funding, ACEP is expanding staffing resources dedicated to state government affairs. The lead position has been elevated to a senior director role and an additional FTE has been re-allocated to expand the team size, which will enable a more proactive strategic deployment for state-level advocacy and provide direct advocacy support to chapters, especially smaller chapters with limited financial and staff resources, to ensure they are equipped with advocacy tools and resources needed to maximize impact and results.

While this growth is still in process, recent new advocacy resources ACEP has developed for chapters have included a new scope of practice advocacy campaign toolkit with talking points, sample media op-eds, social media template posts, and infographics. Additionally, public-facing videos have been developed that encourage the public to ask for an emergency physician for their care.

ACEP's grassroots efforts (sending alerts and encouraging members to contact their legislators on a particular bill or issue) has been expanded beyond federal actions to include state-level actions. ACEP was able to offer chapters three options to leverage a new grassroots software resource: 1) ACEP can set up an action alert link for a chapter at any time that can be shared with members (complimentary) and provide detailed reports of actions taken by chapter advocates to targeted state legislators; 2) ACEP can highlight on our online Advocacy Action Center state-level alerts in addition to the existing federal (complimentary for chapters, with the fee for the add-on module paid for by national ACEP); and, 3) ACEP negotiated a discount for chapters to purchase their own software to allow them a full suite of tools and the ability to host alerts on their own website. Six chapters have moved ahead with this option. Later this fall ACEP will offer an educational session for chapters who might be considering starting their own state-level PAC to expand their advocacy reach. In addition, future programming for the Leadership & Advocacy Conference will now include an expanded focus on state policy issues and tools and tips for grassroots and political action.

Since 2006, ACEP has offered state public policy grants that chapters can apply for and the grants provide financial support to a chapter undertaking a particular public policy initiative as part of their advocacy strategy. The per-grant maximum a chapter can receive has ranged from $6,250 to $12,500 (depending on the level of total funding available in a given year). Grant criteria include demonstrating a significant chapter and member commitment to the public policy effort, including either a dollar-for-dollar match of chapter funds to the grant amount being sought from ACEP or the chapter may provide a substantial amount of in-kind services to support the project. Due to legal restrictions, the grant funding cannot be applied directly to hiring a lobbyist. The grant application can be found here. Past grant recipients have used the funds for campaigns, including to increase Medicaid reimbursement rates for emergency physicians, develop special liability protection under EMTALA, and on balance billing, however, in the last three years no chapter has submitted an application for funding despite the grant funds being available.

Last year ACEP made a significant financial commitment ($25,000 annual dues) in joining the AMA's Scope of Practice Partnership (SOPP), a coalition of 108 national, state, and specialty medical societies working to block legislation that would provide inappropriate expansion of the medical services and procedures non-physician health professionals are allowed to perform. The SOPP has awarded more than $2 million in grants to its members to fund advocacy tools and campaigns. ACEP is eligible to apply for a grant, as member of the SOPP, on behalf of a chapter for a campaign effort in a particular state.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and

levels, including federal, state, and local.

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

ACEP's annual dues revenue for Regular members for the previous fiscal year ending June 30, 2022, was $12,185,678.76. The high-level fiscal impact of returning 10% of national dues revenue to state chapters for advocacy would be $1,218,567.87 in expense added to the bottom line. This number would change slightly on an annual basis as dues revenue fluctuates. Additional unbudgeted staff resources would be required to administer a formal grant program or oversee accountability of spending the funds toward their dedicated purpose, as well as accounting for calculation and payment of the funds on a monthly or annual basis

Consideration should be given to whether there should be restrictions on how these funds are used, relation to PACs in states that have them, and any reporting requirements for accountability. Given the wide variation between chapters, it is possible that not all chapters will have the staff and/or volunteer capacity or the knowledge to use these funds effectively toward state advocacy efforts. There would be additional fiscal impact for staff time required to administer a formal grant program or oversee accountability of spending the funds toward their dedicated purpose, as well as accounting for calculation and payment of these funds on a monthly or annual basis.

ACEP does not have purview over or approval of the member dues rates set at the chapter level. States that wish to raise funds for advocacy initiatives could consider a variety of options which would allow them to allocate greater resources in that area. ACEP is willing to provide operational assistance or subject matter expertise with the establishment of PACs, volunteer committees, or other sustainable methods of increasing a chapter's ability to impact legislation.

Finally, the calculation suggested does not consider differences in dues rates between ACEP member categories and the corresponding amount paid to the chapter. For example, while Candidate members pay dues to ACEP, most do not pay dues for their state chapter (this does vary). Therefore, member count may not be the sole factor that might be considered in allocating rebates to the chapters. There are also members in the Retired, Life, Honorary, and International categories that pay different rates at the national and chapter levels. The exact method of calculating dues to be allocated to this purpose will still need to be refined.

Prior Council Action

None

Prior Board Action

January 2006, approved establishing the State Public Policy Grant Program.

Background Information Prepared by: Mollie Pillman, MS, MBA, CAE
Senior Vice President, Member Engagement

Chris Johnson
Senior Director, State Government Relations

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Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 23(22)

SUBMITTED BY: Young Physicians Section

SUBJECT: Study of Councillor Term Limits

PURPOSE: Requests the Council Steering Committee to study limits to the number of years individuals may serve in the Council and provide a report with recommendations by the 2024 Council meeting.

FISCAL IMPACT: Budgeted Council Steering Committee and staff resources.

WHEREAS, Council involvement is one of the many ways that members can get involved in the College; and

WHEREAS, Young physician retention has been a key focus of the Membership Committee and, per the annual reports, membership in physicians under the age of 50 has been declining, with that of members over the age of 50 having risen in the past few years[1,2]; and

WHEREAS, Some state chapters have already designated resident and young physician positions on their delegations to the ACEP Council; and

WHEREAS, Designated positions may be easier to accomplish in larger chapters, but are more challenging for smaller chapters; and

WHEREAS, Different lengths of experience in councillors add diversity to the opinions shared and discussion that occur during our Council meetings, including the addition of institutional knowledge from longer serving councillors; and

WHEREAS, Encouraging Council turnover will continue to broaden the diversity, equity, and inclusion goals of our Council and our organization; and

WHEREAS, The Steering Committee has organized a task force in the recent past to discuss limits on the size of the Council; therefore be it

RESOLVED, That the Council Steering Committee study limits to the number of years individuals may serve in the ACEP Council and report back to the Council with actionable recommendations by the 2024 Council meeting.

References

1. ACEP Annual Report 2020, https://www.acep.org/globalassets/sites/acep/media/about-acep/annual-report/acepannualreport2020.pdf
2. ACEP Annual Report 2021, https://www.acep.org/globalassets/sites/acep/media/annual-report/acep-annual-report.pdf

Background

This resolution requests the Council Steering Committee to study limits to the number of years individuals may serve in the Council and provide a report with recommendations by the 2024 Council meeting.

The ACEP Bylaws, Article VIII – Council (last sentence), specify that component bodies "shall elect or appoint councillors to terms not to exceed three years. Any limitations on consecutive terms are the prerogative of the

sponsoring body." Additionally, Article VIII – Council, Section 1 – Composition of the Council (last sentence), requires that "Councillors shall be elected or appointed from regular and candidate physician members in accordance with the governance documents or policies of their respective sponsoring bodies."

The Bylaws Committee has an ongoing objective to "review chapter bylaws per the Chapter Bylaws Review Plan." This review ensures conformity with the Model Chapter Bylaws and that there are no conflicts with national ACEP's Bylaws. The Model Chapter Bylaws provide a template and additional guidance for chapters to use when making changes to their Bylaws, including the stipulation that a single term for a councillor cannot exceed three years. However, in accordance with national ACEP Bylaws, chapters determine any limits on consecutive terms.

Each chapter's Bylaws include information on whether councillors and alternate councillors are elected or appointed and the duration of the term of office. Some councillors serve as elected members of the chapter's Board of Directors, or a Board officer, such as the president, serves as a councillor. The term of office for alternate councillors may be different than the term for councillors and some chapters may have councillors elected by the membership with alternate councillors elected by the Board or appointed by the president.

Currently, 6 chapters appoint councillors and alternate councillors, 35 chapters elect councillors and alternate councillors, and 12 chapters have a combination of elected and appointed councillors and alternate councillors.

ACEP's Section Operational Guidelines stipulate that "councillors and alternate councillors are elected positions and serve as officers of the section for a two-year term with the alternate becoming the councillor at the end of the two-year term. If unable to serve, the section must elect a member to fill both positions and resume normal progression from alternate councillor to councillor."

ACEP Strategic Plan Reference

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Budgeted Council Steering Committee and staff resources.

Prior Council Action

Resolution 6(10) Component Bodies and Councillor's Terms of Office adopted. This Bylaws amendment simplified provisions concerning component bodies and limited councillor terms of office to no more than three years.

Prior Board Action

October 2021, approved the revised Model Chapter Bylaws.

April 2008, approved the Sample Operational Guidelines for sections.

Resolution 6(10) Component Bodies and Councillor's Terms of Office adopted.

June 2010, approved cosponsoring Resolution 6(10) Component Bodies and Councillor's Terms of Office.

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

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2022 Council Meeting
Reference Committee Members

Reference Committee B – Advocacy & Public Policy
Resolutions 24-40

Abhi Mehrotra, MD, MBA, FACEP (NC) Chair
Erik Blutinger, MD, MSc (NY)
Angela P. Cornelius, MD, FACEP (TX)
Hilary E. Fairbrother, MD, FACEP (TX)
Puneet Gupta, MD, FACEP (CA)
Diana Nordlund, DO, JD, FACEP (MI)

Jeff Davis
Ryan McBride, MPP

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 24(22)

SUBMITTED BY: Michael Bresler, MD, FACEP
Valerie Norton, MD, FACEP
Lori Winston, MD, FACEP
California Chapter
Massachusetts College of Emergency Physicians

SUBJECT: Access to Reproductive Health Care Services

PURPOSE: That ACEP support nationwide access to a full array of reproductive health care options.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, The United States Supreme Court in *Dobbs v Jackson Women's Health Organization* has limited individuals' rights to receive some forms of health care; therefore be it

RESOLVED, That ACEP support nationwide access to a full array of reproductive health care options.

Resolution References

1. Harris LH, Grossman D. Complications of unsafe and self-managed abortion. N Engl J Med 2020;382:1029-40.
2. Tasset J, Harris LH. Harm reduction for abortion in the United States. Obstet Gynecol 2018;131:621-4.
3. Paltrow LM, Flavin J. Arrests of and forced interventions on pregnant women in the United States, 1973–2005: implications for women's legal status and public health. J Health Polit Policy Law 2013;38:299-343.
4. Myers C, Jones R, Upadhyay U. Predicted changes in abortion access and incidence in a post-Roe world. Contraception 2019;100: 367-73.

Background

The resolution directs the College to support nationwide access to a full[1] array of reproductive health care options.

The issue of access to and provision of prophylaxis, contraception, abortion, and other reproductive health measures is in a state of significant uncertainty as a result of the recent decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization*, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. As noted in the majority opinion by Justice Samuel Alito, the *Dobbs* decision is limited to the question of a "…constitutional right to abortion and no other right," and that "…[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion," such as *Griswold v. Connecticut* that established the right for married couples to purchase and use contraception. More simply, the *Dobbs* ruling is limited solely to the issue of abortion (termination of an established pregnancy) and not contraception or other reproductive health options.

As it does for other important emerging issues impacting emergency physicians and the care of emergency medicine patients, ACEP issued a statement in response to the *Dobbs* ruling expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship (as codified in the policy statement, "Interference in the Physician-Patient Relationship," approved by the Board of Directors in June 2022).

There is wide variation in state regulation of abortion and reproductive health procedures, including prohibitions on abortions in some states even in cases of rape, incest, or where the life or physical health of the pregnant patient is in danger, and some potential efforts to restrict access to or the provision of emergency contraception or other contraceptives. On July 26, when the Supreme Court took the procedural step to enter its judgment overturning *Roe v Wade*, the process began for some states to implement existing state statutes.

Under existing federal law (and in many cases, state laws), it may not be possible to fully guarantee universal access to emergency contraception in all emergency departments. Some physicians, pharmacists, other health care providers, and hospitals/facilities may choose not to administer or provide prophylaxis on moral or religious grounds, and these "conscience clauses" also prohibit discrimination against those who refuse to participate in such services. For example, many Catholic hospitals do not provide abortion, contraception, or sterilization procedures, including in cases of rape, though these policies are not all universal within such systems (e.g., the provision of contraception in cases of rape may be dependent on the policies of the local bishop).

With the legal landscape in flux, there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine and the provision of emergency reproductive health care. Some advocates have expressed concerns that this uncertainty may discourage physicians or hospitals from providing emergency contraception or other reproductive health care out of an abundance of caution to avoid potential legal exposure. ACEP recently joined amicus briefs addressing these issues. On August 15, 2022, ACEP along with the Idaho College of Emergency Physicians, submitted a brief in the U.S. District Court for the District of Idaho in support of in support of the U.S. Department of Justice's challenge to an Idaho law in *United States v. State of Idaho*. If applied to emergency medical care, the brief argued that Idaho Law would force physicians to disregard their patients' clinical presentations, their own medical expertise and training, and their obligations under EMTALA—or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services' guidance on the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). The brief explained that the Federal guidance merely restates physicians' obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

With respect to the issue of full[1] spectrum reproductive care, existing ACEP policy is succinct and limited to the issue of emergency contraception. The ACEP policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy," states in its entirety, "ACEP supports the availability of non-prescription emergency contraception." Prophylaxis and contraception are also discussed as a consideration in the guidelines established under the "Management of the Patient with the Complaint of Sexual Assault" policy, which states:

> "A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines. Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide these services in a timely fashion."

Another issue in the broader debate is the challenge of misconceptions which conflate contraceptives and abortion/abortifacients, though they are medically distinct (the former preventing pregnancy, the latter terminating an established pregnancy).

To this end, some have recently promoted efforts in multiple states to either fully prohibit or significantly restrict access to certain contraceptive options, such as Plan B One-Step (the "morning-after pill"), an emergency contraceptive which is used to prevent pregnancy after unprotected sex or a failure of other contraceptives, as well as intrauterine devices (IUDs) and others. For example, the organization Students for Life of America argues that Plan B can potentially prevent implantation of a fertilized egg (as noted on the packaging of Plan B), thus constituting an abortion under the view that life begins at conception. However, some OB/GYNs have noted this is "a hypothetical that has never been proven."

Ultimately, it is difficult to predict the range of hypothetical scenarios and individual considerations that may arise within EM, and further clarity may be needed from various authorities to address these potential circumstances. ACEP is also continuing to work its way through other associated issues, such as medical liability, privacy and security of medical records and personal health data, and the ability to treat patients across state lines

See the background information for resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care for further information on these new federal and state laws and regulations and how they interact with the Emergency Medical Treatment and Labor Act (EMTALA).

Background Reference

[1]ACEP recognizes that references to "a full array of reproductive health care options" may be interpreted differently by the reader; however, in order to retain consistency with language used by the authors of the resolution, this verbiage is incorporated into the Background section of the document.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Substitute resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted. Directed the College to support the availability of non-prescription emergency contraception.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Called for the College to take the position that a victim of sexual assault should be offered prophylaxis for sexually transmitted diseases, subject to informed consent consistent with current treatment guidelines and revise the policy statement "Management of the Patient with the Complaint of Sexual Assault" accordingly; and that victims of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent consistent with the current treatment guidelines, and that physicians or others who find this morally objectionable or practice at facilities that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide those services in a timely fashion; and revise the aforementioned policy statement accordingly

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted. Called for the College to assume a leadership role in organizing formal collaboration with key stakeholders including clinical, legal, forensic, judicial, advocacy, and law enforcement organizations to establish areas of cooperation, mutual training, standardization, and continuous quality improvement for the benefit of the sexually assaulted patient.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted. Called for ACEP to take the lead in the development of a national multidisciplinary model protocol that would include training programs and standards for the collection of evidence, examination, and treatment of sexually assaulted patients and that funding sources for the project be sought.

Substitute Resolution 10(91) Sexual Assault adopted. Called for ACEP to develop a recommended list of equipment/supplies for evidence collection kits for victims of sexual assault and address the special needs of pediatric sexual assault patients in its guidelines for management of sexual assault patients.

Substitute Resolution 34(89) "Sexual Assault" adopted. Called for ACEP to develop a position paper on the appropriate management of sexual assault victims of all ages and act as a clearinghouse of resource materials concerning issues on the management of sexual assault victims.

Prior Board Action

June 2022, approved the policy statement "Interference in the Physician-Patient Relationship."

January 2021, reaffirmed the policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy;" reaffirmed October 2015 and June 2010; originally approved October 2004.

February 2020, reaffirmed the policy statement "Management of the Patient with the Complaint of Sexual Assault;" reaffirmed April 2014 and October 2008; revised and approved October 2002; reaffirmed 1999; revised and approved December 1994; originally approved January 1992.

Substitute Resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted.

October 2002, revised and approved policy statement "Management of the Patient with the Complaint of Sexual Assault."

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted.

June 1999, reviewed "Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient" handbook prepared by the Sexual Assault Grant Task Force.

June 1999, reaffirmed policy statement "Management of the Patient with the Complaint of Sexual Assault;" originally approved in January 1992.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted.

Substitute Resolution 10(91) Sexual Assault adopted.

Substitute Resolution 34(89) Sexual Assault adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

Leslie Patterson Moore, JD
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Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 25(22)

SUBMITTED BY: Aislinn Black, DO, MPH, FACEP
James Blum, MD
Scott Pasichow, MD MPH
Karina Sanchez, MD
Nikkole Turgeon, MD
Daniel Udrea, MD
Jennifer Walker, MD FACEP
California Chapter
American Association of Women Emergency Physicians Section
Social Emergency Medicine Section
Young Physician Section
Emergency Medicine Residents' Association

SUBJECT: Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care

PURPOSE: Affirm that abortion is a medical procedure and that no physician shall be required to perform an act violative of good medical judgment; that ACEP support the position that abortion is a medical procedure and as such involves shared decision making between patients and their physician regarding various criteria; that ACEP oppose criminalization or mandatory reporting for non-public health monitoring reasons of self-induced abortion; that ACEP support an individual's ability to access a full spectrum of evidence-based reproductive health care; and that ACEP oppose criminalization, penalties for, or other retaliatory efforts against patients, advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services.

FISCAL IMPACT: Budgeted committee and staff resources for policy development and advocacy initiatives.

WHEREAS, Many states have enacted laws that either restrict access to abortion to very early in pregnancy or make all abortions illegal without regard for the health of the mother or the viability of the pregnancy[1]; and

WHEREAS, The American Medical Association (AMA) has asserted that abortion is health care[2] and that all humans have a fundamental right to health care; and

WHEREAS, The American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Osteopathic Association, the American College of Physicians, and the American Psychiatric Association have released a joint statement condemning the end of national abortion protections and advocating for the protection of the patient physician relationship in all health care matters[3]; and

WHEREAS, The AMA has issued briefs in many legal cases in support of continued legal access to safe elective abortions[4]; and

WHEREAS, Worldwide unsafe abortions due to lack of safe access account for 13% of all maternal mortality and long-term health complications for up to 5 million women annually[5]; and

WHEREAS, About 6% of people who undergo a legally and safely performed abortion will visit the ED within 6 weeks of said abortion[6], indicating that a restriction on access to safe abortions will likely result in an increase in complications presenting to the ED; and

WHEREAS, The removal of legal protections for abortion will increase the number of people who seek less safe methods for abortion with less medical oversight, thereby increasing morbidity and mortality from self-induced, unsafe, and unregulated abortion practice[7]; therefore be it

RESOLVED, That ACEP affirms that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure; and be it further

RESOLVED, That ACEP supports the position that the early termination of pregnancy (publicly referred to as "abortion") is a medical procedure, and as such, involves shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients; and be it further

RESOLVED, That ACEP opposes the criminalization or mandatory reporting for non-public health monitoring reasons of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services and will advocate against any legislative efforts to criminalize self-induced abortion; and be it further

RESOLVED, That ACEP supports an individual's ability to access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care; and be it further

RESOLVED, That ACEP opposes the criminalization, imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals.

References

1. Lewis, T. "Overturning Roe v. Wade Could Have Devastating Health and Financial Impacts Landmark Study Showed." *Scientific American*. 3 May 2022. https://www.guttmacher.org/state-policy/explore/overview-abortion-laws
2. "Abortion H-5.995." *AMA Policy Finder*. 2020. https://policysearch.ama-assn.org/policyfinder/detail/abortion?uri=%2FAMADoc%2FHOD.xml-0-4546.xml
3. AMA Press Release. "ACOG, AMA lead amicus brief in U.S. v. Texas." *American Medical Association*. 2021 Oct 21. https://www.ama-assn.org/press-center/press-releases/acog-ama-lead-amicus-brief-us-v-texas
4. AAFP, APA, AAP, AOA, ACOG, ACP "Physicians: SCOTUS Decision Jeopardizes Patient-Physician Relationship, Penalizes Evidence-Based Care." Group of Six. 24 June 2022. http://www.groupof6.org/dam/AAFP/documents/advocacy/prevention/women/ST-G5-SCOTUS-DobbsVJackson-062422.pdf
5. Haddad LB, Nour NM. Unsafe abortion: unnecessary maternal mortality. *Rev Obstet Gynecol*. 2009;2(2):122-126.
6. Upadhyay UD, Desai S, Zlidar V, Weitz TA, Grossman D, Anderson P, Taylor D. Incidence of emergency department visits and complications after abortion. Obstet Gynecol. 2015 Jan;125(1):175-183. doi: 10.1097/AOG.0000000000000603. PMID: 25560122.
7. Foster, DG; et. al. (2022). "The Harms of Denying a Woman a Wanted Abortion Findings from the Turnaway Study." *Advancing New Standards in reproductive health*. https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf

Background

The resolution directs the College to affirm that: 1) abortion is a medical procedure and should be performed only by a duly licensed physician, surgeon, or other medical professional in conformance with standards of good medical practice and the Medical Practice Act of that individual's state; and 2) no physician or other professional personnel

shall be required to perform an act violative of good medical judgment and this protection shall not be construed to remove the ethical obligation for referral for any medically indicated procedure; and, that ACEP support the position that the early termination of pregnancy (publicly referred to as "abortion") is a medical procedure, and as such, involves shared decision making between patients and their physician regarding: 1) discussion of reproductive health care; 2) performance of indicated clinical assessments; 3) evaluation of the viability of pregnancy and safety of the pregnant person; 4) availability of appropriate resources to perform indicated procedure(s); and 5) is to be made only by health care professionals with their patients.

The resolution also directs the College to oppose the criminalization or mandatory reporting for non-public health monitoring reasons of self-induced abortion as it increases patients' medical risks and deters patients from seeking medically necessary services and will advocate against any legislative efforts to criminalize self-induced abortion; support an individual's ability to access the full[1] spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health care, and supports the adequate payment from all payers for said care; and, finally, oppose the criminalization, imposition of penalties, or other retaliatory efforts against patients, patient advocates, physicians, health care workers, and health systems for receiving, assisting, or referring patients within a state or across state lines to receive reproductive health services or medications for contraception and abortion, and will further advocate for legal protection of said individuals.

The issue of access to and provision of prophylaxis, contraception, abortion, and other reproductive health measures is in a state of significant uncertainty as a result of the recent decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization*, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. As noted in the majority opinion by Justice Samuel Alito, the *Dobbs* decision is limited to the question of a "…constitutional right to abortion and no other right," and that "…[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion," such as *Griswold v. Connecticut* that established the right for married couples to purchase and use contraception. More simply, the *Dobbs* ruling is limited solely to the issue of abortion (termination of an established pregnancy) and not contraception or other reproductive health options.

As it does for other important emerging issues impacting emergency physicians and the care of emergency medicine patients, ACEP issued a statement in response to the *Dobbs* ruling expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship (as codified in the policy statement, "Interference in the Physician-Patient Relationship," approved by the Board of Directors in June 2022).

Given wide variation in state regulation of abortion and reproductive health procedures, including new prohibitions on abortions in some states even in cases of rape, incest, or where the life or physical health of the pregnant patient is in danger, and some potential efforts to restrict access to or the provision of emergency contraception or other contraceptives, the legal landscape is still in flux and there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine and the provision of emergency reproductive health care. Some advocates have expressed concerns that this uncertainty may also discourage physicians or hospitals from providing emergency contraception or other reproductive health care out of an abundance of caution to avoid potential legal exposure. Additionally, there are worries that there may be additional civil and criminal penalties at the state level against health care providers for assisting individuals in accessing abortions, or aggressive enforcement of mandatory reporting laws that may put physicians in legal peril.

In years prior to the *Dobbs* decision, there were numerous efforts at the state level to significantly limit abortions and penalize physicians and health care providers who perform the procedure. On July 26, 2022, when the Supreme Court took the procedural step to enter its judgment overturning *Roe v Wade,* the process began for some states to implement existing statutes. In Alabama, a law passed in 2019 makes it a felony for physicians to perform any abortion unless the pregnant patient's life is in jeopardy, punishable by up to 99 years in prison. In Oklahoma, a 2021 law enacted a statewide ban on abortion with exceptions for the life or physical health of the pregnant patient, along with criminal penalties and up to five years in prison for any individual who advises or provides any means of accessing an abortion. After the *Dobbs* decision, Texas law banned abortions from fertilization with the exception of life or physical health of the pregnant patient increasing criminal and civil penalties for providing, advising, or

abetting an abortion. Twenty-six states have enacted what are known as born-alive laws, that require physicians to provide medical care and treatment to a fetus or infant born at any stage of development. Under the Texas law, passed in June 2019, physicians who fail to provide that level of treatment face fines of at least $100,000 and third-degree felony charges that could lead to a prison term of two to ten years.

Under existing federal law (and in many cases, state laws), it may not be possible to fully guarantee universal access to emergency contraception in all emergency departments. Some physicians, pharmacists, other health care providers, and hospitals/facilities may choose not to administer or provide prophylaxis on moral or religious grounds, and these "conscience clauses" also prohibit discrimination against those who refuse to participate in such services. For example, many Catholic hospitals do not provide abortion, contraception, or sterilization procedures, including in cases of rape, though these policies are not all universal within such systems (e.g., the provision of contraception in cases of rape may be dependent on the policies of the local bishop).

With respect to the issue of full[1] spectrum reproductive care, existing ACEP policy is succinct and limited to the issue of emergency contraception. The ACEP policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy," states in its entirety, "ACEP supports the availability of non-prescription emergency contraception." Prophylaxis and contraception are also discussed as a consideration in the guidelines established under the "Management of the Patient with the Complaint of Sexual Assault" policy, which states:

> "A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines. Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide these services in a timely fashion."

Another issue in the broader debate is the challenge of misconceptions which conflate contraceptives and abortion/abortifacients, though they are medically distinct (the former preventing pregnancy, the latter terminating an established pregnancy).

To this end, some have recently promoted efforts in multiple states to either fully prohibit or significantly restrict access to certain contraceptive options, such as Plan B One-Step (the "morning-after pill"), an emergency contraceptive which is used to prevent pregnancy after unprotected sex or a failure of other contraceptives, as well as intrauterine devices (IUDs) and others. For example, the organization Students for Life of America argues that Plan B can potentially prevent implantation of a fertilized egg (as noted on the packaging of Plan B), thus constituting an abortion under the view that life begins at conception. However, some OB/GYNs have noted this is "a hypothetical that has never been proven."

Ultimately, it is difficult to predict the range of hypothetical scenarios and individual considerations that may arise within EM, and further clarity may be needed from various authorities to address these potential circumstances. ACEP is also continuing to work its way through other associated issues, such as medical liability, privacy and security of medical records and personal health data, and the ability to treat patients across state lines.

For emergency medicine specifically, much of the consideration is related to how these new federal and state laws and regulations interact with the Emergency Medical Treatment and Labor Act (EMTALA) – a law that has been in place since 1987. The law includes three main obligations: the screening requirement, the stabilization requirement, and the transfer requirement. First, the law requires hospitals to provide a medical screening examination to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition. If an individual is determined to have an emergency medical condition, the individual must receive stabilizing treatment within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized. If the individual is not stabilized, they may only be transferred if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks.

On July 11, 2022, the Centers for Medicare & Medicaid Services (CMS) issued additional EMTALA guidance, following up on its previous guidance from September 2021. In this updated guidance, CMS reiterates that EMTALA pre-empts any directly contradicting state laws around the medical screening examination, stabilizing treatment, and

transfer requirements. It specifically clarifies that if a physician believes that an abortion needs to be performed to stabilize a patient with an emergency medical condition, the physician MUST provide the treatment regardless of any state law that may prohibit abortions. Further, with respect to what constitutes an "emergency medical condition" (EMC), the guidance states that the determination of an EMC "is the responsibility of the examining physician or other qualified medical personnel. An emergency medical condition may include a condition that is likely or certain to become emergent without stabilizing treatment." Finally, the guidance states that EMTALA pre-empts "any state actions against a physician who provides an abortion in order to stabilize an emergency medical condition in a pregnant individual presenting to the hospital."

In addition to the guidance, HHS Secretary Xavier Becerra, in a letter to providers, further made clear that this federal law pre-empts state law restricting access to abortion in emergency situations.

But even with this new guidance there is still significant grey area. While the guidance notes that EMTALA can be raised as a defense by a physician facing state action, EMTALA does not provide any *proactive* protection to prevent an emergency physician from facing criminal charges brought by the state for providing this federally-mandated care. Some state restrictions only have an exception allowing abortion if it's to prevent the death of the pregnant patient. But EMTALA requires stabilizing treatment to prevent "serious impairment of bodily functions," "serious dysfunction of any bodily organ or part," or to place the health of the patient "in serious jeopardy." This is a significant area of concern, potentially forcing emergency physicians in such states to choose between following EMTALA in order to avoid potential civil monetary penalties, or following the state law in order to avoid potential criminal charges.

ACEP is working to identify other such gaps in existing regulation or statute that could create clinical and legal barriers to how emergency physicians practice medicine. In order to do so, ACEP President Gillian Schmitz has formed a cross-disciplinary task force of experts from across EM to help identify clinical and legal barriers to how emergency physicians practice medicine, and develop recommendations to address them.

As well, ACEP recently joined amicus briefs addressing these concerns. On August 15, 2022, ACEP along with the Idaho College of Emergency Physicians, submitted a brief in the U.S. District Court for the District of Idaho in support of in support of the U.S. Department of Justice's challenge to an Idaho law in *United States v. State of Idaho*. If applied to emergency medical care, the brief argued that Idaho Law would force physicians to disregard their patients' clinical presentations, their own medical expertise and training, and their obligations under EMTALA—or risk criminal prosecution. The next day, on August 16, 2022, ACEP and several prominent medical societies submitted another amicus brief, this time in in the U.S. District Court for the Northern District of Texas in support of the U.S. Department of Health and Human Services' guidance on the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). The brief explained that the Federal guidance merely restates physicians' obligations under EMTALA and describes how those obligations may manifest themselves in real-world emergency room situations involving pregnant patients.

In both cases, the amici have determined the law (ID) or state action (TX) will have damaging professional and legal implications for physicians and adversely impact patient safety. As such, ACEP and other amici, filed the briefs to educate the Courts regarding our physicians' EMTALA obligations as well as the legal and ethical dilemma created by the Idaho legislature's and Texas Attorney General's actions.

Background Reference

[1]ACEP recognizes that references to "a full spectrum of reproductive health care options" may be interpreted differently by the reader; however, in order to retain consistency with language used by the authors of the resolution, this verbiage is incorporated into the Background section of the document.

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- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility, and administrative.

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- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted committee and staff resources for policy development and advocacy initiatives.

Prior Council Action

Substitute resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted. Directed the College to support the availability of non-prescription emergency contraception.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Called for the College to take the position that a victim of sexual assault should be offered prophylaxis for sexually transmitted diseases, subject to informed consent consistent with current treatment guidelines and revise the policy statement "Management of the Patient with the Complaint of Sexual Assault" accordingly; and that victims of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent consistent with the current treatment guidelines, and that physicians or others who find this morally objectionable or practice at facilities that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide those services in a timely fashion; and revise the aforementioned policy statement accordingly.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted. Called for the College to assume a leadership role in organizing formal collaboration with key stakeholders including clinical, legal, forensic, judicial, advocacy, and law enforcement organizations to establish areas of cooperation, mutual training, standardization, and continuous quality improvement for the benefit of the sexually assaulted patient.

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Substitute Resolution 34(89) "Sexual Assault" adopted. Called for ACEP to develop a position paper on the appropriate management of sexual assault victims of all ages and act as a clearinghouse of resource materials concerning issues on the management of sexual assault victims.

Prior Board Action

June 2022, approved the policy statement "Interference in the Physician-Patient Relationship."

January 2021, reaffirmed the policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy;" reaffirmed October 2015 and June 2010; originally approved October 2004.

February 2020, reaffirmed the policy statement "Management of the Patient with the Complaint of Sexual Assault;" reaffirmed April 2014 and October 2008; revised and approved October 2002; reaffirmed 1999; revised and approved December 1994; originally approved January 1992.

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June 1999, reviewed “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient” handbook prepared by the Sexual Assault Grant Task Force.

June 1999, reaffirmed policy statement "Management of the Patient with the Complaint of Sexual Assault;” originally approved in January 1992.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted.

Substitute Resolution 10(91) Sexual Assault adopted.

Substitute Resolution 34(89) Sexual Assault adopted.

Background Information Prepared by: Ryan McBride, MPP
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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 26(22)

SUBMITTED BY: Peter Acker, MD, MPH, FACEP
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Monica Saxena, MD, JD
Kelly Quinley, MD
California Chapter
American Association of Women Emergency Physicians Section
Pediatric Emergency Medicine Section
Social Emergency Medicine Section
* *See Attachment A for list of additional individual cosponsors*.

SUBJECT: Promoting Safe Reproductive Health Care for Patients

PURPOSE: That ACEP promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the ED irrespective of the state in which the patient is seeking care; that ACEP promote legal protections for doctors practicing within best practices; that ACEP encourage hospitals and EM residency programs to provide education and more on miscarriage and post-abortion care; that ACEP broaden its clinical policy to include considerations for miscarriage management; that ACEP continue to develop practices and policies to protect the physician-patient relationship, including legal resources; and that ACEP promote adherence to laws that provide the strongest possible protections for high quality patient care.

FISCAL IMPACT: Budgeted committee and staff resources for policy development and advocacy initiatives.

WHEREAS, Reproductive health services including abortion are healthcare; and

WHEREAS, According to the Centers for Disease Control more than 600,000 American women have abortions each year with almost half of these women living at or below the poverty line; and

WHEREAS, Unplanned pregnancies are associated with higher maternal and child prenatal and perinatal morbidity, poverty and decreased education attainment for mothers and children, and as such hold health equity implications; and

WHEREAS, A federal constitutional right to abortion is no longer guaranteed and more than 26 states have passed laws regulating or prohibiting the provision of abortion care; and

WHEREAS, In December 2021 the Federal Drug Administration approved abortion pills by mail and 19 states prohibit telehealth abortion; and

WHEREAS, In light of these barriers to accessing safe health care, people will seek self-managed abortions or initiate abortions without medical management, and as these cases will clinically appear similar to miscarriages, emergency departments may see a rise in miscarriage cases; and

WHEREAS, Patients with ectopic pregnancies who present to emergency departments in abortion-restricted states may encounter physicians or hospitals who refuse to treat their ectopic pregnancy; and

WHEREAS, In June 2022, ACEP that states the doctor-patient relationship should remain free of legislative, regulatory, or judicial interference in the physician-patient relationship; therefore be it

RESOLVED, That ACEP promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the emergency department irrespective of the state in which the patient is seeking reproductive health care; and be it further

RESOLVED, That ACEP promote legal protections for doctors practicing within the best practices and laws of their own states, irrespective of the state of origin of their patients; and be it further

RESOLVED, That ACEP encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining best clinical practices on miscarriage and post-abortion care, including for patients who have self-managed abortions; and be it further

RESOLVED, That ACEP broaden its clinical policy on Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy to include considerations for miscarriage management; and be it further

RESOLVED, That ACEP continue to develop practices and policies that protect the integrity of the physician-patient relationship including developing legal resources for physicians caring for peri-abortion and post-abortion patients in states where abortion access is limited; and be it further

RESOLVED, That ACEP promote adherence to laws that provide the strongest possible protections for high quality patient care including its continued support of adhering to the federal Emergency Medical Treatment and Labor Act (EMTALA) over state abortion laws when failure to treat or securely transfer a patient with a potentially life-threatening pregnancy-related complication, including but not limited to ectopic pregnancy, severe hemorrhage or uterine infection from either abortion or miscarriage contradicts EMTALA.

Background

The resolution directs the College to promote the equitable and knowledgeable treatment of patients seeking peri-abortion and post-abortion care in the emergency department irrespective of the state in which the patient is seeking reproductive health care; promote legal protections for doctors practicing within the best practices and laws of their own states, irrespective of the state or origin of their patients; encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining best clinical practices on miscarriage and post-abortion care, including for patients who have self-managed abortions; broaden its clinical policy on Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy to include considerations for miscarriage management; continue to develop practices and policies that protect the integrity of the physician-patient relationship including developing legal resources for physicians caring for peri-abortion and post-abortion patients in states where abortion access is limited; and, promote adherence to laws that provide the strongest possible protections for high quality patient care including its continued support for adhering to the federal Emergency Medical Treatment and Labor Act (EMTALA) over state abortion laws when failure to treat or securely transfer a patient with a potentially life-threatening pregnancy-related complication, including but not limited to ectopic pregnancy, severe hemorrhage or uterine infection from either abortion or miscarriage contradicts EMTALA.

The issue of access to and provision of abortion, including peri-abortion and post-abortion care in the emergency department, is in a state of significant uncertainty as a result of the recent decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization*, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. As noted in the majority opinion by Justice Samuel Alito, the *Dobbs* decision is limited to the question of a "…constitutional right to abortion and no other right," and that "…[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion," such as *Griswold v. Connecticut* that established the right for married couples to purchase and use contraception. More simply, the *Dobbs* ruling is limited solely to the issue of abortion (termination of an established pregnancy) and not contraception or other reproductive health options.

As it does for other important emerging issues impacting emergency physicians and the care of emergency medicine patients, ACEP issued a statement in response to the *Dobbs* ruling expressing concerns about the medical and legal implications of judicial overreach into the practice of medicine, reiterating that emergency physicians must be able to practice high quality, objective evidence-based medicine without legislative, regulatory, or judicial interference in the physician-patient relationship (as codified in the policy statement, "Interference in the Physician-Patient Relationship," approved by the Board of Directors in June 2022).

Given wide variation in state regulation of abortion and reproductive health procedures, including new prohibitions on abortions in some states even in cases of rape, incest, or where the life or physical health of the pregnant patient is in danger, and some potential efforts to restrict access to or the provision of emergency contraception or other contraceptives, the legal landscape is still in flux and there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine and the provision of reproductive health care. Some advocates have expressed concerns that this uncertainty may also discourage physicians or hospitals from providing emergency contraception or other reproductive health care out of an abundance of caution to avoid potential legal exposure. Additionally, there are worries that there may be additional civil and criminal penalties at the state level against health care providers for assisting individuals in accessing abortions, or aggressive enforcement of mandatory reporting laws that may put physicians in legal peril.

In years prior to the *Dobbs* decision, there were numerous efforts at the state level to significantly limit abortions and penalize physicians and health care providers who perform the procedure. On July 26, 2022, when the Supreme Court took the procedural step to enter its judgment overturning *Roe v Wade,* the process began for some states to implement existing statutes. In Alabama, a law passed in 2019 makes it a felony for physicians to perform any abortion unless the pregnant patient's life is in jeopardy, punishable by up to 99 years in prison. In Oklahoma, a 2021 law enacted a statewide ban on abortion with exceptions for the life or physical health of the pregnant patient, along with criminal penalties and up to five years in prison for any individual who advises or provides any means of accessing an abortion. After the Dobbs decision, Texas law banned abortions from fertilization with the exception of life or physical health of the pregnant patient increasing criminal and civil penalties for providing, advising, or abetting an abortion. Twenty-six states have enacted what are known as born-alive laws, that require physicians to provide medical care and treatment to a fetus or infant born at any stage of development. Under the Texas law, passed in June 2019, physicians who fail to provide that level of treatment face fines of at least $100,000 and third-degree felony charges that could lead to a prison term of two to ten years.

The Clinical Policies Committee defines a clinical policy as an evidence-based recommendation informed by a systematic review of critically appraised literature developed in accordance with accepted guideline development standards. The ACEP Clinical Policies Subcommittee on Early Pregnancy published "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" in February 2016. It was the most accessed clinical policy in 2021, with 1776 downloads. Clinical policies are comprised of one or more critical questions. Critical questions addressed are drafted as PICO questions. The critical questions addressed in the clinical policy were:

1. Should the emergency physician obtain a pelvic ultrasound in a clinically stable pregnant patient who presents to the ED with abdominal pain and/or vaginal bleeding and a β-hCG level below a discriminatory threshold?
2. In patients who have an indeterminate transvaginal ultrasound result, what is the diagnostic utility of β-hCG for predicting possible ectopic pregnancy?

With respect to the issue of full[1] spectrum reproductive care, existing ACEP policy is succinct and limited to the issue of emergency contraception. The ACEP policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy," states in its entirety, "ACEP supports the availability of non-prescription emergency contraception." Prophylaxis and contraception are also discussed as a consideration in the guidelines established under the "Management of the Patient with the Complaint of Sexual Assault" policy, which states:

> "A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines. Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another

provider who can provide these services in a timely fashion."

Ultimately, it is difficult to predict the range of hypothetical scenarios and individual considerations that may arise within EM, and further clarity may be needed from various authorities to address these potential circumstances. ACEP is also continuing to work its way through other associated issues, such as medical liability, privacy and security of medical records and personal health data, and the ability to treat patients across state lines. For emergency medicine specifically, much of the consideration is related to how these new federal and state laws and regulations interact with the Emergency Medical Treatment and Labor Act (EMTALA) – an essential law that has been in place since 1987. The law includes three main obligations: the screening requirement, the stabilization requirement, and the transfer requirement. First, the law requires hospitals to provide a medical screening examination to every individual who comes to the ED seeking examination or treatment. The purpose of the medical screening exam is to determine whether a patient has an emergency medical condition. If an individual is determined to have an emergency medical condition, the individual must receive stabilizing treatment within the capability of the hospital. Hospitals cannot transfer patients to another hospital unless the individual is stabilized. If the individual is not stabilized, they may only be transferred if the individual requests the transfer or if the medical benefits of the transfer outweigh the risks.

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In addition to the guidance, HHS Secretary Xavier Becerra, in a letter to providers, further made clear that this federal law pre-empts state law restricting access to abortion in emergency situations. Even with this new guidance there is still significant grey area. While the guidance notes that EMTALA can be raised as a defense by a physician facing state action, EMTALA does not provide any *proactive* protection to prevent an emergency physician from facing criminal charges brought by the state for providing this federally-mandated care. Some state restrictions only have an exception allowing abortion if it's to prevent the death of the pregnant patient. But EMTALA requires stabilizing treatment to prevent "serious impairment of bodily functions," "serious dysfunction of any bodily organ or part," or to place the health of the patient "in serious jeopardy." This is a significant area of concern, potentially forcing emergency physicians in such states to choose between following EMTALA in order to avoid potential civil monetary penalties, or following the state law in order to avoid potential criminal charges.

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Prior Council Action

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October 2016, approved the revised "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" and rescinded the 2012 clinical policy.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 27(22)

SUBMITTED BY: James Blum, MD
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Nikkole Turgeon, MD
Jennifer Walker, MD, FACEP
American Association of Women Emergency Physicians Section
Social Emergency Medicine Section

SUBJECT: Equitable Access to Emergency Contraception in the ED

PURPOSE: That ACEP develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide; and, that ACEP advocate for universal access to emergency contraception in the emergency department.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement and advocacy initiatives.

WHEREAS, Emergency medicine upholds the basic human rights principle of non-discrimination including providing medical care without bias to race, color, sex, language, religion, political, or other opinions, national or social origin, property, birth, or other status such as disability, age, marital, and family status, sexual orientation and gender identity, health status, place of residence, economic, and social situation[1]; and

WHEREAS, 55% of patient visits to the ER are women or 72,352,000 out of 129,974,000 visits recorded most recently by the Centers for Disease Control and Prevention[2]; and

WHEREAS, This obligation includes the right to ensure availability, accessibility, acceptability, and quality of contraceptive services without discrimination[1]; and

WHEREAS, In the United States, 76.2% of women aged 18–49 years are considered to be at risk for unintended pregnancy, and the risk for unintended pregnancy varies significantly by age group, race/ethnicity, and urban-rural status[3]; and

WHEREAS, Emergency contraception should be available for populations at most risk for unintended pregnancy including when no contraceptive was used, sexual assault, concern for possible contraceptive failure, or improper or incorrect use[4,5,6]; and

WHEREAS, Emergency contraception can prevent up to 95% of pregnancies when taken within 5 days of intercourse,[4] but is most effective when taken within 24 hours[6]; and

WHEREAS, Many patients in the United States do not have access to primary care or gynecologic services within 24 hours[9,10]; and

WHEREAS, There are many misconceptions about emergency contraceptives including confusion with abortifacients and termination of pregnancy, rather than an understanding that these medications only work prior to establishing pregnancy[4,8]; and

WHEREAS, The American Medical Association (AMA):

1. Recognizes healthcare, including reproductive health services like contraception and abortion, is a human right[11]
2. Opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion[11]; and

WHEREAS, The American College of Obstetricians and Gynecologists (ACOG) expert consensus and practice bulletins recommend:

1. Health care providers integrate copper IUD emergency contraception into their practice with same-day availability.[8]
2. Write advance prescriptions for emergency contraception to increase awareness and reduce barriers to access.[8]; and

WHEREAS, The Emergency Medicine Residents' Association (EMRA) has an existing policy stating that:

> Section III-IV Protecting Access to Women's Health, Reproductive Health, and Organizations That Provide Increased Health Access to Women: EMRA will advocate for policies that protect access to women's health care including reproductive health care. Support increased funding for organizations that provide access to reproductive care.[12]
>
> Section IV-VIII. Healthcare as a Human Right: EMRA firmly believes that all individuals should have access to quality, affordable primary and emergency healthcare services for all people (especially vulnerable and disabled populations, including rural, elderly, and pediatric patients) as a basic human right.[12]; and

WHEREAS, The American College of Emergency Physicians (ACEP) has an existing policy "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy" stating that ACEP supports the availability of non-prescription emergency contraception[13]; and

WHEREAS These misconceptions can lead to further inaccessibility of medical treatment to a vulnerable population during a critical time[5]; therefore be it

RESOLVED, That ACEP develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide; and be it further

RESOLVED, ACEP advocate for universal access to emergency contraception in the emergency department.

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Background

The resolution directs ACEP to develop a policy statement endorsing the accessibility of emergency contraception in emergency departments (EDs) nationwide, and would also direct ACEP to advocate for universal access to emergency contraception in the ED.

Existing ACEP policy regarding emergency contraception is succinct and narrow in scope. As noted in the resolution, the ACEP policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy" states in its entirety, "ACEP supports the availability of non-prescription emergency contraception." Prophylaxis and contraception are also discussed as a consideration in the guidelines established under the "Management of the Patient with the Complaint of Sexual Assault" policy, which states:

> "A victim of sexual assault should be offered prophylaxis for pregnancy and for sexually transmitted diseases, subject to informed consent and consistent with current treatment guidelines. Physicians and allied health practitioners who find this practice morally objectionable or who practice at hospitals that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide these services in a timely fashion."

Under existing federal law (and in many cases, state laws), it may not be possible to fully guarantee universal access to emergency contraception in all emergency departments. Some physicians, pharmacists, other health care providers, and hospitals/facilities may choose not to administer or provide prophylaxis on moral or religious grounds, and these "conscience clauses" also prohibit discrimination against health care providers who refuse to participate in such services. For example, many Catholic hospitals do not provide abortion, contraception, or sterilization procedures, including in cases of rape, though these policies are not all universal within such systems (e.g., the provision of contraception in cases of rape may be dependent on the policies of the local bishop).

The issue of access to and provision of prophylaxis, contraception, abortion, and other reproductive health measures is also in a state of significant uncertainty as a result of the recent decision by the United States Supreme Court in *Dobbs v. Jackson Women's Health Organization*, which held that the right to abortion is not guaranteed under the Constitution, instead leaving the ability to regulate abortion to individual states. As noted in the majority opinion by Justice Samuel Alito, the *Dobbs* decision is limited to the question of a "…constitutional right to abortion and no other right," and that "…[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion," such as *Griswold v. Connecticut* that established the right for married couples to purchase and use contraception. More simply, the *Dobbs* ruling is limited solely to the issue of abortion (termination of an established pregnancy) and not contraception or other reproductive health options.

However, some maintain concerns that access to contraception may also potentially be at risk given Justice Clarence Thomas' concurring opinion in *Dobbs*. While Justice Thomas reiterates that *Dobbs* itself does not address any right beyond abortion, he does suggest that the Court should reconsider "…all of this Court's substantive due process precedents, including *Griswold*, *Lawrence*, and *Obergefell*," adding that "Because any substantive due process decision is 'demonstrably erroneous,'…we have a duty to 'correct the error' established in those precedents." These comments have led some to conclude that access to contraception may also be under threat should the Supreme Court be presented with and opt to consider a similar case that could effectively overturn *Griswold* or other related precedent.

As the resolution notes, while contraceptives and abortion/abortifacients are medically distinct (the former preventing pregnancy, the latter terminating an established pregnancy), there are often common misconceptions conflating the two. The American College of Obstetricians and Gynecologists (ACOG) states that "Intrauterine pregnancy begins when a fertilized egg implants itself in the uterus," and, that "Emergency contraception prevents a pregnancy from occurring after sexual activity. It is not an abortifacient; it does not end a pregnancy." Despite this distinction, much of the debate around the broader issue centers around the more fundamental disagreement of when life begins or whether pregnancy begins at conception or at implantation. Those who believe life begins at the moment of conception or fertilization oppose emergency contraception that prevents the implantation of a fertilized egg, arguing that action constitutes an abortion.

To this end, some have recently promoted efforts in multiple states to either fully prohibit or significantly restrict access to certain contraceptive options, such as Plan B One-Step (the "morning-after pill"), an emergency contraceptive which is used to prevent pregnancy after unprotected sex or a failure of other contraceptives, as well as intrauterine devices (IUDs) and others. For example, the organization Students for Life of America argues that Plan B can potentially prevent implantation of a fertilized egg (as noted on the packaging of Plan B), thus constituting an abortion under the view that life begins at conception. However, some OB/GYNs have noted this is "a hypothetical that has never been proven."

Given wide variation in state regulation of abortion and reproductive health procedures, including "trigger" laws, newly-passed laws in several states (some of which include prohibitions on abortions even in cases of rape, incest, or where the life or physical health of the pregnant patient is in danger), and some potential efforts to restrict access to or the provision of emergency contraception or other contraceptives, the legal landscape is still in flux and there remain many unanswered questions regarding legislative, regulatory, and judicial implications for the practice of emergency medicine, including the provision of emergency contraception. Some advocates have expressed concerns that this uncertainty may also discourage physicians or hospitals from providing emergency contraception out of an abundance of caution to avoid potential legal exposure.

Ultimately, it is difficult to predict the range of hypothetical scenarios and individual considerations that may arise within EM, and further clarity may be needed from various authorities to address these potential circumstances. ACEP is also continuing to work its way through other associated issues, such as medical liability, privacy and security of medical records and personal health data, and the ability to treat patients across state lines.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted committee and staff resources for development of a policy statement and advocacy initiatives.

Prior Council Action

Substitute Resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted. Directed the College to support the availability of non-prescription emergency contraception.

Amended Resolution 32(02) Treatment of Victims of Sexual Assault adopted. Called for the College to take the position that a victim of sexual assault should be offered prophylaxis for sexually transmitted diseases, subject to informed consent consistent with current treatment guidelines and revise the policy statement "Management of the Patient with the Complaint of Sexual Assault" accordingly; and that victims of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent consistent with the current treatment guidelines, and that physicians or others who find this morally objectionable or practice at facilities that prohibit prophylaxis or contraception should offer to refer victims of sexual assault to another provider who can provide those services in a timely fashion; and revise the aforementioned policy statement accordingly

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted. Called for the College to assume a leadership role in organizing formal collaboration with key stakeholders including clinical, legal, forensic, judicial, advocacy, and law enforcement organizations to establish areas of cooperation, mutual training, standardization, and continuous quality improvement for the benefit of the sexually assaulted patient.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted. Called for ACEP to take the lead in the development of a national multidisciplinary model protocol that would include training programs and standards for the collection of evidence, examination, and treatment of sexually assaulted patients and that funding sources for the project be sought.

Substitute Resolution 10(91) Sexual Assault adopted. Called for ACEP to develop a recommended list of equipment/supplies for evidence collection kits for victims of sexual assault and address the special needs of pediatric sexual assault patients in its guidelines for management of sexual assault patients.

Substitute Resolution 34(89) "Sexual Assault" adopted. Called for ACEP to develop a position paper on the appropriate management of sexual assault victims of all ages and act as a clearinghouse of resource materials concerning issues on the management of sexual assault victims.

Prior Board Action

January 2021, reaffirmed the policy statement "Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy;" reaffirmed October 2015 and June 2010; originally approved October 2004.

February 2020, reaffirmed the policy statement "Management of the Patient with the Complaint of Sexual Assault;" reaffirmed April 2014 and October 2008; revised and approved October 2002; reaffirmed 1999; revised and approved December 1994; originally approved January 1992.

Substitute Resolution 19(04) Emergency Contraception for Women at Risk of Unintended and Preventable Pregnancy adopted.

Substitute Resolution 22(01) Sexual Assault Nurse Examiner Programs adopted.

June 1999, reviewed the "Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient" handbook prepared by the Sexual Assault Grant Task Force.

Substitute Resolution 23(96) Sexual Assault Patient National Care Protocol adopted.

Substitute Resolution 10(91) Sexual Assault adopted.

Substitute Resolution 34(89) Sexual Assault adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 28(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD
Charles Pattavina, MD, FACEP

SUBJECT: Billing and Collections Transparency and Interaction with ACEP

PURPOSE: 1) Petition state or federal legislative and regulatory 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. 2) Adopt a new policy statement prohibiting any entity that fails to meet this standard from advertising, exhibiting, sponsoring, or otherwise being associated with ACEP

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives. Potential significant reduction in outside funding support. Potential significant legal expenses to respond to complaints against ACEP.

WHEREAS, It is common knowledge that many American College of Emergency Physicians ("ACEP") members are denied access to information regarding amounts that are billed and collected in their name; and

WHEREAS, As reported to the U.S. Department of Justice ("DOJ") and Federal Trade Commission ("FTC") by ACEP (see, letter to Lina Khan and Jonathan Kanter, dated 4/20/22), a large number of members are experiencing wage suppression and requirements for seeing an increased patient load with no associated wage increase causing members to feel they are being exploited and that their patients are being placed at risk due to these pressures; and

WHEREAS, A lack of transparency regarding data on monetary amounts that are billed and collected in a physician's name from various payers breeds distrust and can lead to a feeling of being exploited and cause additional dissatisfaction for those practicing the demanding specialty of emergency medicine; and

WHEREAS, The voluntary database created partially in response to 2020 Resolutions on Transparency, intended to allow members to understand which entities allow them to "see the books," has been of no practical use to the members in this area; and

WHEREAS, Without transparency regarding what is billed and collected in a physician's name, the efforts to end gender disparity in physician pay will be lacking due to insufficient information; and

WHEREAS, The physician should be able to receive financial information regarding billings and collections made in his or her name, for reasons including, a) to prevent the corporate practice of medicine ("CPOM"), b) to give the physician the ability to review or audit important data related to his or her practice, c) to ensure the following of honest and lawful billing practices, and d) to prevent instances of upcoding, overcharges, or fraud; and

WHEREAS, Without this information the physician risks being a party to fee-splitting whereby a physician gives up a portion of their professional fee above fair market value in return for the right to see patients (receive referrals) in the emergency department ("ED"); and

WHEREAS, The Original Bylaws of the ACEP opposed fee-splitting, stating in pertinent part that "[i]n the practice of medicine, a physician shall limit the source of his income to medical services actually rendered by him to his patients. He should neither pay nor receive a commission for referral of patients;" and

WHEREAS, Participation in prohibited fee splitting has long been recognized as a risk to the EM physician by the ACEP as demonstrated in the 1996 book published by ACEP written by David Kalifon and Daniel Sullivan

called "Before you sign. Contract basics for the emergency physician." This book states: "Medicare, Medicaid and some states' laws prohibit kickbacks and fee-splitting. The Group and the Contractor (the physician) might violate these laws if the Group retains or, phrased differently, the Contractor pays more than fair market value for the services the Group provides to the Contractor." and

WHEREAS, With reports of fee-splitting being 20% or more of the professional fee, this is a significant economic issue for the membership of the ACEP, the value of which could run into the millions over a 20- to 30-year career; and

WHEREAS, AMA policy H-190.971 states that "all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that our AMA develop strategies to assist physicians who are denied such information" (reaffirmed 2017); and

WHEREAS, The FTC in 2004 (8/30/04 letter of Jeffery W. Brennan to Alvin Dunn, Esq.) stated in response to antitrust concerns raised by ACEP, that ACEP could respond to "behavior[s] of market participants that it believes are detrimental to its members or the public"; and

WHEREAS, Denial of this information can be detrimental to ACEP members in regards to unwitting participation in CPOM, fee-splitting, or upcoding, as well as to the public if they are subject to excessive charges; and

WHEREAS, The billing entity is supposed to be answerable to the individual physician; and

WHEREAS, The reputation of an emergency physician can be affected if inflated bills for services are sent to the patient; therefore be it

RESOLVED, That ACEP will petition the appropriate state or federal legislative and regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, will directly 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 be it further

RESOLVED, That ACEP adopt this policy: "Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support or otherwise be associated with ACEP, will, as of January 1, 2023, provide every emergency physician associated with that entity, at a minimum, a monthly statement with detailed information on monetary amounts billed and collected in the physician's name. This information must be provided without the need for the physician to request it. Physicians cannot be asked to waive access to this information. The entities affected include but are not limited to revenue cycle management companies, physician group practices, hospitals, and staffing companies."

Reference

https://www.acep.org/globalassets/acep-response-to-ftc-and-doj-rfi-on-merger-guidelines-04.20.22.pdf

Background

The resolution directs ACEP to petition state or federal legislative and regulatory bodies to require revenue cycle management entities, regardless of their ownership structure, to provide every emergency physician it bills or collects for with a detailed itemized statement of billing and remittances for medical services they provide at least monthly. The resolution also directs ACEP to adopt a new policy statement prohibiting any entity that fails to meet this standard from advertising, exhibiting, sponsoring, or otherwise being associated with ACEP and that these reports should be provided automatically to every member without a requirement to request such reports.

ACEP's policy statement "Emergency Physician Contractual Relationships" and the associated Policy Resource and Education Paper (PREP) convey support for the rights of an emergency physician to review what is billed and collected in their name. Further, the PREP states that "the contracting parties should be ethically bound to honor the

terms of any contractual agreement to which it is party and to relate to one another in an ethical manner."

Although patients are generally billed on behalf of the specific emergency physician who cared for them, the way business is structured in emergency medicine, funds paid by a patient or by a third-party payer on behalf of a patient do not generally go directly to the emergency physician. In most instances, the emergency physician has assigned his or her payments to another entity, generally the entity that has contracted with the emergency physician. The physician, however, is responsible for the accuracy of the charting and also the accuracy of the coding and billing based upon the physician's charting. The bottom of the Health Insurance Claim Form 1500 (required by many government payers) reads:

> *SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.*
> *NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."*

The resolveds of this resolution are almost the exact language of two resolveds from Referred Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine (the last three resolveds were referred to the Board of Directors). Regarding the first resolved statement of this resolution, and in response to the 2020 referred resolution, ACEP's Public Affairs staff contacted both Majority and Minority congressional staff to discuss potential legislative or other approaches to address billing and collections transparency. Broadly, while there was some interest from congressional staff in the overarching concept of transparency, the most common concerns raised were questions about the role of the federal government in this matter and a reluctance about stepping into contract issues between two private entities. Several congressional staff members noted that federal pushes for increased transparency are typically motivated by the direct patient/consumer impact. Additionally, Board members met with the original authors of the 2020 resolution to discuss the intent of the resolved and to brainstorm options. There were questions about what federal mechanisms could be used for implementation and enforcement, with conditions of participation (COPs), labor law, and FTC. Several staff noted that this option could be further explored, but we should anticipate there will likely be substantial pushback from the hospital community. Separate from these Congressional discussions, ACEP Public Affairs staff and General Counsel investigated whether the False Claims Act (31 U.S.C. §§ 3729–3733), or FCA, could provide a lever for physicians to secure reporting of what has been billed and collected in their name. While the FCA provides mechanisms for penalty (including a private right of action for whistleblowers) if incorrect or fraudulent billing is suspected in Medicare, Medicaid, and other federal programs, there is no specific legal requirement around billing transparency under the law. The False Claims Act only applies when a person "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval" or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent". Under the law, "knowingly" means that "a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information;" and "require no proof of specific intent to defraud." Subsequently, ACEP engaged outside counsel to advise on whether securing regular reporting of billing in a physician's name could inadvertently subject that physician to potential liability under the False Claims Act, since provision of this information could now leave them considered to be "knowing." ACEP developed a primer on the False Claims Act to help empower emergency physicians to better understand their rights under federal law and empowers them to gain access to Medicare billings made in their name. The primer is organized by employment type/payment arrangement.

Like many professional associations, ACEP provides venues for competitors to communicate with its members such as exhibiting at meetings, sponsoring events, and advertising in publications. While some court decisions allow associations to offer or deny access to these venues on arbitrary grounds, there is also case law holding that a denial of essential means of competition may be made the basis for antitrust challenges against associations. Since ACEP is the oldest and largest association of emergency physicians and its *Scientific Assembly* is the largest emergency medicine meeting in the world, excluding certain competitors from these venues could have a significant, adverse impact on those competitors' ability to compete and could result in antitrust litigation filed against ACEP.

ACEP's "Antitrust" policy statement states: "The College is not organized to and may not play any role in the competitive decisions of its member 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 policy further specifies:

- There will be no discussions discouraging or withholding patronage or services from, or encouraging exclusive dealing with any health care provider or group of health care providers…
- There will be no discussions about restricting, limiting, prohibiting, or sanctioning advertising or solicitation that is not false, misleading, deceptive, or directly competitive with College products or services.
- There will be no discussions about discouraging entry into or competition in any segment of the health care market.
- There will be no discussions about whether the practices of any member, actual or potential competitor, or other person are unethical or anti-competitive, unless the discussions or complaints follow the prescribed due process provisions of the College's Bylaws.

Regarding the second resolved of this resolution, and in response to the 2020 referred resolution with almost the exact language, ACEP's General Counsel engaged Powers, Pyles, Sutter & Veville, P.C., a legal firm with specialized expertise in healthcare and representation of nonprofit organizations, as outside counsel to review the resolution and provide a third-party outside legal opinion on the antitrust risk to ACEP to implement the referred resolution as written. At its June 2021 meeting, outside counsel presented the Board of Directors with available case law and previous legal opinions shared on this matter. It was the recommendation of outside counsel that the findings of all four available legal opinions were consistent and clearly demonstrated that there was substantial risk to implementing the referred resolution as written. However, suggestions were made by general and outside counsel that meet the intent of the resolution. Specifically, ACEP could seek to obtain non-competitive information from all emergency physician-employing entities, including exhibitors, advertisers, and sponsors of ACEP meetings and products, with the intent to increase transparency and demonstrate all employers' adherence to key ACEP policy statements related to employer best practices. Following the Board presentation, the Board and staff developed a questionnaire to all emergency physician-employing entities, including exhibitors, advertisers, and sponsors of ACEP meetings and products, asking them to provide information about their organizations. The questionnaire included 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", which specifically mention due process and transparency in billing. Several iterations of the draft questionnaire were discussed with ACEP members, including the original authors of the resolution, and the final was distributed in September 2021. Completed employer survey responses were made available to all members through various channels. An employer database was developed and is available at www.acep.org/EmployerProfile. Promotion of the employer responses was promoted at ACEP21 using QR codes in the onsite program for employer exhibitors, on meter boards, and on tabletop signs for each booth and Job Fair table. Additionally, promotion of the survey responses was included in the ACEP21 mobile app and promotion also occurred in *EM Today, Weekend Review*, social media, ACEP.org and a From the College note in *ACEP Now.*

Approximately 19% of all corporate support ACEP received in FY 2021-22 was derived from physician groups, staffing companies, and hospitals/clinics. Combined, they contributed $541,000 in advertising, exhibits, and all other sponsorship of ACEP programs and activities. Further, ACEP uses advertising to promote employment opportunities, affinity partnerships, member benefits and resources in various channels, including our job board (www.emcareers.org), our monthly publication *ACEP Now*, digital advertising in our e-newsletters and more. Prohibiting these types of agreements would eliminate funding used to offset the cost of key member benefits, including the Annals of Emergency Medicine, *ACEP Now,* and member counseling services and limit member access to employment opportunities and resources.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted staff resources for advocacy initiatives. Potential significant reduction in outside funding support. Potential significant legal expenses to respond to complaints against ACEP.

Prior Council Action

Referred Amended Resolution 29(20) Billing and Collections Transparency in Emergency Medicine (last three resolveds) referred to the Board of Directors. The resolution sought for ACEP to adopt policy that: "No member of ACEP will, directly or indirectly, deny another emergency physician the ability to receive detailed itemized billing and remittance information for medical services they provide."; petition the appropriate state or federal legislative and regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, will directly 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 adopt this policy: "Any entity that wishes to advertise in ACEP vehicles, exhibit at its meetings, provide sponsorship, other support or otherwise be associated with ACEP will as of January 1, 2021, provide every emergency physician associated with that entity, at a minimum, a monthly statement with detailed information on what has been billed and collected in the physician's name. This information must be provided without the need for the physician to request it. Physicians cannot be asked to waive access to this information. The entities affected include but is not limited to revenue cycle management companies, physician groups, hospitals, and staffing companies."

Amended Resolution 29(20) Billing and Collections in Emergency Medicine (first two resolveds) adopted. Directed ACEP to update the "Emergency Physician Contractual Relationships" and "Emergency Physician Rights and Responsibilities" policy statements with specific language.

Amended Resolution 30(20) Protection and Transparency adopted. Directed ACEP to establish policy encouraging 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 Contract Management Group (CMG) as a result of the physician providing his or her services without any requirement of the physician requesting it.

Prior Board Action

April 2021, approved the revised policy statement 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."

April 2021, approved the revised policy statement "Emergency Physician Rights and Responsibilities."

Amended Resolution 29(20) Billing and Collections in Emergency Medicine (first two resolveds) adopted

Amended Resolution 30(20) Protection and Transparency adopted.

January 2019, reaffirmed the policy statement "Antitrust;" reaffirmed June 2013 and October 2007; revised and approved October 2001; originally approved June 1996 replacing a policy statement with the same title that was approved in 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: Jeffrey Davis
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Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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(22)

SUBMITTED BY: Pain Management & Addiction Medicine Section
Donald Stader, MD, FACEP
John Spartz, MD
Nathan Novotny

SUBJECT: Buprenorphine is an Essential Medicine and Should be Stocked in Every ED

PURPOSE: 1) advocate for the FDA adding buprenorphine to its list of essential medications; 2) advocate that EDs stock buprenorphine and medications for opioid use disorder; 3) work with the AHA, AMA, state agencies, and federal agencies to promote availability of medications for opioid use disorder in EDs and hospital settings; and 4) support initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, The opioid crisis continues to escalate, exacerbated by the COVID-19 pandemic, with greater than 103,572 drug overdose deaths in the United States reported over the from January 2021 to January 2022[1]; and

WHEREAS, 1.08 million (14.08%) of all drug-related ED patient visits were related to opioids in 2021, including overdose, complications of opioid use, and seeking treatment for opioid use disorder (OUD)[2]; and

WHEREAS, Buprenorphine is an effective treatment for OUD and associated with reductions in illicit opioid use, mortality, HIV, Hepatitis C, criminal activity, and health care costs [3-8]; and

WHEREAS, Disparities in timely buprenorphine prescription filling rates after opioid-related ED visits across sex, race and age persist despite a slight increase nationwide from 2014-2020, further emphasizing the need for buprenorphine administration in the ED for more uniform access to life-saving, equitable care[9]; and

WHEREAS, Buprenorphine treatment initiated in the ED is associated with reduction in illicit opioid use and significant increase in post-ED addiction treatment [10,11]; and

WHEREAS, Buprenorphine provides excellent relief of opioid withdrawal and is more effective for this than other medications such as clonidine, ondansetron, NSAIDs and other management modalities; and

WHEREAS, Many hospitals and emergency departments do not stock buprenorphine[12], and are not required to stock buprenorphine and other medications for opioid use disorder (MOUD) by accrediting bodies or government agencies; and

WHEREAS, Emergency departments that do not stock buprenorphine are unable to provide the highest quality of evidence based care for patients with OUD or in opioid withdrawal; and

WHEREAS, The FDA publishes a "List of Essential Medicines, Medical Countermeasures and Critical Inputs" that are medically necessary to have available at all times in an amount adequate to serve patient needs and in the appropriate dosage forms[13]; and

WHEREAS, This FDA list does not list buprenorphine as an essential medication[13]; and

WHEREAS, This FDA list is generally composed of medicines "most needed for patients in U.S. acute care

medical facilities, which specialize in short-term treatment for severe injuries or illnesses, and urgent medical conditions[13];" and

WHEREAS, This FDA list aims to include medications that are "medically necessary to have available in adequate supply which can be used for the widest populations to have the greatest potential impact on public health[13];" and

WHEREAS, This FDA list is often used as a reference on what emergency departments are required to stock; and

WHEREAS, Buprenorphine is already listed on the World Health Organization Model List of Essential Medicines[14]; and

WHEREAS, Buprenorphine qualifies as a medicine needed in acute care medical facilities for short-term treatment of OUD and opioid withdrawal; and

WHEREAS, Buprenorphine is a necessary treatment option for every ED patient with OUD or in opioid withdrawal, especially during the current public health crisis surrounding opioids in the United States; therefore be it

RESOLVED, That ACEP advocate on behalf of its patients and members that the FDA add buprenorphine to its list of essential medications; and be it further

RESOLVED, That ACEP recommend and advocate that every emergency department stock buprenorphine and medications for opioid use disorder so that patients with opioid use disorder or in opioid withdrawal may receive the best evidence-based care; and be it further

RESOLVED, That ACEP work with the American Hospital Association, American Medical Association, state agencies, and federal agencies to promote availability of medications for opioid use disorder in emergency departments and hospital settings; and be it further

RESOLVED, That ACEP support hospitals and emergency physicians in initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder to enhance best evidence-based practices in emergency medicine throughout the United States.

Resolution References

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12. Pham S, Haigh A, Barrett E. Statewide Availability of Buprenorphine/Naloxone in Acute Care Hospitals. J Addict Med. 2022;16(1):e48-e51. doi:10.1097/ADM.0000000000000833
13. Executive Order 13944 List of Essential Medicines, Medical Countermeasures, and Critical Inputs. U.S. Food and Drug Administration. https://www.fda.gov/about-fda/reports/executive-order-13944-list-essential-medicines-medical-countermeasures-and-critical-inputs. Published May 23, 2022. Accessed June 29, 2022.
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Background

The resolution calls for the College to: 1) advocate for the FDA adding buprenorphine to its list of essential medications; 2) advocate that EDs stock buprenorphine and medications for opioid use disorder; 3) work with the AHA, AMA, state agencies, and federal agencies to promote availability of medications for opioid use disorder in EDs and hospital settings; and 4) support initiating treatment protocols for opioid use disorder and opioid withdrawal using buprenorphine and medications for opioid use disorder.

Buprenorphine is a partial opioid agonist approved by the FDA as a medication-assisted treatment (MAT). It helps address effects of physical dependency including reducing cravings and withdrawal symptoms, increases safety in the case of overdose, and lowers the potential for misuse. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "Buprenorphine offers several benefits to those with OUD and to others for whom treatment in a methadone clinic is not appropriate or is less convenient." It is "the first medication to treat OUD that can be prescribed or dispensed in physician offices," and as a result, helps to significantly expand access to OUD treatment for patients who would otherwise be unable to receive treatment.

The resolution calls for buprenorphine to be added to the FDA list of essential medicines (Drug and Biologic Essential Medicines, Medical Countermeasures, and Critical Inputs for the List Described in Section 3c) of the Executive Order 13944). In August 2020, President Donald Trump issued Executive Order 13944 to direct the U.S. Food and Drug Administration (FDA) to identify a list of essential medicines, medical countermeasures, and critical inputs that are medically necessary to have available at all times in an amount adequate to serve patient needs and in the appropriate dosage forms. The executive order seeks to ensure sufficient and reliable, long-term domestic production of these products, and to minimize potential shortages by reducing our dependence on foreign manufacturers of these products. The list was developed by the FDA in consultation with other federal partners, and the essential medicines identified "…are those that are most needed for patients in U.S. acute care medical facilities, which specialize in short-term treatment for severe injuries or illnesses, and urgent medical conditions." As the resolution notes, buprenorphine is not currently listed as an essential medicine.

There is a significant need for effective, accessible treatments for opioid use disorder (OUD) in the United States. The 2020 National Survey on Drug Use and Health (NSDUH) showed that about 2.7 million people in the United States who are 12 years old or older, not experiencing homelessness, and not incarcerated or institutionalized, met the diagnostic criteria for a past-year OUD. This number underestimates U.S. residents living with OUD, given that more than 500,000 people are experiencing homelessness (including 1 in 3 military veterans living with OUD) and that does not survey the approximately 2.3 million people who are incarcerated in the United States. Fewer than one-third of those who initiate treatment for a substance use disorder in the United States receive medication. The need for treatment with MOUD outpaces the current capacity for care, and access to MOUD is not spread equally across the United States. Initiation of buprenorphine for the treatment of OUD in the emergency department (ED), combined with linkage to outpatient care, is a critical component of an effective strategy to reduce the national mortality and morbidity among persons living with opioid addiction.

Given the impact of 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. Though the ED may not be the site for long-term care for OUD, it can be an entry point into care, providing patients with immediate access to MOUD, including initiation, and warm handoff to a longer-term care. 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.

In a survey published by RAND in 2022, researchers examined records that capture 92% of prescriptions filled at U.S. retail pharmacies, identifying buprenorphine prescriptions written by emergency physicians and filled between February 1, 2019, and November 30, 2020. The study found that during 2019 to 2020, 71.5% of patients filling buprenorphine prescriptions written by emergency physicians did not fill subsequent buprenorphine prescriptions from other clinicians. That trend was even greater after the COVID-19 public health emergency was declared. ACEP consensus recommend a direct referral or scheduling an appointment with a prescriber who accepts the patient's insurance after a buprenorphine prescription is given to a patient in an emergency department. However, this approach works only if the local clinicians are accepting new buprenorphine patients, and studies suggest that many buprenorphine-prescribing clinicians are not treating many patients or are not accepting new ones. One effective strategy to address this gap is for emergency departments to provide medication directly, however many hospitals and emergency departments do not stock buprenorphine, and are not required to stock buprenorphine and other medications for opioid use disorder (MOUD) by accrediting bodies or government agencies

The College supports increased access to ED-initiated MAT using buprenorphine. Initiating MAT in the ED helps individuals stay in treatment longer, reduces illicit opioid use and infectious disease transmission, and decreases overdose deaths.[1] In addition, the available data demonstrate that patients with OUD who are started on buprenorphine in the ED—and for whom there is a clinic to maintain treatment after treatment in the ED – are twice as likely at 30 days to remain in treatment for OUD, than patients who receive a referral alone (78 percent of patients started on MAT in the ED remain in treatment at 30 days, compared to only 37 percent of those who receive a referral alone).[2] Substantially increased participation in MAT after ED buprenorphine initiation has been replicated in additional studies.[3,4,5]

Furthermore, studies of patients with OUD in California and elsewhere have demonstrated an instantaneous reduction in mortality after buprenorphine-assisted detoxification, justifying its use in the ED even when access to long-term maintenance and follow-up is not available.[6] Finally, a study conducted using a retrospective chart review of 158 patients treated at a single ED with buprenorphine for opioid withdrawal found a greater than 50 percent reduction (17 percent versus 8 percent) in return-rate to the same ED for a drug-related visit within one month, compared to the return-visit rate after usual care.[7] In all, research suggests that the sooner emergency physicians can start patients on the right path, and keep them engaged in treatment, the more successful their recovery can be.

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[1] Bao YP, Wang RJ, et al. Effects of medication-assisted treatment on mortality among opioids users: a systematic review and meta-analysis. Mol Psychiatry. 2018 Jun 22.
[2] D'Onofrio G, O'Connor PG, Pantalon MV, et al, JAMA. 2015 Apr 28;313(16):1636-44.
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There are many regulatory barriers to providing MOUD. However, the federal government has been slowly chipping away at these barriers. In late April 2021, the U.S. Department of Health and Human Services released new buprenorphine practice guidelines that removed 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.

Despite the effectiveness of utilizing buprenorphine for treatment purposes, there are currently significant barriers to its use—the greatest of which is the "X-waiver" requirement mandated by the Drug Addiction Treatment Act (DATA) of 2000. Originally, under the DATA 2000 law, physicians wishing to prescribe buprenorphine outside of opioid treatment programs (OTPs) were required take an 8-hour course and receive a waiver from the Drug Enforcement Administration (DEA). While the Biden Administration released guidance in April 2021 effectively eliminating the training and mandatory certification requirements, this exception still comes with a 30-patient limit and physicians who wish to prescribe buprenorphine still need to obtain an X-waiver. Additionally, if practitioners want to treat more than 30 patients at one time, they must still complete the training and meet all other requirements that are in place around counseling and other ancillary services.

It also often takes 60 to 90 days to receive the waiver once the course is completed and the license application is submitted. ACEP and others have argued X-waiver requirement has led to misperceptions about MAT and has maintained or increased stigma about OUD and the treatment of this disease. Due to the stigma, some clinicians are not willing to pursue this DEA license or even engage in treatment of patients with OUD.

For several years, the College has actively advocated for policies to help reduce barriers to ED-initiated MAT, including the "Easy Medication Access and Treatment for Opioid Addiction Act" (Easy MAT Act) to allow emergency physicians without an X-waiver to dispense from the ED up to a three-day supply of buprenorphine at one time to a patient suffering from acute withdrawal symptoms, and the bipartisan "Mainstreaming Addiction Treatment Act" (MAT Act) to effectively fully eliminate the X-waiver. The Easy MAT Act was included as a provision in a stopgap federal funding bill in December 2020 and is now law. Meanwhile, ACEP advocacy on the MAT Act to eliminate the X-waiver continues – the bill was recently included as part of a larger legislative package of mental health and substance use disorder legislation, the "Restoring Hope for Mental Health and Well-Being Act of 2022" (H.R. 7666), which passed the House of Representatives on June 22, 2022, in a broadly bipartisan 402-20 vote and now awaits further action in the Senate.

The resolution also calls for ACEP to work with organizations like the AHA, AMA, and state and federal agencies to promote availability of medications for opioid use disorder in emergency departments and hospital settings. While not specific to the issue of adding buprenorphine to the FDA list of essential medications, the AMA also supports legislative efforts to remove the X-waiver requirements altogether, and AMA Policy "Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972" states support for "eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder." The AHA provides a toolkit, "Stem the Tide: Addressing the Opioid Epidemic" that includes a section on options to identify and treat OUDs, including information on MAT as well as buprenorphine training programs.

In June 2022, the U.S. House passed the Restoring Hope for Mental Health and Well-Being Act of 2022 (H.R. 7666), which included the Mainstreaming Addiction Treatment (MAT) Act (H.R. 1384/S. 445). ACEP has strongly supported efforts in Congress to advance and pass the Mainstreaming Addiction Treatment (MAT) Act legislation as it improves emergency physicians' ability to treat opioid use disorder and calls for removal of the buprenorphine X-waiver.

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.

In June 2020, the ACEP Board approved Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department, and 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.

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 leaders and subject matter experts developed the Emergency Medicine Medications for Addiction Treatment waiver training, along with an EM MAT "Core" Training (a shortened EM MAT waiver training covering all topics relevant to and essential for care on OUD patients in the ED).

In August 2022, ACEP launched the EM Opioid Advisory Network. This is a new ACEP initiative formed by leaders and experts from the Pain Management & Addiction Medicine Section and the Pain & Addiction Care in the Emergency Department (PACED) accreditation program that connects emergency physicians combating the opioid crisis with expert advice on managing Opioid Use Disorder patients presenting in the ED, creating a protocol to initiate buprenorphine, and more. This is a free, open access service that is available to emergency health care professionals.

ACEP has also developed:

- **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
- **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.**
- **Initiation of Buprenorphine and Pain Management in the ED-Implementation Workshop**. Topics covered in the workshop covered everything from setting up an ED-Buprenorphine program, Naloxone program, stigma, and pain management in the ED.
- EM Substance Use Disorder Residency Curriculum
- 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

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted. Directed

ACEP 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; and 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.

Resolution 39(21) Recommit to Lessening Opioid Deaths in America not adopted. The resolution called for ACEP to 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.

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 emergency physicians 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 follow-up.

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

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted.

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 and rescinded the June 2012 Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.

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.

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.

Background Information Prepared by: Fred Essis, MBA, MA
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PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 30(22)

SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, MD, FACEP

SUBJECT: Compassionate Access to Medical Cannabis Act – "Ryan's Law"

PURPOSE: Support allowing patients access to medical cannabis; endorse and support passage of Ryan's Law across the U.S.; and, endorse, support, and assist chapters in the passage of Ryan's Law legislation in their states.

FISCAL IMPACT: Budgeted committee and staff resources for federal and state advocacy initiatives.

WHEREAS, In 1996 California became the first state to legalize the use of medical cannabis when citizens passed the Compassionate Use Act; and

WHEREAS, 36 states, the District of Columbia, and four U.S. territories allow medical cannabis use; and

WHEREAS, The fastest growing demography of people using medical cannabis is people 65 and older; and Whereas Medical organizations that have issued statements in support of allowing access to medical cannabis include the American Nurses Association, American Public Health Association, American Medical Student Association,[1]National Multiple Sclerosis Society, Epilepsy Foundation, and Leukemia & Lymphoma Society; and

WHEREAS, On January 12, 2017 the National Academies of Science, Engineering & Medicine released a report entitled "Health Effects of Cannabis and Cannabinoids: Current State of Evidence and Recommendations for Research", which concluded there was conclusive or substantial scientific evidence that medical cannabis was an effective treatment for chronic pain in adults, anti-emetics in chemotherapy-induced nausea and spasticity symptoms in MS and moderate scientific evidence that medical cannabis was an effective treatment for obstructive sleep apnea and

WHEREAS, Many terminally ill patients are admitted to acute care hospitals with chronic pain and nausea due to chemotherapy; and

WHEREAS, According to a survey from Morse Life Health System Hospice and Palliative Care 87% of Americans support medical cannabis as an option for treatment in cases where the patient has received a terminal diagnosis; and

WHEREAS, Hospitals in Israel, Germany, Canada and other countries have developed policy and procedures for inpatient use of medicinal cannabis; and

WHEREAS, The AMA Code of Ethics, Opinion 10.01 - Fundamental Elements of the Patient- Physician Relationship that states "The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives." should apply to inpatients; and

WHEREAS, Ryan's Law allows terminal ill patients to use medical cannabis in hospitals; and

WHEREAS, Ryan's Law specifically prohibit the smoking or vaping of medical cannabis for hospitalized terminally ill patients; and

WHEREAS, Ryan's Law allows any hospital investigated by the federal government for using a scheduled 1 drug to immediately prohibit the use of medical cannabis in the hospital; and

WHEREAS, The Ryan's Law team is advocating for a version of Ryan's Law in 14 other states and the United States Congress for 2022 and if approved these laws will also require health care facilities and hospitals to allow terminally ill patients use of some types of medical cannabis; therefore be it

RESOLVED, That ACEP support allowing patients access to medical cannabis; and be it further

RESOLVED, That ACEP endorse and support the passage of Ryan's Law across the entire United States; and be it further

RESOLVED, That ACEP endorse, support, and assist ACEP chapters in the passage of Ryan's Law legislation in their states.

Background

The resolution calls for ACEP to support allowing patients access to medical cannabis; endorse and support the passage of Ryan's Law across the U.S.; and, endorse, support, and assist ACEP chapters in the passage of Ryan's Law legislation in their states.

The Compassionate Access to Medical Cannabis Act, or "Ryan's Law," is a California law requiring health care facilities to allow the use of medical cannabis on their premises for terminally ill patients with a valid medical cannabis card or recommendation from their physician. The law requires health care facilities to not interfere with or prohibit eligible patients from consuming medical cannabis on-site (smoked or vaped cannabis products are excluded); list medical cannabis use in a patient's record; obtain a copy of the patient's valid medical cannabis license or physician recommendation before allowing any consumption; write and distribute guidelines detailing the new protocols; and, ensure that the patient's cannabis is stored and secured in a locked container when not being consumed.

However, recognizing the current legal disparities between state laws and federal law,a provision was added to the law. This provision was included to ensure that hospitals and facilities are not forced to choose between complying with state law and not federal law (or vice versa), ensuring they do not face the threat of potentially losing access to federal funds for operating in accordance with state law. Hospitals may comply with federal demands in the case of a federal agency ordering a facility to stop allowing a patient to consume medical cannabis..

The legalization of both recreational and medicinal use of cannabis continues to be highly controversial, enhanced by conflicting studies demonstrating various effects experienced in states where marijuana use has been legalized. The medical use of cannabis is legalized in 37 states, three 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 19 states, the District of Columbia, the Northern Mariana Islands, and Guam. Another 13 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.

Despite legalization in several states, marijuana remains a Schedule I drug under the federal Controlled Substances Act, along with drugs like cocaine, LSD, heroin, MDMA (ecstasy), and psylocibin, among others. Schedule I drugs are those with a high potential for abuse, no current accepted medical treatment use within the U.S., and a lack of accepted safety for use under medical supervision.

Last year, the Council adopted Amended Resolution 50(21) Complications of Marijuana Use directing ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in the ED, provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis-related ED diagnoses, and develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department. In response to the resolution, the Clinical Policies Committee is in the process of

developing practice guidelines and the Public Health & Injury Prevention Committee has developed patient information on the risks and potential effects of marijuana use and physician information on the management of THC presentations in the ED that will soon be available on the ACEP website.

ACEP's policy statement "Medical Cannabis," states:

> The American College of Emergency Physicians (ACEP) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including cannabis and cannabis derivative products, for medical use. Currently, in many states, cannabis and related cannabinoids are being recommended for patient use by physicians when little evidence has been provided regarding appropriate indications, efficacy, dosages, and precautions of these drugs. ACEP supports the rescheduling of cannabis and encourages the Food & Drug Administration (FDA), Drug Enforcement Administration (DEA), and other appropriate organizations to facilitate scientifically valid, well-controlled studies of the use of cannabis and cannabis derivative products for treatment of disease and of its impact on societal health.

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.". This legislation is 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. This legislation is also 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

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted staff time and resources, potential costs associated with assisting chapters.

Prior Council Action

Amended Resolution 50(21) Complications of Marijuana Use adopted. Directed ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in the ED; provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses; and develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department.

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

Amended Resolution 50(21) Complications of Marijuana Use adopted.

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: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 31(22)

SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, MD ,FACEP

SUBJECT: Decriminalization of All Illicit Drugs

PURPOSE: Endorse and support decriminalization of personal possession and use of small amounts of all illicit drugs in the U.S. and endorse and support chapters to develop and introduce state legislation decriminalizing personal possession and use of small amounts of all illicit drugs.

FISCAL IMPACT: Budgeted committee and staff resources. Potential unbudgeted costs for legislative drafting or consulting for development of model legislation.

WHEREAS, In 2001 Portugal became the first country to decriminalize the personal possession and use of small amounts of all illicit drugs; and

WHEREAS, Since it decriminalized all illicit drugs, Portugal has seen a dramatic drops in drops in problematic drug use, HIV and hepatitis infection rates, overdose deaths, drug-related crime, and incarceration rates; and

WHEREAS, The following countries have decriminalized drug use: Antigua + Barbuda, Argentina, Armenia, Australian States: South Australia, Australian Capital Territory, Northern Australia, Belize, Bolivia, Chile, Colombia, Costa Rica, Croatia, Czech Republic, Estonia, Germany, Italy, Jamaica, Mexico, Netherlands, Paraguay, Peru, Poland, Portugal, Russian Federation, South Africa, Spain, Switzerland, Uruguay, Virgin Islands (US Territory); and

WHEREAS, On Election Day 2020, Oregonians overwhelmingly passed Measure 110 that made the possession of small amounts of cocaine, heroin, LSD, and methamphetamine, among other drugs, punishable by a civil citation – akin to a parking ticket – and a $100 fine; and

WHEREAS, Alaska, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Nevada, New Hampshire, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington DC have decriminalized to some degree the personal possession and use of illicit drugs; therefore be it

RESOLVED, That ACEP endorse and support the decriminalization of the personal possession and use of small amounts of all illicit drugs in the United States instead making that a civil penalty with referral to treatment; and be it further

RESOLVED, That ACEP endorse and support ACEP chapters to develop and introduce state legislation that decriminalizes the personal possession and use of small amounts of all illicit drugs and instead making that a civil penalty with referral to treatment.

Background

The resolution directs the College to endorse and support the decriminalization of the personal possession and use of small amounts of all illicit drugs in the United States instead making that a civil penalty with referral to treatment, and also directs the College to endorse and support ACEP chapters to develop and introduce state legislation that decriminalizes the personal possession and use of small amounts of all illicit drugs and instead making that a civil penalty with referral to treatment.

Decriminalization of drugs typically refers to the elimination of criminal penalties for the possession and use of illicit drugs, possession and use of paraphernalia and related equipment used to introduce drugs into the body, and low-level drug sales (i.e., not large-scale trafficking). To date, twenty-six states in the U.S. and the District of Columbia (D.C.) have decriminalized the possession of small amounts of marijuana, and in November 2020, Oregon became the first state in the country to decriminalize possession of all drugs and increase access to support services. Since the passage of this ballot measure (the "Drug Addiction Treatment and Recovery Act," Measure 110), similar efforts have been either introduced or initiatives have been launched in several states and the U.S. Congress. Such efforts include bills aimed specifically at decriminalization of marijuana and others, like the "Drug Policy Reform Act" (H.R. 4020), that would decriminalize drug possession at the federal level, promote evidence-based treatment- and recovery-focused health approaches, and expunge criminal records and provide resentencing opportunities.

Worldwide, Portugal is considered the primary case study for decriminalization, having decriminalized the personal use and possession of all illicit drugs in 2001. Portugal's law did not make illicit drugs legal, nor did it decriminalize drug trafficking. Instead of incarceration or criminal penalties, law enforcement officers encountering individuals in possession of drugs may confiscate the drug and refers the individual to substance use disorder (SUD) services, managed under regional networks of "dissuasion commissions" operated through the Portugal Ministry of Health. These commissions consist of health, social, and legal services workers who connect individuals directly with SUD treatment, harm reduction services, and therapy, depending on an individual's needs or desires. While there are no longer any criminal penalties, individuals may be served with fines or required to provide community service or attend required therapy interventions.

The success or failure of Portugal's decriminalization example is still a matter of debate more than two decades later, with disagreement among proponents and opponents on what lessons can be learned from the country's experience given the available data. Some, like the U.S. Office of National Drug Control Policy, suggest that "[i]t is difficult, however, to draw any clear, reliable conclusions…regarding the impact of Portugal's drug policy changes." A more recent review of the available scientific literature published in the *Current Opinion in Psychiatry* journal (July 2018) concluded that:

> "[s]cientific evidence supporting drug addiction as a health disorder and the endorsement by the [United Nations] strengthen the case for decriminalization. However, studies reporting the positive outcomes of decriminalization remain scarce. The evidence needs to be more widespread in order to support the case for decriminaliazation."

According to the Drug Policy Alliance, while Portugal's rate of drug use has stayed about the same, arrests, incarceration, disease, overdoses, and other associated harms with drug use and SUD are all down. Additionally, Portugal's drug use rates are below the average in Europe and far lower than drug use rates in the U.S. Within the first decade after the law was enacted, three-quarters of individuals with opioid use disorder (OUD) were in medication-assisted treatment (MAT) programs, the number of people in drug treatment programs increased by more than 60 percent, overdose fatalities dropped significantly, incarceration rates and prison overcrowding were dramatically reduced, and bloodborne disease diagnoses like HIV also fell.

However, there were also negative effects in the years following decriminalization. One study found that after the law was enacted, drug experimentation increased even though it did not lead to regular drug use. Murders increased by 41 percent in the first five years following passage, but began to fall again after, and large-scale drug trafficking increased. Further complicating efforts to analyze the full effects of the law is the fact that even prior to enactment, drug consumption and possession convictions typically resulted in fines, not incarceration, and the country already had low rates of incarceration for drug use.

Proponents of drug decriminalization focus on the relatively recent shift in understanding substance use disorder as a health issue, rather than a criminal justice issue or as a personal failing. Supporters also note that drug arrests are the most commonly arrested offense in the U.S. with one drug arrest every 23 seconds, and that there are significant long-term consequences that may limit an individual's ability to secure public benefits, employment, housing, child welfare services, immigration, and others, if they have a criminal drug offense on their record. Supporters argue that removing criminal penalties would reduce incarceration and the associated public costs, allow law enforcement to reprioritize resources for other purposes, promote health care, treatment, and safety efforts rather than criminal punishment,

reduce stigma for both drug use and treatment, and would reduce or eliminate barriers to evidence-based harm reduction strategies. Additionally, with more accessible community services, such as safe use/injection facilities, needle exchange programs/services, and more, proponents suggest there will be a significant public health impact in reduced bloodborne pathogen and disease transmission, lower rates of overdose and overdose deaths, and higher rates of successful long-term recovery given access to treatment and recovery programs.

Opponents of decriminalization note that there remains limited data on the effects of decriminalization, including a lack of reporting of adverse trends such as increases in drug-related deaths and overall safety of the drug supply. With respect to the safety of the drug supply, many communities throughout the U.S. have witnessed increases in fentanyl contamination in heroin, opioids, benzodiazepines, cocaine, and other stimulants (along with other effects of the COVID-19 pandemic, the volatility of the illicit drug supply is presumed to be a likely contributing factor in the estimated 107,622 overdose deaths recorded in 2021, a 15 percent increase compared to 2020). Additionally, some (particularly law enforcement) are concerned about the potential for increased rates of violent crime and drug trafficking, especially given the substantial influx of illicit fentanyl and other synthetic opioids in the U.S. drug supply. Others note concerns about the current lack of health care, SUD/OUD treatment, and social service infrastructure needed to support decriminalization laws (a challenge noted in Oregon even by supporters of the state's decriminalization effort). Other persistent challenges remain as well, including continued stigma and bias among health care providers who may have received little or no training on providing SUD/OUD treatment.

ACEP Strategic Plan Reference

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- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

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- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted committee and staff resources. Potential unbudgeted costs for legislative drafting or consulting for development of model legislation

Prior Council Action

Amended Resolution 50(21) Complications of Marijuana Use adopted. Directed ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in the ED; provide education and guidance to emergency physicians in relationship to documentation and overall awareness of cannabis related ED diagnoses; and develop and disseminate public facing information on the complications of marijuana use as seen in the emergency department.

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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.

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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.

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Prior Board Action

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June 2019, approved the policy statement "Medical Cannabis."

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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: Ryan McBride, MPP
ACEP Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 32(22)

SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, MD, FACE

SUBJECT: Supervised Consumption Facilities/Safe Injection Sites

PURPOSE: Support the development and implementation of Supervised Consumption Facilities/Supervised Injection Sites (SCF/SIS) in the United States that would be designed, monitored, and evaluated to include additional data to inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harm and health care costs related to injection drug use.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, The United States is in an epidemic of drug overdose deaths, and it is clearly and compellingly evident that current policies are not working; and

WHEREAS, Supervised Consumption Facilities (SCF), also known as Supervised Injection Sites (SIS), are medically supervised facilities designed to provide a hygienic environment in which people are able to consume illicit recreational drugs intravenously and prevent deaths due to drug overdoses and these sites are part of a proven harm reduction strategy to reduce substance use problems and the facilities provide immediate access to rescuer medical staff, sterile injection equipment, information about drugs and basic health care, treatment referrals, and counseling; and

WHEREAS, The benefits of SCF/SIS are well established, they reduce overdose deaths because a rescuer is always present, they decrease infectious disease transmission (primarily HIV and hepatitis C), they increase the number of individuals initiating treatment for substance use disorders, they decrease the number of IV drug users using in public settings and who discard their used syringe and needles there; and

WHEREAS, The first modern SCF/SIS was opened in Berne, Switzerland in June 1986; and

WHEREAS, There are 39 government authorized SCF in Canada as of July 2019; and

WHEREAS, Currently there are approved SCF/SIS operating in 11 countries globally, including Canada, Germany, and Switzerland; and

WHEREAS, In the United States the first government-authorized supervised injection site began operating in New York City on November 30, 2021; and

WHEREAS, SCF/SIS, besides saving lives, are cost effective and in San Francisco, for example, one analysis concluded that for every dollar spent on such sites, $2.33 in emergency medical, law enforcement, and other costs would be reduced, producing a yearly net savings of $3.5 million; and

WHEREAS, Recent articles in the *New England Journal of Medicine* (May 26, 2022) and the *Journal of the American Medical Association* (April 26, 2022) illustrate the value of SCF/SIS as an additional method of reducing the ravages of substance use disorders on users and communities; and

WHEREAS, American Medical Association policy supports the development and implementation of pilot supervised injection facilities in the United States that are designed, monitored, and evaluated to generate data to

inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harms and health care costs related to injection drug use; therefore it be

RESOLVED, That ACEP support the development and implementation of Supervised Consumption Facilities/Supervised Injection Sites (SCF/SIS) in the United States that would be designed, monitored, and evaluated to include additional data to inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harm and health care costs related to injection drug use.

Background

This resolution directs the College to support the development and implementation of Supervised Consumption Facilities/Supervised Injection Sites (SCF/SIS) in the United States that would be designed, monitored, and evaluated to include additional data to inform policymakers on the feasibility, effectiveness, and legal aspects of SCF/SIS in reducing harm and health care costs related to injection drug use.

Supervised Consumption Facilities or Supervised Injection Sites (also known as Overdose Prevention Centers (OPCs), Drug Consumption Rooms (DCRs), and Supervised Consumption Services (SCS)) are locations where individuals can inject self-provided intravenous drugs under medical supervision in order to prevent drug overdoses and overdose deaths. SCF/SISs are intended as harm reduction strategies – in addition to providing a safe location to consume self-provided drugs staffed with trained medical personnel, they typically offer sterile consumption equipment, fentanyl test strips or other testing equipment, as well as counseling and referrals for health care, substance use treatment, and other social services. According to the Drug Policy Alliance, there are approximately 200 SIFs operating in 14 countries throughout the world. In the United States, New York City launched the country's first such facilities in November 2021, and several other cities (including San Francisco, Boston, Seattle, and Philadelphia, among others) continue to consider them. However, since September 2014, at least one unsanctioned safe consumption site was in operation in an undisclosed U.S. city, and it is possible that other unsanctioned facilities have existed or continue to operate.

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 902,000 report having used heroin in the past 12 months, according to the NIH National Survey on Drug Use and Health. According to the Centers for Disease Control and Prevention (CDC), there were an estimated estimated 107,622 overdose deaths recorded in 2021, a 15 percent increase compared to 2020. In fact, the CDC highlights that more than 932,000 people have died since 1999 from a drug overdose. This is part of an overall trend of increasing opioid overdose deaths that are directly related to overdoses from prescription opioids.

The concept of SCF/SIS have been proposed as a public health intervention to help save lives by reducing overdoses, deaths, and preventable illnesses like HIV, hepatitis C and soft tissue infections. The establishment of these facilities in the U.S. remains a controversial topic as critics argue such policies endorse illicit drug use, encourage first-time drug use, and do not curb addiction or address drug-related crime (and in fact may increase it), while supporters point to benefits like a decreased prevalence of preventable diseases as well as reduced overdose rates that help contribute to a reduced need for emergency services. Recent medical literature and study does appear to provide evidence of harm reduction, including reduced overdose deaths, lower rates of infectious disease transmission, and greater initiation of substance use disorder (SUD) treatment, without corresponding increases in crime or nuisance in the surrounding area.

There are also additional legal aspects with regard to possession and use of illegal drugs and paraphernalia that occur at the federal, state, and local levels that will need to be addressed if SIFs are to be established in the U.S. Several U.S. cities and the state of Rhode Island have approved the concept, but no authorized sites were actually operating until New York's opened in November 2021. And even despite New York's experience, their legal status under federal law remains a barrier due to recent court rulings regarding a 1986 federal law against running a venue for

illicit drug use that has, to date, prevented a similar SIS from opening in Philadelphia.

In 2017, the American Medical Association adopted a policy to support the development and implementation of pilot SIFs in the U.S. that are designed, monitored and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use (AMA Policy – Pilot Implementation of Supervised Injection Facilities, H-95.925 (2017)). Since adoption of this policy, AMA publicly supported a new Rhode Island law (including helping develop the regulations) for new sites that are expected to go into operation soon. AMA also provided background and technical assistance to multiple state medical societies considering similar legislation, including a California bill several years ago to authorize pilot sites that but was vetoed by the governor. A new bill to authorize pilot sites is currently awaiting the governor's signature (AMA discussed with the California Medical Association but did not directly engage on the bill). And in December, 2020, the Litigation Center of the American Medical Association and State Medical Societies joined the Pennsylvania Medical Society, Philadelphia County Medical Society and about a dozen other organizations in an amicus brief, to provide information to the U.S. Court of Appeals for the 3rd Circuit that years of evidence show that these facilities provide evidenced-based medical and health interventions that help save lives, offer access to necessary services, and provide support to people who use drugs. The case continues to be battled in the courts.

The College supports the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision, and endorses SIFs as an effective public health intervention in areas and communities heavily impacted by IV drug use (Amended Resolution 31(17) Development and Study of Supervised Injection Facilities). Per this resolution, the ACEP 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." The College also supports federal funding for syringe services programs and advocates for changes to laws to permit syringe services programs in addition to access to naloxone and educational material, as well as informing patients of the risks of fentanyl analogues and other harmful admixtures and the utilization and limitations of fentanyl test strips and other methods for testing for contaminants and adulterants (Amended Resolution 26(21) Advocacy for Syringe Service Programs and Fentanyl Test Strips).

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Amended Resolution 26(21) Advocacy for Syringe Service Programs and Fentanyl Test Strips adopted. Directed the College to support federal funding of syringe services programs; 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 update harm reduction materials and resources available to members to include informing patients of the risks of fentanyl analogues and other potential harmful admixtures and the utilization and limitations of fentanyl test strips and other methods of testing for contaminants and adulterants.

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

Amended Resolution 26(21) Advocacy for Syringe Services Programs and Fentanyl Test Strips adopted.

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: Fred Essis, MBA, MA
Congressional Lobbyist

Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Telehealth Bridge Model for the Treatment of Opioid Use Disorder

PURPOSE: Support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder care and advocate for state and federal regulatory and legislative solutions to permit ongoing integration of opioid use disorder treatment including medication therapy through telehealth.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, More than 100,000 Americans died of an overdose in 2021, primarily due to illicit opioids[1]; and

WHEREAS, The staggering number of preventable overdose deaths requires utilization of every tool at our disposal to mitigate this tragic loss of life; and

WHEREAS, Medication treatment for opioid use disorder (OUD), including buprenorphine, is associated with significant improvements in outcomes including reductions in overdose mortality, illicit substance use, incidence of infectious hepatitis and HIV, and criminal justice involvement[2]; and

WHEREAS, Low barrier access to buprenorphine therapy is evidence-based and recommended by the National Academy of Medicine and the American Society of Addiction Medicine[2,3]; and

WHEREAS, Patients evaluated on the same day as presentation are 7x more likely to engage in treatment than those who are forced to wait 2 or more days[4]; and

WHEREAS, Gaps in knowing where to go for treatment, difficulty accessing care, long wait times, and geographical distance from treatment providers are significant barriers to accessing evidence-based medication treatment for OUD[5-8]; and

WHEREAS, Delivery of buprenorphine therapy via telehealth has been found to result in comparable outcomes, report higher patient satisfaction, reduce healthcare costs, and increase access to buprenorphine therapy[9]; and

WHEREAS, Telehealth offers a feasible, evidence-based mechanism to overcome some barriers to care, and

WHEREAS, Emergency Department (ED) initiation of buprenorphine coupled with referral to close outpatient follow up is recommended for patients with OUD[10]; and

WHEREAS, A commonly cited barrier to implementing ED buprenorphine induction processes is lack of rapidly accessible follow up care[11]; and

WHEREAS, Only 12% of patients treated in the ED for nonfatal opioid overdoses subsequently receive medication treatment for OUD and only 28.5% of patients prescribed buprenorphine from the ED fill another buprenorphine prescription within 30 days[12]; and

WHEREAS, Low barrier telehealth buprenorphine treatment programs, many implemented by emergency medicine physicians, have demonstrated excellent engagement and retention in evidence-based OUD treatment using both audiovisual and audio-only platforms[13]; and

WHEREAS, A telehealth bridge clinic model developed and implemented by emergency physicians rapidly engaged 96% of vulnerable patients referred to it for opioid use disorder treatment on buprenorphine therapy with no significant difference between audiovisual or audio-only telehealth[14]; and

WHEREAS, Current low-barrier telehealth programs have been established under temporary waivers of The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 under the COVID-19 Public Health Emergency declaration; and

WHEREAS, Solutions to permit the establishment of a practitioner-patient relationship through telehealth have been proposed by emergency physicians in order to maintain access to evidence-based care for patients with opioid use disorder[15;] and

WHEREAS, Rapidly accessible, low barrier telehealth programs may serve as a reliable and readily available solution for ED referral for ongoing buprenorphine care following discharge regardless of geography and local addiction treatment capacity allowing for broader implementation of evidence-based ED opioid use disorder care; therefore be it

RESOLVED, That ACEP support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder care; and be it further

RESOLVED, That ACEP advocate for state and federal regulatory and legislative solutions that will permit the ongoing integration of opioid use disorder treatment including medication therapy through telehealth into the continuum of addiction care.

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Background

This resolution calls on ACEP to support the development and implementation of low-barrier telehealth medication treatment services to address gaps in opioid use disorder (OUD) care and to advocate for state and federal regulatory and legislative solutions that will permit the ongoing integration of OUD treatment including medication therapy through telehealth into the continuum of addiction care.

ACEP believes buprenorphine is an extremely valuable tool in the emergency department (ED) to help start patients on the path towards recovery. Initiating medication assisted treatment (MAT) in the ED helps individuals stay in treatment longer, reduces illicit opioid use and infectious disease transmission, and decreases overdose deaths.[1] In addition, the available data demonstrate that patients with OUD who are started on buprenorphine in the ED – and for whom there is a clinic to maintain treatment after treatment in the ED – are twice as likely at 30 days to remain in treatment for OUD than patients who receive a referral alone (78 percent of patients started on MAT in the ED remain in treatment at 30 days, compared to only 37 percent of those who receive a referral alone).[2] Substantially increased participation in MAT after ED buprenorphine initiation has been replicated in additional studies.[3,4]

Furthermore, studies of patients with OUD have demonstrated a reduction in mortality after buprenorphine-assisted detoxification, justifying its use in the ED even when access to long-term maintenance and follow-up is not available.[5] Finally, a study conducted using a retrospective chart review of 158 patients treated at a single ED with buprenorphine for opioid withdrawal found a greater than 50 percent reduction (17 percent versus 8 percent) in return-rate to the same ED for a drug-related visit within one month, compared to the return-visit rate after usual care.[6] In all, research suggests that the sooner we can start patients on the right path and keep them engaged in treatment, the more successful their recovery.

Despite the demonstrated effectiveness of buprenorphine , there are many regulatory barriers in place. Currently, the Drug Addiction Treatment Act of 2000 (DATA 2000), requires physicians and other health care practitioners must have an “X-waiver,” to prescribe buprenorphine to patients with OUD

Advocacy efforts by ACEP and others have been working to chip away at these barriers. ACEP believes that the X-waiver requirement is a significant barrier to MAT initiation in the emergency department. In April 2021, the government released guidance that effectively eliminated the training and mandatory certification requirements for the X-waiver.

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ACEP's lobbying efforts continue to support the Mainstreaming Addiction Treatment (MAT) Act, which would fully eliminate the waiver requirement. On June 22, 2022, the U.S. House of Representatives passed the Restoring Hope for Mental Health and Well-Being Act of 2022 (H.R. 7666), which included the MAT Act. Current advocacy efforts are focusing on introduction and passage of a companion bill in the U.S. Senate and a final signature from the President of the United States.

ACEP has long supported legislation sponsored by emergency physician and U.S Representative Raul Ruiz (D-CA/36th) to refine the Three-Day Rule 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 law requires the Attorney General (who will delegate this to the Drug Enforcement Administration or 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)." This Act required a change in the current restriction against dispensing more than one day's worth of medication at a time, thus allowing patients to receive one day's-worth of medication while at the emergency department (ED) and then take the two remaining days of medication home. As of the date of this writing, the Attorney General has not issued this revision. In the meantime, the DEA announced on March 23, 2022, that in line with the objective of the Easy MAT Act, practitioners who wish to dispense the full three days of medication to patients at one time can make a request to DEA to receive permission to do so. Practitioners have to email the DEA to obtain approval. Requests for exception must be emailed to ODLP@dea.gov under the subject line: "Request for Exception to Limitations on Dispensing for OUD."

Despite some regulatory successes, barriers to the treatment of OUD still exist. Existing ACEP policy supports the use of telehealth services by board-certified emergency physicians. ACEP believes that use of telehealth reduces barriers to care. With respect to telehealth and opioid use disorder (the topic of the resolution)there are few specific references in ACEP policy to the use of telehealth in this context. ACEP President Mark Rosenberg, DO, FACEP, convened a Telehealth Task Force in 2021. Contained within the task force report was a statement that ACEP should advocate for expanded use of telehealth, including prescribing of controlled substances for opioid use disorder via telehealth during the COVID-19 public health emergency (PHE).

At the beginning of the PHE, the DEA issued waivers to allow DEA-registered practitioners to prescribe controlled substances to their patients without having to interact in-person with their patients. Under the DEA's policy (which became effective on March 31, 2020), authorized practitioners can prescribe buprenorphine over the telephone to new or existing patients with OUD without having to first conduct an examination of the patient in person or via telehealth.

The DEA also plans to issue two regulations regarding the use of telehealth to prescribe controlled substances. One rule relates to the Ryan Haight Online Pharmacy Consumer Protection Act of 2008. The Act required an in-person medical evaluation as a prerequisite to prescribing or dispensing controlled substances, except in the case of practitioners engaged in the practice of telemedicine. The definition of the ''practice of telemedicine'' includes seven distinct categories that involve circumstances in which the clinician might be unable to satisfy the Act's in-person medical evaluation requirement yet nonetheless has sufficient medical information to prescribe a controlled substance. One specific category within the Act's definition of the ''practice of telemedicine'' includes a practitioner who has obtained a special registration from the DEA. However, the DEA must issue regulations to effectuate this special registration provisions. This proposed rule would permit such a special registration. The other rule would clarify the ability of clinicians with X-waivers to prescribe buprenorphine to patients with OUD via an audio-only encounter (i.e., by telephone).

Both rules are being reviewed by the Office of Management and Budget within the White House, but it is unclear when they will be issued.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- Create awareness around the business of emergency medicine and have difficult discussions about possibilities and protections.

Fiscal Impact:

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Resolution 39(21) Recommit to Lessening Opioid Deaths in America not adopted. Directed ACEP to 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.

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.

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 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 follow-up.

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

January 2022, discussed the recommendations contained in the Telehealth Task Force report.

October 2021, filed the Telehealth Task Force report. A workgroup of Board members was assigned to review the recommendations in the report and provide an analysis to the Board of Directors at their January 27-28, 2022, meeting.

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.

February 2020, approved the revised policy statement "Emergency Medicine Telehealth;" originally approved June 2016.

February 2020, approved changing the name of the ED Pain & Addiction Management Accreditation Program to Pain & Addiction Care in the ED (PACED).

Amended Resolution 52(19) Telehealth Emergency Physician Inclusion adopted.

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 Pain 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, 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 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: Jeffrey Davis
Regulatory and External Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 34(22)

SUBMITTED BY: New York Chapter

SUBJECT: Emergency Department Safety

PURPOSE: Work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the ED.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, The safety of patients and staff in the Emergency Department is of utmost importance; and

WHEREAS, A 35 year-old man was shot in the arm while in the ED waiting room at Jacobi Hospital in Bronx, NY, on January 25, 2022, at 12:30 pm; and

WHEREAS, There have since been numerous additional incidents; therefore be it

RESOLVED, That ACEP work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the ED.

Background

This resolution calls on ACEP to work with the American Hospital Association, other relevant stakeholders, and law enforcement officials to ensure best practices are established and promoted to protect patients and staff from weapons in the emergency department (ED).

Violence in health care is a common occurrence. An ACEP survey from 2018 showed that nearly half of emergency physicians have experienced violence and 80 percent of emergency physicians said that violence was harming patient care. These trends have not improved, and we still continuously hear stories about attacks or other violent episodes from health care workers across the country. In fact, since the onset of the pandemic, violence against hospital employees has markedly increased — and there is no sign it is receding. Studies indicate that 44 percent of nurses report experiencing physical violence and 68 percent report experiencing verbal abuse during the pandemic.[1]

ACEP has taken an active role in trying to address the problem of violence in the ED. In 2019, ACEP partnered with the Emergency Nurses Association (ENA) to launch an ongoing campaign called "No Silence on ED Violence" to equip and empower our respective members to effect needed safety improvements at their hospitals, while engaging state and federal policymakers, stakeholder organizations and the public at large to generate action to address this crisis. A webpage was created, stopedviolence.org, to serve as a resource and advocacy hub for violence in the ED.

Furthermore, in 2020, ACEP was part of an Action Team sponsored by the National Quality Forum to identify and propose ways to overcome key barriers to appropriately responding to and reporting violent incidents in health care settings and preventing future ones from occurring. The work of the Action Team culminated with the release of an issue brief that included a specific set of priority challenges for policymakers and other stakeholders to address.

ACEP supports the "Workplace Violence Prevention for Health Care and Social Service Workers Act" (H.R. 1195, S.4182) that passed the House of Representatives in April of 2021 and was introduced in the Senate in May of 2022. This bipartisan effort takes critical steps to address ED violence by requiring the Occupational Safety and Health

Administration (OSHA) to issue enforceable standards to ensure health care and social services workplaces implement violence prevention, tracking, and response systems. ACEP also supports the Safety from Violence for Healthcare Employees (SAVE) Act, which was introduced in the House of Representatives in June of 2022. This bipartisan bill would help curb violence in the emergency department and criminalize assault or intimidation against health workers.

One of the main focuses of the 2022 Leadership & Advocacy Conference was protecting emergency physicians from ED violence. Emergency physicians at all career levels met with legislators about ED violence and asked legislators to establish important, common sense procedures to protect emergency physicians, health care workers, and patients from violence in the health care workplace.

ACEP and the American Nurses Association sent a letter to and subsequently met with the National District Attorneys Association in April 2022 to discuss state-level prosecutorial approaches to offenders who assault health care workers, asking that assailants be subject to the same penalties of those who assault airline workers.

In early 2022, The Joint Commission established and started enforcing new workplace violence prevention requirements to guide hospitals in developing strong workplace violence prevention programs. ACEP contributed to the development of these new requirements by participating in an expert workgroup and supplying comments.

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence and the Threat of 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.

Reference

[1]E.g., Byon H, et al., Nurses' experience with Type II workplace violence and underreporting during the COVID-19 pandemic. Workplace Health Saf. 2021 21650799211031233.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Amended Resolution 32(21) Firearm Ban in EDs Excluding Active Duty Law Enforcement adopted. Directed 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; endorse and promote screening for weapons in the emergency department; and promote public education and academic research to decrease workplace.

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.

Substitute Resolution 21(14) Emergency Department Mental Health Information Exchange adopted. This resolution called for ACEP to research the feasibility of identifying and risk-stratifying patients at high risk for violence and devise strategies to help emergency care providers with stakeholders to mitigate patients' risk of self-directed for interpersonal harm and investigate the feasibility and functionality of sharing patient information under HIPAA.

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.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

Amended Resolution 22(98) Violence Prevention adopted. Directed the College to establish a national dialogue between interested parties on this issue and that ACEP encourage the National Institute of Mental Health and Centers for Disease Control and Prevention among others to make financial support available for research into this area.

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 11(93) Violence Free Society adopted. Directed the College to develop a policy on violence free society and to educate members about the preventable nature of violence and the important role physicians can play in violence prevention.

Amended Resolution 44(91) Health Care Worker Safety adopted. It directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action

Amended Resolution 32(21) Firearm Ban in EDs Excluding Active Duty Law Enforcement 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.

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."

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

August 2014, reviewed the information paper "Hospital-Based Violence Intervention Programs."

Resolution 37(13) Establishing Hospital-Based Violence Intervention Program adopted

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 22(98) Violence Prevention adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Amended Resolution 11(93) Violence-Free Society adopted.

Background Information Prepared by: Erin Grossman
External Affairs Coordinator

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 35(22)

SUBMITTED BY: Massachusetts College of Emergency Physicians

SUBJECT: Workplace Violence Towards Health Care Workers

PURPOSE: Advocate legislation at the state and federal level that includes clear penalty language outlining punishment and consequences for those who assault a healthcare worker while at work and delivering care.

FISCAL IMPACT: Budgeted staff time and resources.

WHEREAS, Per the Bureau of Labor Statistics, workers in the healthcare and social service industries experience the highest rates of injuries caused by workplace violence and are five times as likely to get injured at work than workers overall[1]; and

WHEREAS, Staffing shortages throughout our healthcare workforce continue to decrease our ability to safely care for patients; and

WHEREAS, Safety concerns around workplace violence are a significant factor predicting who leaves the healthcare professions[2]; and

WHEREAS, Two states – Wisconsin and Utah – have been able to codify penalties against those who assault healthcare workers; and

WHEREAS, There are currently no federal laws penalizing violence against healthcare workers[3]; and

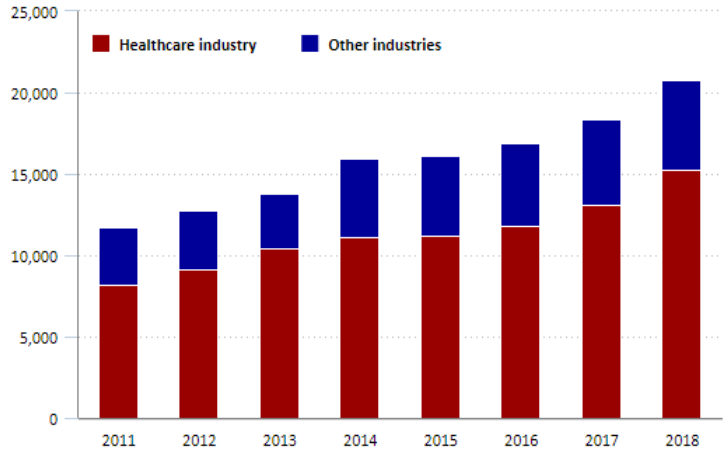
WHEREAS, The goal in codifying the consequent penalty for assaulting a healthcare worker is to increase workers' sense of safety and security in order to perform their jobs; therefore be it

RESOLVED, That ACEP advocate legislation at the state and federal level that includes clear penalty language outlining punishment and consequences for those who assault a healthcare worker who is at work and delivering care.

References

1. https://www.bls.gov/iif/oshwc/cfoi/workplace-violence-healthcare-2018.htm

Chart 2. Number of nonfatal workplace violence injuries and illnesses with days away from work, 2011-18



2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6896814/, https://www.ajmc.com/view/violence-against-healthcare-workers-a-rising-epidemic, https://www.healthcaredive.com/news/threats-obscenities-homicide-healthcare-workers-pandemic/619971/
3. Current US 117th Congress (2021-2022): HR 1195 passed in House 4/2021; S.4182 introduced 5/11/2022
   - No penalty language
   - Primarily asks employers to enact policies to prevent violence and protect workers; OSHA to enforce

Background

The resolution directs ACEP to advocate legislation at the state and federal level that includes clear penalty language outlining punishment and consequences for those who assault a healthcare worker while at work and delivering care.

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. ACEP recently completed a similar survey, intended to assess the effects of the COVID-19 pandemic on violence against emergency physicians. The results of this survey are expected to be published sometime near the 2022 ACEP *Scientific Assembly.*

Workplace violence continues to be a top legislative priority for ACEP's federal advocacy efforts and was one of the three key advocacy priorities during the 2022 Leadership & Advocacy Conference in Washington, D.C. ACEP helped inform and supports the "Workplace Violence Prevention for Health Care and Social Service Workers," (H.R. 1195/S. 4182) ensuring that the legislation gives appropriate consideration to emergency department needs, and has advocated for this legislation for several years. The legislation, which would require OSHA to require health care employers to implement violence prevention programs, was passed in the House of Representatives in April 2021 and awaits further action in the Senate. ACEP's support for the legislation was also specifically noted during committee consideration of the bill and on the House floor during debate and final passage.

ACEP also helped inform and supports the "Safety from Violence for Healthcare Employees (SAVE) Act," (H.R. 7961), recently-introduced bipartisan legislation that would establish federal criminal penalties for violence against health care workers (as this resolution seeks to do), based on federal penalties that already exist for violence against airline and airport employees. This legislation is also supported by the American Hospital Association. ACEP president Gillian Schmitz, MD, FACEP, was quoted in the press release issued by the sponsors of the legislation on June 7, 2022.

In 2021, ACEP also 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 went 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. The Workplace Violence Standards Fact Sheet provides an overview of the new standards.

In 2019, ACEP began a partnership 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 continues working closely with ENA on this issue. Additionally, ACEP has communicated with the American Nurses Association (ANA) and the National District Attorneys Association (NDAA) to gain a better understanding of the various issues that contribute to the current workplace violence landscape where violence against emergency physicians and other health care workers is either not reported or not prosecuted, and the College continues working to develop a better

understanding of the patchwork of state laws related to health care workplace violence. In May 2022, No Silence on ED Violence Press Conference leaders and members of ENA and ACEP, together with Senator Tammy Baldwin (D-WI), held a press conference on Capitol Hill calling on Congress to pass legislation aimed at reducing violence against health care workers."

ACEP has additional resources and policies specifically addressing violence in the emergency department. The policy statement "Protection from Violence and the Threat of 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 Strategic Plan Reference

Advocacy – ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Career Fulfillment – ACEP supports you in addressing your career frustrations and seeking avenues for greater career fulfillment, and commits to addressing tough issues head on.

Fiscal Impact

Budgeted staff time and resources.

Prior Council Action

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 Programs adopted. This resolution called for ACEP to promote awareness of hospital-based violence intervention programs as evidence-based solutions for violence reduction and coordinate with relevant stakeholders to provide resources for those who wish to establish hospital-based violence intervention programs.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted. Directed ACEP to increase awareness of violence against healthcare providers , advocate for a federal standard mandating workplace violence protections in the ED setting and for state laws that maximize the criminal penalty for violence against healthcare workers in the ED.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action

June 2022, approved the revised policy statement "Protection from Violence and the Threat of Violence in the Emergency Department;" revised and approved with the title "Protection from Violence in the Emergency Department" April 2016; revised and approved June 2011; revised and approved with the title "Protection from Physical Violence in the Emergency Department Environment" April 2008; reaffirmed October 2001 and October 1997; originally approved October 1997.

Resolution 55(17) Workplace Violence adopted.

May 2016, reviewed the information paper "Emergency Department Violence: An Overview and Compilation of Resources."

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 Programs adopted.

Amended Resolution 34(10) Violence Prevention in the Emergency Department adopted.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 36(22)

SUBMITTED BY: New York Chapter
EMS-Prehospital Care Section

SUBJECT: Emergency Medical Services Are Essential Services

PURPOSE: Declare EMS an essential service and engage in a public education campaign and work with the AMA and other stakeholders to actively promote the inclusion of EMS among federally- and locally-funded essential services.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives. Unbudgeted resources of $50,000 – $100,000, or possibly more, for a public education campaign depending on the scope and duration of the campaign.

WHEREAS, Emergency Medical Services (EMS) is widely viewed[i] as an essential public service, as it ensures public health and safety and provides equal access to medical services[ii]; and

WHEREAS, Unlike other first responders like fire and police departments, EMS has not been defined as an essential service[iii] by the federal government; and

WHEREAS, In 39 states, EMS is not considered an essential service so local government is not required to provide it to constituents[iv]; and

WHEREAS, Not being defined as an essential service, EMS has not been supported[v] by sustainable funding strategies; and

WHEREAS, Since the 1980s, federal support and leadership in EMS have been incrementally eroded[vi]; and

WHEREAS, In the absence of consistent and adequate funding, the result has been highly variable, fractured systems increasingly dependent on volunteer workforces[vii]; and

WHEREAS, Inconsistent funding has disproportionately impacted access to emergency services both in rural areas where system development lagged, and in urban areas where demand may outstrip available resources[viii]; and

WHEREAS, Currently access to services, training, and quality of EMS response vary greatly[ix] and exacerbate disparities in access to care[x]; and

WHEREAS, No Federal agency oversees EMS administration, system integration and coordination, training, and quality[xi]; and

WHEREAS, Poor coordination of response may lead to inefficient practices[xii] including potentially unnecessary transports to hospitals[xiii], increased interhospital transfers[xiv], and delays in definitive intervention[xv]; and

WHEREAS, EMS providers are not required to accept insurance, and reimbursement structures have not been well defined or standardized, often resulting in outsized patient bills[xvi]; and

WHEREAS, In the wake of the COVID pandemic, we have recognized that a well-organized EMS system can function as a force multiplier for local health and public health systems[xvii], and that an overwhelmed EMS system constitutes a public health hazard[xviii]; therefore be it

RESOLVED, That ACEP declare EMS an essential service and engage in a public information campaign to educate the public in this regard; and be it further

RESOLVED, That ACEP work with the American Medical Association and other stakeholder organizations to actively promote the inclusion of Emergency Medical Services among federally- and locally-funded essential services.

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[ii] https://www.ems.gov/pdf/advancing-ems-systems/Reports-and-Resources/Prehospital_EMS_Essential_Service_And_Public_Good.pdf
[iii] https://www.distancecme.com/essential-service-ems-why-arent-first-responders-recognized/
[iv] https://www.distancecme.com/essential-service-ems-why-arent-first-responders-recognized/
[v] https://www.naemt.org/docs/default-source/advocacy-documents/positions/ems-as-an-essential-service-revised-2-25-21.pdf?sfvrsn=ceaded93_2
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[xii] https://napawash.org/academy-studies/an-analysis-of-prehospital-emergency-medical-services-as-an-essential-servi
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[xviii] COVID Causes EMS Care Rationing in California.(Inside Track). (2021). The New American (Belmont, Mass.), 37(3), 7–7.

Background

The resolution directs the College to declare EMS an essential service and engage in a public information campaign to educate the public in this regard; and, work with the American Medical Association (AMA) and other stakeholder organizations to actively promote the inclusion of Emergency Medical Services (EMS) among federally- and locally-funded essential services.

As the resolution notes, EMS is deemed an essential service in only 11 states: Connecticut, Delaware, Hawaii, Indiana, Louisiana, Nebraska, Nevada, Oregon, Pennsylvania, Virginia, and West Virginia. EMS is also not deemed an essential service at the federal level.

While no federal agency oversees EMS administration, system integration and coordination, training, and quality, in 2005, Congress established the Federal Interagency Committee on Emergency Medical Systems (FICEMS) to "ensure coordination among Federal agencies supporting local, regional, State, tribal, and territorial EMS and 911 systems. FICEMS was also created to improve the delivery of emergency medical services (EMS) throughout the nation." The U.S. Department of Defense (DoD), Department of Health and Human Services (HHS), Department of Homeland Security (DHS), Federal Communications Commission (FCC), and Department of Transportation are all member agencies of FICEMS.

Nearly since the inception of structured EMS in the 1970s, EMS funding has been left to states and local governments, leading to a lack of national coordination and inconsistencies in EMS systems, resulting in disparate training, capabilities, personnel, and pay. Even prior to the COVID-19 pandemic, EMS agencies throughout the country have struggled with these issues and increasing difficulty in retaining volunteer EMTs, and the stresses of the COVID-19 pandemic only exacerbated these problems. As a result, the challenges of already-strained state and local budgets coupled with extreme surges in EMS demand without additional capacity (and in some cases, reduced capacity due to staffing challenges associated with COVID-19) have pushed many EMS systems to the breaking point or beyond.

However, the ability to manage EMS at the local or state levels also provides medical directors and administration of the local hospitals and EMS services the ability to 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.

A 2014 analysis identified three advantages and one disadvantage to designating EMS as an essential service. The advantages are ensuring a minimum capability throughout a state, providing flexibility to organize and finance EMS systems to reflect local circumstances, and providing resources to support voluntary improvement over time, while a disadvantage is the financial burden that a statutory mandate to provide EMS imposes on counties. The paper also observed that EMS is perhaps best understood as a "'common' good (a good where it is difficult or impossible to exclude users from the benefit, but where there is a marginal cost to provide the benefit to additional individuals," and as a common good, EMS systems face the challenges of financing and limiting overuse (i.e., non-urgent calls). Potential approaches to address these challenges include funding EMS maintenance and readiness costs through taxation and the marginal cost of delivering services through user fees, and that user fees could be used to deter overuse (but this effect is dependent on whether such fees are paid directly by users rather than insurers).

ACEP's policy statement "Emergency Medical Services Interfaces with Health Care Systems" states that ACEP believes that emergency medical services (EMS) constitute an integral component in the continuum of acute medical care, and lays out a variety of principles supported by the College. Among others, these principles include acknowledging that EMS plays an essential role in the clinically effective, fiscally responsible regionalization of health care, providing acute medical assessment and interventional care contemporaneous with navigation of patients, and that appropriate funding of coordinated continuum of care systems (e.g. trauma systems) is essential to promoting the availability of regionalization of health care. Additionally, EMS systems must have significant involvement, funding, and leadership decision-making authority in any regionalized system of health care to best provide necessary out-of-hospital acute assessment and care to patients, including safe, timely navigation of patients.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted staff resources for advocacy initiatives. Unbudgeted resources of $50,000 – $100,000, or possibly more, for a public education campaign depending on the scope and duration of the campaign.

Prior Council Action

Resolution 26(01) Emergency Care as an Essential Public Service adopted. Directed the College to champion the principle that emergency care is an essential public service and make it a key concept in advocacy efforts on behalf of America's emergency medical services safety net.

Prior Board Action

February 2018, approved the policy statement "Emergency Medical Services Interfaces with Health Care Systems."

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 37(22)

SUBMITTED BY: New York Chapter

SUBJECT: Enhance Patient Safety and Physician Wellness

PURPOSE: Support the protection of the integrity of the quality improvement/patient safety/peer review process and its participants and work with chapters to identify and lobby against state laws that limit these important discussions

FISCAL IMPACT: Budgeted committee and staff resources for state advocacy initiatives.

WHEREAS, Medical error causes 250,000 excess deaths annually in the USA (per National Patient Safety Board); and

WHEREAS, Medical error causes "second victim syndrome," which multiplies physician stress, impacts wellness, and factors into a disproportionately high physician suicide rate; and

WHEREAS, The medical profession's shift from a culture of "shame and blame" to one of accepting human fallibility and building peer support (as noted in the American Medical Association (AMA)) peer support declaration) is hamstrung by several state laws (such as those in CA, NY, and FL) which limit or effectively prohibit the participation of physicians in Quality Assurance (QA) reviews and Morbidity and Mortality (M&M) discussions of cases in which they were involved; and

WHEREAS, Such state laws deny physicians a safe space in which to process their feelings and take part in debriefings that would enhance coping with traumatic events; and

WHEREAS, A culture of openness and free discussion of problematic cases, especially by those directly involved, will contribute to patient safety, physician support, and enhanced learning, and must include not only institutional peer review activities, but also individual wellness sessions; and

WHEREAS, A model of full disclosure and openness exists in the airline industry and has dramatically improved airline safety, while the toll from medical error remains unacceptably high; therefore be it

RESOLVED, That ACEP support the protection of all participants in discussions of cases of potential medical error, whether Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), or any patient safety forum, from legal discovery; and be it further

RESOLVED, That ACEP encourage and support state chapters in identifying pending or existing state laws limiting free discussion of cases of potential medical error in quality assurance/quality improvement, Morbidity & Mortality Conferences (M&M), Root Cause Analysis (RCA), and similar environments, and in lobbying against them.

Background

This resolution calls for ACEP to support the protection of all participants in discussions of cases of potential medical errors such as quality assurance (QA)/quality improvement (QI), M&M, RCA, and other patient safety forums from legal discovery. It also asks ACEP to work with state chapters to identify pending or existing state laws that will pierce the protections afforded to these patient safety discussions.

The conceptual framework of evaluating poor outcomes can be traced back to Florence Nightingale and the Crimean war. Dr. Ernest Amory Codman, a surgeon from Massachusetts General Hospital, is credited with creating a transparent process that examined patient outcomes that would later become M&M. The anesthesia study commission improved the process by discussing the cases in a confidential open forum. In 1952, the Centers for Disease Control and Prevention's *Morbidity and Mortality Weekly Report* was first published. In 1983, the Accreditation Council for Graduate Medical Education (ACGME) recognized the importance of these patient safety discussions in physician education and they became a requirement for all training programs.

The Health Care Quality Improvement Act (HCQIA) of 1986 was designed to protect peer review activities from discoverability and established the National Practitioner Data Bank, an information clearinghouse, to collect and release certain information related to the professional competence and conduct of physicians and other designated healthcare professionals.

The Institute for Medicine (IOM) published its landmark report "To Err Is Human: Building a Safer Health System in 2000. The magnitude of the problem of medical error became clear. The report estimated that between 44,000 and 98,000 deaths per year in U.S. hospitals were attributable to medical error. The report also framed medical errors as a systems issue rather than mistakes by individuals. Creating an environment where physicians and other healthcare workers can report and examine patient safety events is essential to improving systems and patient care. Greater reporting and analysis of patient safety events will yield increased data and better understanding of patient safety events. One barrier to these discussions has been the fear of increased liability risk for physicians.

ACEP's policy statement "Disclosure of Medical Errors" states:

> "ACEP recognizes that substantial obstacles, including unrealistic expectations of physician infallibility, lack of training about disclosure of errors, and fear of increased malpractice exposure, may obstruct the free disclosure to patients of medical errors. To overcome these obstacles, ACEP recommends the following initiatives:
> - Health care institutions should develop and implement policies and procedures for identifying and responding to medical errors, including continuous quality improvement (CQI) systems and procedures for disclosing significant errors to patients.
> - Medical educators should develop and provide specific instruction to trainees at all levels on identifying and preventing medical errors and on communicating truthfully and sensitively with patients or their representatives about errors.
> - States should enact legislation that makes apology statements by physicians related to disclosure of medical errors inadmissible in malpractice actions."

Several other ACEP policy statements address reporting and analysis of errors, near miss, or adverse events:

> "Pediatric Readiness in the Emergency Department"
> "encourage establishing a culture of safety that encourages reporting of near miss or other adverse events that can be analyzed to provide feedback into the system in a continuous quality improvement mode."
>
> "Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided"
> "Quality improvement efforts focus on peer protection and blame free disclosure to improve future processes, which would be hindered by the specter of criminal liability for routine patient care events."
>
> "A Culture of Safety in EMS Systems"
> "EMS systems should implement and support the Just Culture approach to facilitate honest and prompt reporting of risk and error and to support analysis of near miss and adverse events in an environment of professionalism and accountability for systems and individuals."

The Patient Safety and Quality Improvement Act (PSQIA) of 2005 passed in response to the IOM report and these concerns. It was designed to facilitate the confidential review and reporting of adverse patient events. The PSQIA created a federal peer review privilege and thereby affording substantial protections from the discovery of information related to adverse events when provided to a patient safety organization (PSO). In addition, the collection of patient safety information in relation to reporting to a PSO is also protected.

There is variability in state-based peer review protections for patient safety work. All 50 states and the District of Columbia have laws granting confidentiality and privilege protections for peer review activities. In almost all states there are exemptions from legal protections if the information is relevant to complaints involving criminal activity or discipline against a physician. The District of Columbia and 17 other states have additional gaps in protection[1]In the 2017 case *Charles v. Southern Baptist,* the Supreme Court of Florida ruled that patient safety documents were not protected from discovery. Other states (including Florida in many cases) protect patient safety documents within the Patient Safety Organization (PSO) models.

The degree to which protections are lacking for emergency medicine physicians participating in patient safety actives is unknown. Further investigation is needed to identify priority states and opportunities for policy improvement in the short- and long-term at the national, state and chapter levels

Background Reference

1. Lindor RA, Campbell RL, Reddy S, Hyde RJ. State Variability in Peer Review Protections Heightens Liability Risks. Mayo Clin Proc Innov Qual Outcomes. 2021 Feb 6;5(2):476-479. doi: 10.1016/j.mayocpiqo.2020.10.011. PMID: 33997643; PMCID: PMC8105528.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Develop and implement an ongoing, two-way system to identify and address the issues that hinder wellness and career satisfaction for emergency physicians and allow for members to be heard in more meaningful and effective ways.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- Expand and strengthen the role, approach, and impact of state-level advocacy.

Fiscal Impact

Budgeted committee and staff resources for state advocacy initiatives.

Prior Council Action

Amended Resolution 21(00) Peer Review and the Mandatory Federal Reporting of Errors adopted. called for the College to support initiatives in several areas of peer review including that information discovered during the peer review process be kept confidential and not discoverable in any legal action.

Prior Board Action

June 2022, approved the policy statement "Protection of Physicians and Other Health Care Professionals from Criminal Liability for Medical Care Provided."

April 2021, approved the revised policy statement "A Culture of Safety in EMS Systems;" originally approved March 2014.

June 2018, approved the revised policy statement "Pediatric Readiness in the Emergency Department" with

the current title; revised and approved April 2009; originally approved December 2000 titled "Guidelines for the Care of Children in the Emergency Department.

April 2017, approved the revised policy statement "Disclosure of Medical Errors;" revised and approved April 2010; originally approved September 2003.

Amended Resolution 21(00) Peer Review and the Mandatory Federal Reporting of Errors adopted.

Background Information Prepared by: Jonathan Fisher, MD, MPH, FACEP
Senior Director, Workforce and EM Practice

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 38(22)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Focus on Emergency Department Patient Boarding as a Health Equity Issue

PURPOSE: Use legislative venues and lobbying efforts, focus regulatory bodies to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve ED capacity; and, define criteria to determine when an ED is considered over capacity and hospital action plans are triggered to activate.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives and committee or task force support. Unbudgeted expenses of $20,000-$30,000 for an in-person meeting if needed. Unbudgeted and unknown additional costs could be required if data is needed from third-party sources.

WHEREAS, Health care is focusing on social determinants of health and health equity is a primary public health concern; and

WHEREAS, Emergency department boarding has grown significantly in the last several years; and

WHEREAS, Emergency department boarding is a widespread problem and a source of patient harm, and thus health inequity; therefore be it

RESOLVED, That ACEP, through legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services, The Joint Commission, etc., to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; and be it further

RESOLVED, That ACEP publish best-practice action plans for hospitals to improve emergency department capacity; and be it further

RESOLVED, That ACEP, through task force work, define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

References

https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217
https://www.healthaffairs.org/do/10.1377/forefront.20220325.151088/

Background

The resolution directs the College use legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services (CMS), the Joint Commission, etc., to establish a reasonable matrix of standards including boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve emergency department capacity; and, through task force work, define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

Emergency department boarding is a scenario where patients are kept in the ED for extended periods of time because of a lack of available inpatient beds or space in other facilities where they could be transferred. Shortages of physicians, nurses, and other health care providers across the health care continuum, exacerbated by an influx of extremely sick patients (both due to COVID-19 cases as well as non-COVID-19-related cases resulting from delayed

care during the pandemic), have significantly contributed to the growing issue of boarding.

Empirical studies have shown boarding contributes to worse patient outcomes and increased mortality related to downstream delays of treatment for both high- and low-acuity patients. In addition to disrupting the ED workflow and creating operational inefficiencies, it often also creates additional dangers, such as ambulance diversion, increased adverse events, preventable medical errors, more walkouts by patients, lower patient satisfaction, violent episodes in the ED, and higher overall health costs. This problem is only worsening as ED volumes return to normal levels after a substantial drop in visits during the early stages of the COVID-19 pandemic.

Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and their overall health, especially for those with mental or behavioral health needs. In fact, ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system. Some research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental health care.

ACEP has been working on a study of ED boarding with the Emergency Department Benchmarking Alliance (EDBA). The EDBA report is in progress and is expected to be released by fall 2022. It is anticipated that this study will address Amended Resolution 48(21) Financial Incentives to Reduce ED Crowding. The resolution directed the College to study financial and other incentives that might be used to reduce emergency department crowding. ACEP will assess the next steps needed to further address the resolution once the report coordinated by the EDBA is released.

ACEP issued a report in 2016, developed by the Emergency Medicine Practice Committee, "Emergency Department Crowding: High Impact Solutions." The report was developed to identify and disseminate proven ways to decrease input, as well as novel approaches to increase throughput and increase output. This document is available on ACEP's resource page, "Crowding & Boarding," along with links to other relevant information papers, policy statements, resources regarding state approaches, and others.

Addressing boarding and crowding have been longstanding priorities of the College, and federal legislative and regulatory advocacy efforts continue as well. ACEP has reached out to both CMS and The Joint Commission to determine what federal action can be taken to address the issue. Addressing boarding and crowding have also been included as key priorities in communications with Congress during the 117th Congress as legislators in both the House and Senate develop legislative efforts to address the nation's mental health crisis, and ACEP staff continue to discuss potential solutions with legislators in both chambers.

Recently, in the Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment Systems (IPPS) final rule, CMS decided to remove the electronic clinical quality measure (eCQM) version of ED-2, the Admit Decision Time to ED Departure Time for Admitted Patients Measure from the Hospital Inpatient Quality Reporting (IQR) program beginning in the calendar year 2024 reporting period. In ACEP's comments on the FY 2022 IPPS proposed rule, we strongly opposed the removal of this measure to track how long patients wait before a decision is made to admit them—especially since ED boarding represents one of the single greatest threats to patient safety in the ED setting. ACEP's comments also noted that unlike other clinical areas for which multiple measures may exist, ED-2 is one of only measures to track this statistic and provide incentives or enforcement to help reduce wait times and boarding.

CMS' decision relied heavily on one meta-analysis of 12 studies that did not find a clear association between ED boarding and in-hospital mortality, thus concluding the costs associated with the measure outweigh its continued use in the program. Despite being provided with nearly 70 studies that clearly establish a link between boarding and patient mortality (many of which also detail the prevalence of psychiatric boarding), CMS finalized the policy and eliminated one of the only available measures to help track and mitigate boarding. We believe there was and continues to be validity and value in this measure and ACEP has asked Congress to work with CMS to reverse this decision, or alternatively, whether through legislative or regulatory action, develop a new and meaningful measure to determine how long an ED patient has waited before a medical decision has been made to admit the patient.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

Fiscal Impact

Budgeted staff resources for advocacy initiatives and committee or task force support. Unbudgeted expenses of $20,000-$30,000 for an in-person meeting if needed. Unbudgeted and unknown additional costs could be required if data is needed from third-party sources.

Prior Council Action

Amended Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted. Directed the College to study financial and other incentives that might be used to reduce Boarding of admitted patients in the emergency department.

Resolution 21(21) Diversity, Equity, and Inclusion. Directed the College to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion within the next year; 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 report to the 2022 Council the outcome of the summit and have a roadmap created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

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 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

Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted.

Resolution 21(21) Diversity, Equity, and Inclusion 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.

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.

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

October 2017, reviewed the information paper "Disparities in Emergency Care."

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.

April 2017, reviewed the information paper "Implicit Bias and Cultural Sensitivity: Effects on Clinical and Practice Management."

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: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 39(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Signage at Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient EDs Without Onsite Physicians

PURPOSE: Advocate for requiring Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient EDs without onsite emergency physicians to post clear signage in the waiting room and exam rooms noting the lack of physician coverage.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives.

WHEREAS, ACEP 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; 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 the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety; and

WHEREAS, ACEP believes that all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric, care delivered by emergency physician-led care teams; and

WHEREAS, The 2021 ACEP EM Physician Workforce of the Future Report suggested a looming surplus of emergency physicians; and

WHEREAS, Currently, there are workforce limitations to providing the gold standard of care in certain rural or frontier areas; and

WHEREAS, Critical Access Hospitals (CAHs), Rural Emergency Hospitals (REHs) and Outpatient Emergency Departments (OEDs) have provided emergency service care to patients in rural and frontier areas; and

WHEREAS, ACEP has a policy statement "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" most recently approved March 2022; therefore be it

RESOLVED, That ACEP advocate for requiring Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient Emergency Departments without onsite emergency medicine physicians to post clear signage in the waiting room and exam rooms noting the lack of physician coverage.

References

1. https://www.acep.org/globalassets/new-pdfs/policy-statements/guidelines-reg-the-role-of-physician-assistants-and-nurse-practitioners-in-the-ed.pdf
2. https://www.acep.org/patient-care/policy-statements/emergency-physician-rights-and-responsibilities/
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.health.pa.gov/topics/Documents/Facilities%20and%20Licensing/Hospital%20Guidance%20to%20Implement%20an%20OED.pdf

6. https://tigerweb.geo.census.gov/tigerweb2020/

Background

This resolution calls for ACEP to advocate for requiring Critical Access Hospitals, Rural Emergency Hospitals, and Outpatient Emergency Departments without onsite emergency medicine physicians to post clear signage in the waiting room and exam rooms noting the lack of physician coverage.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states that ACEP "believes that regardless of where a patient lives, all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric care delivered by emergency physician-led care teams." The policy includes a set of principles that mirror the points in the "whereas" statements of the resolution.

Although the "whereas" statements reiterate ACEP's previous-stated policies, the resolution itself focuses specifically on signs in the emergency department (ED). Therefore, it is important to understand the signage requirements under the Emergency Medical Treatment and Labor Act (EMTALA).

Section 1866(a)(1)(N)(iii) of the Social Security Act details the EMTALA-required signage for all Medicare-participating hospitals offering emergency services. Additionally, the Centers for Medicare & Medicaid Services (CMS) and the Office of the Inspector General (OIG) within the U.S. Department of Health and Human Services (HHS) have indicated that some signs are *not allowed* under the law.

ACEP staff emailed with the EMTALA compliance office within CMS about what signs are permitted/prohibited and received the following response:

> "CMS, along with our colleagues in the Office of Inspector General of Health & Human Services, has discouraged hospitals from placing additional signage in the ED or other required hospital locations that may in any way act to deter or discourage individuals from staying for medical screening examinations and stabilizing treatment. This does not mean that all signage is prohibited. If signage is identified as a concern, hospitals would be expected to demonstrate how it is in compliance with CMS requirements and does not deter or discourage individuals from staying for statutorily required medical screening examinations."

CMS also notes that signs posted in an ED are evaluated on a case-by-case basis. Given this, if an individual surveyor finds that the signs contemplated by this resolution "deter or discourage" patients from seeking emergency care, facilities would be subject to EMTALA related penalties/fines.

Finally, it is important to note, while EMTALA only applies to Medicare-participating hospitals, some states, such as Texas, have laws in place that impose EMTALA-type regulations on non-Medicare facilities as well. This further expands the number of facilities that may run into difficulties with the specific signage contemplated in the resolved.

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- Create awareness around the business of emergency medicine and have difficult discussions about possibilities and protections.

Fiscal Impact

Budgeted staff resources for advocacy initiatives.

Prior Council Action

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 68(21): Patient's Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth) not adopted. Asked ACEP to 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.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. It directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process and provide a of findings to the Council by July 1, 2022.

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.

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.

Prior Board Action

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved: 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

March 2022, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2020 with the current title; revised and 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 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 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

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.

April 2020, approved revised policy statement "Freestanding Emergency Departments;" originally approved June 2014.

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

April 2017, approved the revised policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" revised 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."

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.

Background Information Prepared by: Jeffrey Davis
Regulatory and External Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 40(22)

SUBMITTED BY: Andrew Bern, MD, FACEP
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Michigan College of Emergency Physicians
Wisconsin Chapter
Diversity, Inclusion, & Health Equity Section
Social Emergency Medicine Section
Young Physicians Section

SUBJECT: Support for Medicaid Expansion

PURPOSE: Develop a policy statement in support of the expanding Medicaid to the levels allowable by federal law and develop a toolkit to assist ACEP chapters in efforts to advocate for Medicaid expansion in their states.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, ACEP affirms that "all Americans must have health care coverage[1];" and

WHEREAS, Provisions of the Patient Protection and Affordable Care Act intended for adults with incomes up to 138% of the federal poverty level to be eligible for Medicaid benefits in all states, and provided states that opted to expand Medicaid with enhanced federal funds for the newly Medicaid-eligible population[2]; and

WHEREAS, As of July 2022, 12 states have not yet expanded their Medicaid program[2]; and

WHEREAS, As of 2019, the uninsured rate in the 12 non-expansion states was nearly double (15.5%) as compared to the uninsured rate in expansion states (8.3%)[3]; and

WHEREAS, There are an estimated 3.8 million people across the 12 non-expansion states who are currently uninsured and would be newly eligible for Medicaid should it be expanded as intended by federal law[3,4]; and

WHEREAS, Medicaid expansion has provided coverage to millions of uninsured individuals and has shown

reductions in uncompensated care provided by physicians and hospitals[5,6]; and

WHEREAS, Medicaid plays a significant role in funding emergency departments nationally as it is the primary payer for the majority of emergency department visits[7]; and

WHEREAS, States that expanded Medicaid witnessed significant changes to emergency department payer mix, including a reduction in uninsured visits[8]; and

WHEREAS, Follow-up care after an emergency department visit is more likely to be optimized for patients with stable Medicaid coverage relative to the uninsured; evidence has shown better access to medical care, prescription drugs, dental care, and completion of outside referrals among those with continuous Medicaid coverage relative to the uninsured who only have access at community health centers[9]; and

WHEREAS, Follow-up care coordination and discharge planning after an emergency department visit may be more readily achievable among an increasing share of patients with stable insurance coverage, including Medicaid, which would have implications for emergency department reimbursement under alternative payment models such as the ACEP-developed Acute Unscheduled Care Model (AUCM)[10]; and

WHEREAS, Evidence has shown reductions in all-cause mortality, decreased uninsurance rates, decreased rates in delayed care due to costs, and improvements in self-reported health[11], as well as reductions in suicide rates[12] among states that expanded Medicaid relative to those that have not; therefore be it

RESOLVED, That ACEP develop a policy statement in support of the expansion of Medicaid to the levels allowable by federal law in recognition of the benefit of increasing health care access to eligible patients, including some of our most vulnerable, while decreasing the uncompensated care provided by emergency physicians; and be it further

RESOLVED, That ACEP develop a toolkit to assist ACEP state chapters in their efforts to advocate for such expansion of Medicaid in their states.

Resolution References

1. American College of Emergency Physicians, "Universal Health Care Coverage," Jan. 2021. https://www.acep.org/globalassets/new-pdfs/policy-statements/universal-health-care-coverage.pdf (accessed May 22, 2022).
2. Kaiser Family Foundation, "Status of State Medicaid Expansion Decisions: Interactive Map | KFF," Jun. 15, 2022. https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ (accessed Jun. 15, 2022).
3. R. Garfield, K. Orgera, and A. Damico, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid," *KFF*, Jan. 21, 2021. https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ (accessed May 20, 2022).
4. D. K. Branham, C. Peters, and B. D. Sommers, "Estimates of Uninsured Adults Newly Eligible for Medicaid If Remaining Non-Expansion States Expand," *Assistant Secretary for Planning and Evaluation Office of Health Policy*, p. 4, May 2021.
5. [5] G. Lukens, "Medicaid Expansion Cuts Hospitals' Uncompensated Care Costs," *Center on Budget and Policy Priorities*, Apr. 20, 2021. https://www.cbpp.org/blog/medicaid-expansion-cuts-hospitals-uncompensated-care-costs (accessed Jun. 01, 2022).
6. MACPAC, "Annual Analysis of Disproportionate Share Hospital Allotments to States," Mar. 2022. https://www.macpac.gov/publication/annual-analysis-of-disproportionate-share-hospital-allotments-to-states-3/ (accessed Jun. 01, 2022).
7. R. Sun, Z. Karaca, and H. S. Wong, "Trends in Hospital Emergency Department Visits by Age and Payer, 2006-2015," Healthcare Cost and Utilization Project, Statistical Brief #238. Accessed: Feb. 13, 2019. [Online]. Available: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb238-Emergency-Department-Age-Payer-2006-2015.jsp
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9. V. Seo *et al.*, "Access to care among Medicaid and uninsured patients in community health centers after the Affordable Care Act," *BMC Health Services Research*, vol. 19, no. 1, p. 291, May 2019, doi: 10.1186/s12913-019-4124-z.
10. American College of Emergency Physicians, "Empowering Emergency Medicine Through the Acute Unscheduled Care Model." https://www.acep.org/globalassets/new-pdfs/advocacy/the-aucm-framework-issue-brief_1.29.201.pdf (accessed Jun. 01, 2022).
11. B. D. Sommers, K. Baicker, and A. M. Epstein, "Mortality and Access to Care among Adults after State Medicaid

Expansions," *New England Journal of Medicine*, vol. 367, no. 11, pp. 1025–1034, Sep. 2012, doi: 10.1056/NEJMsa1202099.
12. H. Patel, J. Barnes, N. Osazuwa-Peters, and L. J. Bierut, "Association of State Medicaid Expansion Status With Rates of Suicide Among US Adults," *JAMA Network Open*, vol. 5, no. 6, p. e2217228, Jun. 2022, doi: 10.1001/jamanetworkopen.2022.17228.

Background

The resolution asks the College to develop a policy statement in support of expanding Medicaid to the levels allowable by federal law and develop a toolkit to assist ACEP chapters in efforts to advocate for Medicaid expansion in their states

The Affordable Care Act (ACA; P.L. 111-148) expanded eligibility for the Medicaid program in order to increase access to healthcare coverage for all low-income individuals and families, up to 138 percent of the federal poverty level (FPL), regardless of age, family status, or health. Prior to the ACA, Medicaid was traditionally limited to low-income children, pregnant women, adults with disabilities, and nursing home residents.

While the expansion was originally intended to apply nationwide, part of the U.S. Supreme Court's decision in *National Federation of Independent Business v. Sebelius* in 2012 ruled that the Medicaid expansion in the ACA was an unconstitutionally coercive use of Congress' spending power, as it required states to significantly and rapidly extend Medicaid coverage to new beneficiaries or lose all federal Medicaid funding. As a result, Medicaid expansion is voluntary, and as of 2022, thirty-eight states and the District of Columbia have expanded Medicaid. The states that have not expanded Medicaid are: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin[1], and Wyoming.

As a result, there are more than an estimated 2.2 million American adults in what is known as the "Medicaid Coverage Gap," where their incomes are below the federal poverty level (i.e.: too low to qualify for tax credits through the ACA marketplaces), but too high to qualify for their state's Medicaid program. Additionally, many individuals have seasonal, sporadic, or otherwise temporary employment that can lead to eligibility fluctuations or "churn" within the Medicaid program. These fluctuations can disrupt patient access to care, negatively affect health outcomes, and add substantial administrative burden to state Medicaid programs. While children under 19 years of age have continuous eligibility for twelve months either through the Children's Health Insurance Program (CHIP) or Medicaid, the vast majority of states do not offer continuous eligibility for adults. Analysis indicates that continuous eligibility can stabilize coverage for adults with only a modest increase in total medical costs, but this may balance out due to lower administrative costs associated with churn.

The federal government pays 90 percent of the costs of covering individuals eligible as a result of the expansion, with states covering the remaining 10 percent. States that have not expanded Medicaid receive only their normal Medicaid funding. Since 2013, Medicaid and CHIP enrollment has increased by 53 percent, and a 2022 report indicates that more than 21 million people have gained health insurance coverage since the passage of the ACA in 2010. The COVID-19 pandemic also drove a significant increase in Medicaid enrollment due tothe financial impact of job loss and income disruption . In order to provide stability, given the uncertainties for the economy and labor market due to the pandemic, the federal government required states to maintain continuous Medicaid coverage until the end of the COVID-19 public health emergency (PHE). After the end of the PHE, Medicaid enrollees will have their eligibility redetermined, but states will have 12 months to perform those eligibility redeterminations.

Proponents of Medicaid expansion note that there are many added benefits of expansion besides just the increased access to health care for vulnerable populations. These include lower overall health care spending in expansion states, lower rates of evictions, lower amounts of debt sent to collections, a greater likelihood of children receiving their annual checkups, greater adherence to medication, increased early detection of cancer due to wider access to screenings and preventive care, lower mortality rates, and increased access to opioid and substance use disorder treatment.

The resolution authors accurately note that specifically for the emergency department, expanded Medicaid coverage results in a a decrease in uninsured visits that are often unpaid or low-pay. While some states initially experienced higher ED volumes post-expansion, the longer-term trends appear to reduce hospitalizations and increase overall

professional revenue due to the increased number of patients with some form of insurance coverage. Additionally, there have been reductions health care disparities for minority populations, though these reductions are lower than what had been expected by policymakers and analysts. Additionally, expansion states were better positioned to respond to the COVID-19 public health emergency, especially for minority and other historically underserved populations that experienced significant disparities in impacts and health effects of COVID-19.

Opponents of Medicaid expansion cite ongoing state budget challenges, noting that covering even the 10 percent portion of the costs associated with the expansion population amounts to a significant or unfeasible additional cost for already-strained state budgets, with some further noting that Medicaid costs often grow faster than overall revenue. Some also view Medicaid as a low-quality option for healthcare coverage that is higher cost, has low competition, features limited healthcare options, and does not increase access to quality care. Others have noted that Medicaid payment rates to physicians are substantially lower than other payers and often only cover a small fraction of the actual costs of providing care, so increasing Medicaid coverage rather than increasing access to other private coverage options will cost Medicaid providers more in the long run.

ACEP's policy statement, "Universal Health Care Coverage," states that ACEP believes:

- All Americans must have health care coverage;
- Health care coverage will contain a benefits package that provides for timely, unrestricted access to quality emergency care;
- Any benefit package should reflect generally accepted standards of medical practice supported by outcome-based evidence, where available.

Specifically related to Medicaid, ACEP policy opposes the imposition of copays for Medicaid beneficiaries seeking care in the ED, as well as the imposition of work requirements mandating employment or the pursuit of employment for Medicaid beneficiaries to obtain or retain access to health insurance coverage. ACEP also supports the extension of Medicaid coverage to 12-months post-partum and developed resources that were distributed to chapters for state advocacy initiatives. ACEP has not taken an overall public position in favor or in opposition to Medicaid expansion specifically.

Background Reference

[1]Wisconsin is a unique case as the only non-expansion state that does not have a coverage gap. Though the state has not opted to expand Medicaid under the ACA, Wisconsin's Medicaid program covers all low-income adults up to 100% FPL (and thus only receives its normal level of federal Medicaid funding).

ACEP Strategic Plan Reference

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- ACEP fights for your rights across all landscapes and levels, including federal, state, local, facility and administrative.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- ACEP revolutionizes acute unscheduled care to anticipate emerging trends in clinical and business practices and develops new career opportunities for emergency physicians.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 39(19) Work Requirements for Medicaid Beneficiaries adopted. Directed ACEP to oppose mandatory work requirements for Medicaid beneficiaries to prove they are employed, or seeking employment, to get or keep health insurance.

Amended Resolution 29(19) Extending Medicaid Coverage to 12-Months Post-Partum adopted. The resolution directed that ACEP support the extension of Medicaid coverage to 12 months postpartum.

Resolution 24(18) ED Copayments for Medicaid Beneficiaries adopted. Directed ACEP to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED and submit a resolution to the American Medical Association House of Delegates to oppose imposition of copays for Medicaid beneficiaries seeking care in the ED.

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.

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.

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.

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

Prior Board Action

June 2022, approved the policy statement "Work Requirements for Medicaid Beneficiaries."

January 2021, reaffirmed the policy statement "Universal Health Care Coverage;" reaffirmed June 2015; revised and approved August 2009; originally approved December 1999.

October 2019, approved the policy statement "Opposition to Copays for Medicaid Beneficiaries."

Amended Resolution 39(19) Work Requirements for Medicaid Beneficiaries adopted.

Amended Resolution 29(19) Extending Medicaid Coverage to 12-Months Post-Partum adopted.

Resolution 24(18) ED Copayments for Medicaid Beneficiaries adopted.

July 2018, reviewed the information paper "Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine."

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.

Substitute Resolution 31(14) Financing 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.

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

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

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

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

Background Information Prepared by: Ryan McBride, MPP
Congressional Affairs Director

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
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2022 Council Meeting
Reference Committee Members

Reference Committee C – Emergency Medicine Practice
Resolutions 41-58

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Andrea Austin, MD, FACEP (CA)
Lisa M. Bundy, MD, FACEP (MS)
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RESOLUTION: 41(22)

SUBMITTED BY: Pain Management & Addiction Medicine Section

SUBJECT: Addressing Stigma in the Emergency Department

PURPOSE: Develop an educational program to identify and address stigma in the ED that can be provided to residency programs as a standard part of residency training.

FISCAL IMPACT: Budgeted committee and section resources. Unbudgeted additional staff resources of potentially 10-50 hours depending on the scope of the project and potential partnership with EMRA and CORD. There may also be an opportunity for grant funding.

WHEREAS, Stigma is a negative attitude or idea about a mental, physical, or social feature of a person or group of people; and

WHEREAS, Stigma, in healthcare, is a set of negative and often unfair beliefs held by clinicians about patients with a particular condition; and

WHEREAS, Stigma by clinicians against patients with stigmatizing conditions can be associated with higher rates of unemployment, higher rates of homelessness, decreased self-esteem, and lower quality of life for those patients; and

WHEREAS, Stigma by clinicians against patients with stigmatizing conditions is associated with a higher mortality for those patients; and

WHEREAS, Stigma by clinicians against patients with stigmatizing conditions can result in clinicians withholding certain treatments from those patients; and

WHEREAS, Stigma by clinicians against patients with stigmatizing conditions causes patients to feel shame about their conditions and not disclose those conditions to their treating providers; and

WHEREAS, Stigma by clinicians against patients with stigmatizing conditions causes patients to avoid medical care so as to avoid feeling stigma; and

WHEREAS, Stigma by clinicians against patients with substance use has contributed to rising rates of overdose deaths in the United States; and

WHEREAS, Providing education to clinicians about stigma against patients reduces the amount of stigma that patients experience; and

WHEREAS, Using person-first language such as “patient with diabetes” instead of labeling language such as “diabetic” can reduce amount of stigma that patients experience; and

WHEREAS, Avoiding the use of inherently judgmental terms in healthcare such as “dirty urine” and replacing them with objective terms such as “abnormal urine toxicology screen” can reduce the amount of stigma that patients experience; therefore be it

RESOLVED, That ACEP develop an educational program on identifying and addressing stigma in the emergency department that can be provided to residency programs as a standard part of residency training, highlighting the role of important practices such as person-first language.

Background

This resolution requests ACEP to develop an educational program to identify and address stigma in the ED that can be provided to residency programs as a standard part of residency training.

Stigma in health facilities undermines diagnosis, treatment, and successful health outcomes. Addressing stigma is fundamental to delivering quality healthcare and achieving optimal health. Health condition-related stigma may be experienced in all spheres of life; however, stigma in health facilities is particularly egregious, negatively affecting people seeking health services at a time when they are at their most vulnerable, such as patients presenting to emergency departments. Within the health system, stigma toward a person living with a specific disease undermines access to diagnosis, treatment, and successful health outcomes. Additionally, stigma is a threat to public health as it influences health outcomes in many ways by carving pathways to health disparities.

ACEP has worked to address stigma in various patient populations such as patients with substance use disorder, sickle cell disorders, and patients who are part of the LGBTQ community. The ACEP Public Health & Injury Prevention Committee also developed the information paper Stigma in the Emergency Department.

On January 23, 2020, ACEP convened a summit, "Addressing the Opioid Stigma in the Emergency Department." The summit gathered 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 opioid use disorder (OUD). ACEP is part of a large coalition of national professional organizations that make up the Opioid Response Network (ORN), which is led by the American Academy of Addiction Psychiatry and funded by the Substance Abuse and Mental Health Services Administration. Through targeted breakout sessions that developed specific recommendations based on consensus, attendees developed concrete strategies to reduce stigma and improve the experience for ED patients with opioid use. Attendees used stories from ED patients with OUD and recommendations for previously enacted successful strategies from other professional organizations to develop these strategies. ACEP also hosted the Initiation of Buprenorphine and Pain Management in the ED-Implementation Workshop and topics covered in the workshop included everything from setting up a ED-Buprenorphine program, Naloxone program, stigma, and pain management in the ED.

Sickle cell disease (SCD), while considered a rare disease, is the most common genetic blood disorder and affects approximately 100,000 Americans, primarily of African and Hispanic descent. Individuals with SCD can experience multiple life-threatening problems during their lifetime. Much of their acute care is delivered in the emergency department (ED), yet patients often relate poor experiences in this setting. In recognition of the need to improve the care offered to patients with SCD in the ED, ACEP collaborated with multiple public, private, and professional partners and created the Emergency Department Sickle Cell Care Coalition (EDSC^3). Its purpose is to provide a national forum dedicated to the improvement of the emergency care of patients with SCD in the United States.

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.

Development of an education program could include involvement with several ACEP committees (Academic Affairs, Education, Public Health & Injury Prevention, Diversity, Equity, & Inclusion) and sections (Pain Management & Addiction Medicine and Social Emergency Medicine) as well as partnership with the Emergency Medicine Residents' Association (EMRA) and the Council of Residency Directors in Emergency Medicine (CORD). The scope of the project could range from a PowerPoint presentation to a comprehensive education module, development of a paper, development of a webinar, etc.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Objective 2 – Position ACEP as the standard bearer for well workplaces in emergency medicine to increase job security for all emergency physicians and improve access and outcomes for patients

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

- Objective 3 – Empower members, through tools and information, to advocate for themselves within their own workplaces, regardless of employment model.

Fiscal Impact

Budgeted committee and section resources. Unbudgeted additional staff resources of potentially 10-50 hours depending on the scope of the project and potential partnership with EMRA and CORD. There may also be an opportunity for grant funding.

Prior Council Action

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted. Directed ACEP 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; and 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.

Substitute Resolution 41(21) Take Home Naloxone Programs in Emergency Departments adopted. Directed ACEP to 1) amend the 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; and 5) educate emergency physicians about strategies to implement Take Home Naloxone programs in their ED.

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.

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 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders adopted. It called for ACEP to promote awareness of ACEP policy statements that oppose barriers to physicians seeking treatment for mental health and substance use issues, work with the AMA and state medical societies to advocate for changes by state medical boards for protections for licensure for physicians that seek help and treatment, and partner with other stakeholders to investigate the effectiveness and quality of Physician Health Programs.

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

physician's mental health to more appropriately address impairment vs. illness.

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

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted.

Substitute Resolution 41(21) Take Home Naloxone Programs in Emergency Departments adopted.

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 2020, reviewed the information paper Stigma in the Emergency Department.

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our Emergency Departments and Healthcare Institutions adopted.

Substitute Resolution 23(19) Expanding Emergency Physician Utilization and Ability to Prescribe Buprenorphine adopted.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders was adopted.

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

October 2017, reviewed the information paper "Disparities in Emergency Care."

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 42(22)

SUBMITTED BY: Arkansas Chapter

SUBJECT: Emergency Department/Emergency Medicine Experience for Residents from Other Specialties

PURPOSE: Develop a policy statement supporting a required rotation in emergency medicine for residents in other specialties and further collaborate with the ACGME Review Committees to include requirements for emergency medicine rotations for residents in other specialties.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency medicine or emergency department experience is an important part of the Accreditation Council for Graduate Medical Education (ACGME) Program Requirements of many specialties; and

WHEREAS, The ACGME Program Requirements for Emergency Medicine residencies provide clear and concrete requirements for training site resources, patient volume, patient acuity, and faculty qualifications; and

WHEREAS, The ACGME Program Requirements of other specialties lack these requirements, leading many residents from other specialties to receive inadequate Emergency Medicine experience in low resource, low volume, and/or low acuity departments from unqualified faculty; and

WHEREAS, The ACGME Program Requirements for Emergency Medicine make little mention of residents from other programs, stating only that they shall not interfere with the education of Emergency Medicine residents; therefore, be it

RESOLVED, That ACEP establish policy to appreciate and support the efforts of other specialties to require emergency department or emergency medicine experience of their residents, with specific support for the equity of their experience with that of emergency medicine residents; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education to reaffirm existing requirements that residents from other specialties do not detract from the education of emergency medicine residents; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education to expand the program requirements for emergency medicine regarding the education of residents from other services; specifically stating that the following requirements apply equally:

a. Training site resources (e.g., clinical support personnel).
b. Training site volume and acuity, with sites for these residents subject to the same requirements as the primary clinical site for emergency medicine residents.
c. Qualifications of faculty members supervising these residents.
d. Designation of a physician qualified to supervise emergency medicine residents as a core faculty member of the other residency or residencies who is responsible for the emergency medicine experience of that residency.; and be it further

RESOLVED, That ACEP work with the Accreditation Council for Graduate Medical Education and other specialties to reference emergency medicine new requirements in the requirements for other residencies that require emergency department or emergency medicine experience (e.g., internal medicine, family medicine, transitional year, etc.) such that the required experience is substantially similar for all residents and specifically all residents who

require emergency medicine or emergency department experience should receive a substantially similar experience at training sites with or without an emergency medicine residency regarding:

a. Training site resources.
b. Training site volume and acuity.
c. Faculty qualifications.
d. Designation of a core faculty member, qualified to supervise emergency medicine residents, responsible for the emergency medicine experience of the residency.

Background

This resolution asks ACEP to develop a policy statement supporting a required rotation in emergency medicine for residents in other specialties and further collaborate with the Accreditation Council for Graduate Medical Education (ACGME) Review Committees to include requirements for emergency medicine rotations for residents in other specialties.

The ACGME is an independent not-for-profit organization that sets and monitors educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans. The ACGME oversees the accreditation of residency and fellowship programs in the US. In the 2021-2022 academic year, there are 12,740 accredited residency and fellowship programs in 182 specialties and subspecialties. Specialty-specific committees (Review Committees) create a uniform set of high standards for each accredited specialty and subspecialty applied across all accredited US residency and fellowship programs educating and training physicians in those fields to ensure the highest quality physicians and patient care.[1]

Residents from other specialties who rotate in the emergency department are often referred to as off-service residents. An emergency medicine rotation provides off-service residents with an appreciation of the unique aspects of the specialty. Off-service residents will gain an understanding of the treatment approach to the undifferentiated patient, the concept of an appropriate ED work-up, the process of decision making with incomplete information in a time-sensitive manner, and the skills for effective communication with consultants and colleagues. They will also learn about the constraints that drive this different approach and the strategies emergency physicians use to provide excellent patient care. In the past, the ACEP Academic Affairs Committee developed a national standardized curriculum for off-service resident education during an emergency medicine rotation.[2]

ACEP has a related policy statement focusing on medical students, "Guidelines for Undergraduate Education in Emergency Medicine." The policy 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 "should be driven by experts board certified in the field of emergency medicine."

The Council and the Board of Directors adopted Substitute Resolution 61(21) Advocating for a Required Emergency Medicine Rotation at All U.S. Medical Schools that directed ACEP to advocate that all U.S. medical schools, allopathic and osteopathic, require formal exposure to the specialty of emergency medicine, including but not limited to a formal clerkship or other activities to ensure that graduating medical students understand the role of emergency departments and the practice of emergency medicine. Over the last year, ACEP has met with ACGME leadership multiple times. We have leveraged our relationship with the organization, as well as other emergency medicine partners, to identify and enforce new standards that will sustain the highest quality, comprehensive training for all emergency medicine residencies. ACEP will continue to build on this foundation and will continue working to ensure all residents receive quality training in emergency medicine.

Background References

[1]https://www.acgme.org/about-us/overview/

[2]Kessler CS, Marcolini EG, Schmitz G, Gerardo CJ, Burns G, DelliGatti B, Marco CA, Manthey DE, Gutman D, Jobe K, Younggren BN, Stettner T, Sokolove PE. Off-service resident education in the emergency department: outline of a national standardized curriculum. Acad Emerg Med. 2009 Dec;16(12):1325-1330. doi: 10.1111/j.1553-2712.2009.00605.x. PMID: 20053254.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 61(21) Advocating for a Required Emergency Medicine Rotation at All U.S. Medical Schools adopted. ACEP to advocate that all U.S. medical schools, allopathic and osteopathic, require formal exposure to the specialty of emergency medicine, including but not limited to a formal clerkship or other activities to ensure that graduating medical students understand the role of emergency departments and the practice of emergency medicine.

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.

Prior Board Action

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.

Substitute Resolution 61(21) Advocating for a Required Emergency Medicine Rotation at All U.S. Medical Schools adopted.

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.

Substitute Resolution 39(88) Development of Emergency Medicine in Medical Schools adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 43(22)

SUBMITTED BY: Pain Management & Addiction Medicine Section

SUBJECT: Endorsing ED Resident Competency in Buprenorphine Initiation

PURPOSE: 1) Support the integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs; and 2) coordinate with other organizations in emergency medicine to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The opioid crisis continues to escalate, exacerbated by the COVID-19 pandemic, with > 107,000 U.S. deaths in the past 12 months; and

WHEREAS, Patients present to the ED with opioid overdose, complications of opioid use, and seeking treatment for opioid use disorder (OUD) and with few options for treatment initiation 24/7 as the ED can provide; and

WHEREAS, Buprenorphine treatment is associated with reductions in illicit opioid use, mortality, HIV, Hepatitis C, criminal activity, and health care 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[8]; and

WHEREAS, Regulations governing buprenorphine treatment and, specifically, ED buprenorphine treatment continue to evolve; and

WHEREAS, The Department of Health and Human Services released practice guideline exemptions on April 27, 2021, indicating that physicians are no longer required to complete dedicated buprenorphine or opioid use disorder treatment training in order to apply for an X-waiver[9]; and

WHEREAS, Many emergency physicians are not comfortable with initiating or prescribing buprenorphine treatment due, in part, to a lack of experience or training[10]; and

WHEREAS, Emergency medicine residents may care for patients with opioid withdrawal and opioid use disorder who will need initiation of opioid agonist treatment and will provide care for patients with opioid use disorder after residency in many practice locations whether urban or rural; 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, Current residency training requirements are not adequately preparing residents to treat patients with OUD, as highlighted by responses from a 2020 survey in which only 135/288 (46.9%) reported any experience prescribing buprenorphine in the ED and 140/288 (48.6%) reported they have or will receive X-waiver training during residency for readiness to provide buprenorphine with referral to treatment[11]; and

WHEREAS, Brief trainings focused on buprenorphine initiation targeting EM clinicians have been shown to promote understanding of the ED use of buprenorphine and translate into clinical practice[12], and

WHEREAS, The ACEP Board has supported the development of consensus recommendations on the treatment of ED patients with OUD, including the initiation of buprenorphine[13]; 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 integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs; and be it further

RESOLVED, That ACEP coordinate with other organizations in emergency medicine (Council of Residency Directors in Emergency Medicine, Society for Academic Emergency Medicine, and the American Board of Emergency Medicine) to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency and should focus on identification of patients with opioid use disorder and initiation of buprenorphine treatment as well as sharing harm reduction information and resources such as clean syringes, naloxone, and fentanyl test strips, depending on local practice and availability.

References

1. Bart G. Maintenance medication for opiate addiction: the foundation of recovery. J Addict Dis. 2012;31(3):207-225.
2. National Academies of Sciences E, Medicine, Health, Medicine D, Board on Health Sciences P, Committee on Medication-Assisted Treatment for Opioid Use D. The National Academies Collection: Reports funded by National Institutes of Health. In: Mancher M, Leshner AI, eds. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US). Copyright 2019 by the National Academy of Sciences. All rights reserved. 2019.
3. Schuckit MA. Treatment of Opioid-Use Disorders. N Engl J Med. 2016;375(4):357-368.
4. Tkacz J, Volpicelli J, Un H, Ruetsch C. Relationship between buprenorphine adherence and health service utilization and costs among opioid dependent patients. J Subst Abuse Treat. 2014;46(4):456-462.
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6. Weiss RD, Potter JS, Griffin ML, et al. Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. Drug Alcohol Depend. 2015;150:112-119.
7. D'Onofrio G, Chawarski MC, O'Connor PG, et al. Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention. J Gen Intern Med. 2017;32(6):660-666.
8. D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. Jama. 2015;313(16):1636-1644.
9. HHS Releases New Buprenorphine Practice Guidelines, Expanding Access to Treatment for Opioid Use Disorder [press release]. U.S. Department of Health & Human Services, 2021.
10. Hawk KF, D'Onofrio G, Chawarski MC, et al. Barriers and Facilitators to Clinician Readiness to Provide Emergency Department-Initiated Buprenorphine. JAMA Netw Open. 2020;3(5):e204561.
11. Yu M, Hawk K. Resident Attitudes, Experiences, and Preferences on Initiating Buprenorphine in the Emergency Department: A National Survey. Academic Emergency Medicine Education and Training. Accepted, in press.
12. Khatri UG, Lee K, Lin T, et al. A Brief Educational Intervention to Increase ED Initiation of Buprenorphine for Opioid Use Disorder (OUD). J Med Toxicol. 2022;18(3):205-213.
13. Hawk K, Hoppe J, Ketcham E, et al. Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department. Ann Emerg Med. 2021;78(3):434-442.

Background

The resolution calls for ACEP to support the integration of buprenorphine training and harm reduction skills into the core curriculum for residents graduating from Accreditation Council for Graduate Medical Education accredited emergency medicine programs; and coordinate with other organizations in emergency medicine (Council of Residency Directors in Emergency Medicine, Society for Academic Emergency Medicine, and the American Board of Emergency Medicine) to further endorse integration of buprenorphine training and harm reduction skills into curriculum or simulation sessions during residency.

Residency training is structured to systematically address the pathology and treatment of disease encountered in the emergency department. Residents are trained to make lifesaving diagnoses and perform complex procedures. The data supporting the initiation of buprenorphine in the emergency department are clear and compelling, but many current EM residents have not received training on its use. Current residency training requirements are not adequately preparing residents to treat patients with OUD, as highlighted by responses from a 2020 survey in which only 135/288 (46.9%) reported any experience prescribing buprenorphine in the ED and 140/288 (48.6%) reported they have or will receive X-waiver training during residency for readiness to provide buprenorphine with referral to treatment.

Emergency medicine residents care for patients with opioid withdrawal and opioid use disorder who need initiation of opioid agonist treatment and brief trainings focused on buprenorphine initiation targeting EM clinicians have been shown to promote understanding of the ED use of buprenorphine and translate into clinical practice. They will provide care for patients with opioid use disorder after residency in many practice locations whether urban or rural and increasing the comfort level and implementation of evidence-based buprenorphine and other opioid use disorder interventions in the ED within residents will improve the care provided to patients and reduce individual and societal harms associated with opioid use and overdose.

ACEP recently launched the Substance Use Disorder Emergency Medicine Residency Curriculum. This was a collaboration between ACEP, ABEM, CORD, and EMRA that led to the development of a curriculum for emergency medicine residency programs. This curriculum aims to teach residents about SUD disease processes and evidence-based treatment options, reduce stigma, and empower emergency physicians to actively engage patients in treatment. The learning objectives for the Substance Use Disorder (SUD) Curriculum with the focus on Emergency Medicine (EM) and EM Residents were identified using the objectives from the comprehensive SUD curriculum for Medical Professionals and conducting a two-part modified Delphi to prioritize and focus objectives pertinent to and relevant for EM. The curriculum is comprised of approximately 20-minute modules covering: Introduction to Opioids, Treatment and Management of Opioid Use Disorder, Alcohol and Benzodiazepines, Tobacco, Cannabis and Vaping, Stimulants, and Special Populations.

In addition, ACEP has also developed:

- **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
- A series **of free webinars on various topics related to Opioid Use Disorder and Treatment and Management of OUD in the ED.**
- **Initiation of Buprenorphine and Pain Management in the ED-Implementation Workshop**. Topics covered in the workshop covered everything from setting up an ED-Buprenorphine program, Naloxone program, stigma, and pain management in the ED.
- E-QUAL Network Opioid Initiative

The American Board of Emergency Medicine (ABEM) Model of the Clinical Practice of Emergency Medicine (EM Model) serves as the basis for the content specifications for all ABEM examinations. The ABEM 2019 EM Model lists and classifies the following relevant topics in Medical Knowledge, Patient Care, and Procedural Skills:

- Opioid use disorder (14.1.6 and 17.1.2.3) – Critical
- Medication-assisted treatment (MAT) – Emergent

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

Member Engagement and Trust – Every member feels involved and personally connected, in different ways and at different levels, and trusts ACEP and its leadership.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted. Directed ACEP 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; and 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.

Resolution 39(21) Recommit to Lessening Opioid Deaths in America not adopted. The resolution called for ACEP to 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.

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 follow-up.

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

Resolution 58(21) Updating and Enhancing ED Buprenorphine Treatment Training and Support adopted.

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 and rescinded the June 2012 Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department.

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.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 44(22)

SUBMITTED BY: Amit Arwindekar, MD, FACEP
Howard K Mell, MD, FACEP

SUBJECT: Competencies of Independent Emergency Medicine Nurse Practitioners and Physician Assistants

PURPOSE: 1) Revise current policy statements regarding the role of NPs and PAs working in the ED; 2) Advocate with CMS and other third-party payers to exclude care provided by NPs and PAs where there is not in-person, real-time physician supervision from an emergency physician (as defined by ACEP) for billing/reimbursement purposes.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Nurse practitioners (NPs) and physician assistants (PAs) have become increasingly present in emergency departments (ED) across the country over the last 10 years; and

WHEREAS, The original intent of using NPs and PAs in EDs was to augment emergency care with physician-led teams; and

WHEREAS, NPs and PAs are now being used to displace qualified emergency physicians even where there is an adequate supply of such physicians; and

WHEREAS, The practice of replacing board-certified/eligible emergency physicians (EPs) with NPs and PAs is being increasingly used by staffing organizations to improve their financial position and not to ensure quality of care; and

WHEREAS, The training, experience, and competencies of a qualified emergency NP and PA is undefined and therefore inconsistent; and

WHEREAS, NPs and PAs are increasingly handling the full scope of medical cases, including critically ill and complicated patients; and

WHEREAS, The essential training, knowledge, and skills required to handle the full scope of emergency medical problems is clearly defined by the American Board of Emergency Medicine as necessary to diagnose and manage serious emergency conditions; and

WHEREAS, ACEP has a responsibility to the specialty of emergency medicine, both patients and board-certified EPs, to advocate for the essential credentials of NPs and PAs qualified to treat all patients in EDs; and

WHEREAS, Those EPs who are charged with working alongside NPs and PAs may be held responsible for the care provided by such NPPs as well as to provide back-up management of NP and PA patients as well as primary care of their own patient load; and

WHEREAS, This supervisory responsibility may exceed that capacity of EPs working as well as confer excessive liability; therefore be it

RESOLVED, That ACEP adopt as policy, a position that every patient presenting to an emergency department should be assessed, in person, by a board-certified/board-eligible emergency physician as defined by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine

(AOBEM) or a physician formerly board certified in emergency medicine as defined by ABEM or ABOEM who is now board certified by an alternate national board; and be it further

RESOLVED, That ACEP adopt as policy a position that if no board-certified/board-eligible emergency physician is available, that the absolute minimum standard to providing emergency care is that every patient presenting to an emergency department is assessed, in person, by a licensed physician who is board certified/board eligible in an medical specialty as defined by the American Board of Medical Specialties or the American Osteopathic Association, or who was formerly so certified and is now a member of an alternate national board; and be it further

RESOLVED, That ACEP adopt as policy, a position that nurse practitioners and physician assistants should never practice emergency medicine without in-person, real-time physician supervision; and be it further

RESOLVED, That ACEP advocate with the Centers for Medicare & Medicaid Services and third-party payers to exclude care provided by a nurse practitioners and physician assistants without in-person, real-time physician supervision from the definition of emergency medicine for the purposes of billing or reimbursement.

Background

This resolution calls for the College to adopt as policy three positions pertaining to the use of only physicians to assess, in person, every patient presenting to an emergency department.

- The first position would establish that every patient presenting to the ED be assessed, in person, by a Board certified/board-eligible emergency physician.
- Barring that, the second position would establish that every patient presenting to the ED be assessed, in person, by another licensed physician.
- The third position further asserts that NPs and PAs should never practice emergency medicine without in-person, real-time physician supervision.

These positions are discordant with two current ACEP policies:

- Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department. Approved March 2022.
- Definition of an Emergency Physician. Approved April 2017.

Specific changes requested in this resolution would:

1. Remove the current exception that permits off-site, real-time supervision by an emergency physician via telemedicine for CMS-designated Critical Access Hospitals and Rural Emergency Hospitals.
2. Add ‘formerly (ABEM/AOBEM) board-certified’ individuals to the group of emergency physicians (as defined by ACEP) who can care for patients and provide supervision.
3. Add non-EPs to provide supervision when an EP is not available, provided they are licensed, board certified in some medical specialty as defined by ABMS or AOA and a member of an alternative board.

In addition, it calls for the College to advocate with the Centers for Medicare and Medicaid Services (CMS) and other third-party payers to exclude care provided by NPs and PAs where there is not in-person, real-time physician supervision from an emergency physician (as defined by ACEP) for billing/reimbursement purposes.

ACEP’s existing policy regarding the role of NPs and PAs was revised in March 2022. The policy states unequivocally that NPs and PAs should not practice independently in the ED.

“ACEP believes that PAs and NPs should not perform independent, unsupervised care in the ED. [1]

The policy further states that the gold standard for care in the ED is the emergency physician as defined by ACEP.

> *"Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency 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) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.* [2]"

The policy also states that the emergency physician who supervises a PA or NP should be on-site and have the opportunity to be involved in the care of all patients seen by that PA or NP.

> *"The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP, whether the supervision is provided "Onsite" or "Offsite" as defined below* [1]
>
> *For all patients being cared for by a PA or NP within the ED, the on-duty emergency physician should solely determine which level of supervision is appropriate.* [1]"

However, current policy does allow for "off-site" supervision through telemedicine in federally designated Critical Access Hospitals and Rural Emergency Hospitals.

> *"The only CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "Offsite" by telehealth means are as follows:*
> *○ Critical Access Hospitals (CAHs)*
> *○ Rural Emergency Hospitals (REHs).* [1]"

ACEP's policy statement "Definition of an Emergency Physician" states:

> *"An emergency physician is defined as a physician who is certified (or eligible to be certified) by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine, or who is eligible for active membership in the American College of Emergency Physicians.*
>
> *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*." [2]"

The multi-organizational Emergency Physician Workforce Task Force reported on a survey of residents and fellows completing their training in July 2019. At that time, this group related some difficulty finding employment. They also reported a larger number of positions in rural areas rather than in urban areas. Despite this fact, few, if any, of the graduates reported taking a job in a rural area, despite offers that were an average of approximately $100,000 per year more than in urban areas. Despite an increased supply of emergency physicians and higher salaries, in rural areas there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board-certified physicians working in rural EDs.

In terms of the fourth resolved, ACEP does not have the authority to dictate the billing or reimbursement practices of the government's regulatory agencies, particularly in terms of how it reimburses other medical groups.

Background References

1. ACEP. Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department [policy statement]. Approved March 2022.
2. ACEP. Definition of an Emergency Physician [policy statement]. Approved April 2017.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Objective 4 – Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called 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.

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. Requested that ACEP develop a policy statement recommending that NPs and PAs working in EDs 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 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.

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 on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

March 2022, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2020 with the current title; revised and 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 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 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

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.

June 2020, filed the final report of the Emergency PA/NP 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).

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

June 2012, reviewed the information paper "Physician Assistants and Nurse Practitioners in Emergency Medicine."

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take 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.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted.

May 2001, discussed the recommendations of the Staffing Task Force.

September 1999, the MLP/EMS Task Force recommendations were presented to the Board. The Board approved dissemination of the survey results.

Background Information Prepared by: Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 45(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Offsite Supervision of Nurse Practitioners and Physician Assistants

PURPOSE: Revise the current policy "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" so that onsite emergency physician presence to supervise nurse practitioners and physicians is stated as the gold standard for staffing all emergency departments.

FISCAL IMPACT: Budgeted committee and staff resources.

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) 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; 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 the patients. 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 believes that all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric, care delivered by emergency physician-led care teams; and

WHEREAS, ACEP has a policy statement "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" most recently approved March 2022; therefore be it

RESOLVED, That the ACEP policy statement "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" be revised so that onsite emergency physician presence to supervise nurse practitioners and physician assistants is stated as the gold standard for staffing all emergency departments.

References

1. https://www.acep.org/globalassets/new-pdfs/policy-statements/guidelines-reg-the-role-of-physician-assistants-and-nurse-practitioners-in-the-ed.pdf
2. https://www.acep.org/patient-care/policy-statements/emergency-physician-rights-and-responsibilities/
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

Background

This resolution asks the College to revise the current policy statement "Guidelines Regarding the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department," so that onsite emergency physician presence to supervise nurse practitioners and physicians be stated as the gold standard for staffing all emergency departments.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states unequivocally that nurse practitioners (NPs) and physician assistants (PAs) should not practice independently in the ED:

> *"ACEP believes that PAs and NPs should not perform independent, unsupervised care in the ED."*

It further states that the gold standard for care in the ED is the emergency physician as defined by ACEP:

> *"Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency 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) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine."*

It also states that the emergency physician who supervised a PA or NP should be on-site and have the opportunity to be involved in the care of all patients seen by the PA or NP:

> *"The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP, whether the supervision is provided "Onsite" or "Offsite" as defined below*
>
> *For all patients being cared for by a PA or NP within the ED, the on-duty emergency physician should solely determine which level of supervision is appropriate. [1]"*

However, the current policy statement does permit "off-site" supervision through telemedicine in federally designated Critical Access Hospitals and Rural Emergency Hospitals:

> *"The only CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "Offsite" by telehealth means are as follows:*
> *○ Critical Access Hospitals (CAHs)*
> *○ Rural Emergency Hospitals (REHs)."*

This resolution seeks to clarify that such off-site, real-time supervision by an emergency physician via telehealth for CMS-designated Critical Access Hospitals and Rural Emergency Hospitals is not the gold standard.

There is on-going work to establish an ED accreditation program within ACEP. A task force, created in early 2021, has completed its work and presented its report to the Board in June 2022. Their recommendations were based on current ACEP policy statements including the updated "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." A second task force has been appointed to further develop proposed criteria and develop a business plan for the program. It is anticipated that such a program will have greater impact than our policy statements.

The task force report included a discussion of the lack of emergency physicians in rural areas. This subject has also been addressed in all of the previous rural emergency medicine task forces. All of the prior rural EM task forces have supported the concept of supervision of NPs and PAs via telehealth in rural, low volume hospitals. The most recent task force highlighted a few sites where this has been implemented, such as Mayo. It should be noted, however, that currently these rural programs do not require telehealth supervision of all patients. The emergency physician is able to view patient information such as age and chief complaint and may request involvement in any patient care.

The multi-organizational Emergency Physician Workforce Task Force report in 2020 included a survey of residents and fellows completing their training in July 2019. At that time, this group related some difficulty finding employment. They also reported a larger number of positions in rural areas rather than in urban areas. Despite this fact, few, if any, of the graduates reported taking a job in a rural area, despite offers that were an average of approximately $100,000 per year more than in urban areas. Even with the increased supply of emergency physicians

and higher salaries, there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board-certified physicians working in rural EDs.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Objective 4 – Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called 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.

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.

Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners adopted. 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. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all

tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

March 2022, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2020 with the current title; revised and 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 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 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

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, 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.

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 ED.

June 2012, reviewed the information paper "Physician Assistants and Nurse Practitioners in Emergency Medicine."

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take 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.

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: Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 46(22)

SUBMITTED BY: Illinois College of Emergency Physicians

SUBJECT: Safe Staffing for Nurse Practitioner and Physician Assistant Supervision

PURPOSE: Make recommendations on the minimum staffing ratios of physicians to nurse practitioners and physician assistants.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Nurse Practitioners (NPs) and physician assistants (PAs) have become increasingly common in emergency departments; and

WHEREAS, Physician-led teams in emergency medicine are critical to patient safety; and

WHEREAS, Board-certified/eligible emergency physicians are often asked to supervise more NPs and PAs and more patients than is safe for patient care; and

WHEREAS, Those emergency physicians who are charged with working alongside NPs and PAs may be held responsible for the care provided by such NPs and PAs as well as to provide back-up management of NPP patients in addition to the primary care of their own patient load; and

WHEREAS, Such supervisory responsibility confers significant liability on the emergency physician; therefore be it

RESOLVED, That ACEP research and make recommendations regarding the minimum staffing ratios of physicians to nurse practitioners and physician assistants, taking into account appropriate variables (such as patient acuity, non-physician provider competencies, available clinical resources, etc.) to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Background

This resolution calls for the College to make recommendations on the minimum staffing ratios of physicians to nurse practitioners and physician assistants.

ACEP's policy statement "Staffing Models and the Role of the Emergency Department Medical Director" places the responsibility for staffing models (ratios) on the local ED medical director.

> *"...it is the responsibility of the emergency department (ED) medical director to identify the most appropriate local staffing model to achieve operational efficiency while maintaining clinical quality and physician-directed or supervised care."*
>
> *"Though multiple staffing models utilizing physicians and other clinicians exist, the needs of each individual ED are unique. The utilization and distribution of staff within the ED should be determined at the site level by local ED leadership, who are responsible for and/or have a role in staff hiring, training/onboarding, and supervision."*
>
> *"The medical director and other local physician leaders should be responsible for establishing local*

> *processes and practices that ensure both sufficient physician training/onboarding and availability, as well as the opportunity for safe supervision of other clinicians to ensure clinical quality."*

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states "the medical director of the ED and the director of emergency nursing should assess staffing needs on a regular basis." It further states:

> *"staffing patterns should accommodate the potential for unexpected arrival of additional critically ill or injured patients. A plan should exist for the provision of additional nursing, physician assistant, advanced practice registered nurse, and physician support in times of disaster, natural or man-made."*

Additionally, the policy statement "Emergency Physician Rights and Responsibilities" states that:

> *"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 the patients. The facility management must provide sufficient support to ensure high-quality emergency care and patient safety. 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."*

ACEPs recently revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" affirms that PAs and NPs should not perform independent, unsupervised care in the ED:

> *"The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP, whether the supervision is provided "Onsite" or "Offsite" as defined below."*
>
> *"The only CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "Offsite" by telehealth means are as follows:*
> - *Critical Access Hospitals (CAHs)*
> - *Rural Emergency Hospitals (REHs)"*
>
> *"Since the supervising emergency physician is not physically present when providing "Offsite Supervision," the PA or NP caring for the patient MUST discuss ALL patients with the supervising physician."*
>
> *"Emergency physicians should always have the authority and opportunity to be involved in the care of any patient presenting to the ED and seen by a PA or NP while they are on duty. Emergency physicians must be allowed to determine their level of interaction, care, and involvement for patients seen by a PA or NP under their supervision."*

This policy also notes that:

> *"Multiple staffing models utilizing PAs and NPs exist. The use of PAs and NPs in the ED should be determined at the site level by local ED physician leadership, who are responsible for PA/NP hiring, supervision, and credentialing of clinical privileges. These emergency physician leaders 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."*

ACEP policy does not address specific ratios for emergency physicians or other staff. Currently, only California specifies a set nurse:patient ratio based on a unit's specialty. For the ED, that is one nurse for every four patients. Massachusetts has a set ratio of nurse:patient for the ICU. During the pandemic, over half of California's hospitals

were granted waivers that permitted nurse:patient ratios in the ED of 1:6. Looking at other specialties, anesthesia has several models of providing oversight to Certified Registered Nurse Anesthetists (CRNAs). In the medical direction where anesthesiologists are involved in key portions of the patient's care, there is a physician:CRNA ratio of 1:4.[1] The Accreditation Council for Graduate Medical Education (ACGME) has a guideline for supervision of residents based on a patient per hour model that the attending physician would have to oversee. This ratio is set at 4.0 patients per faculty hour or less averaged over the year, but applies these to only adult critical care areas, not fast track or urgent care areas.[2]

A recent multi-organization emergency medicine work group led by ACEP to raise the bar on ACGME emergency medicine program requirements recommended reducing this number to 3.0 patients per hour as part of a set of recommendations to improve resident education.

Background References

[1] https://www.anesthesiologynews.com/Review-Articles/Article/10-18/9-Steps-to-Implementing-An-Anesthesia-Care-Team-Model/52866?sub=8A1D6A43692A7635579A393636615F2FAF0FC54528C1BF9B141847653C4B39

[2] https://www.acgme.org/globalassets/pdfs/faq/110_emergency_medicine_faqs_2017-07-01.pdf

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Objective 4 – Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called 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.

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.

Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners adopted. 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. This resolution called for ACEP to work with NP and PA organizations on the

development of curriculum and clinically based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

March 2022, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2020 with the current title; revised and 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 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 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

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 "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

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.

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

April 2020, approved the policy statement "Staffing Models and the Role of the Emergency Department Medical Director."

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.

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take 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.

Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 47(22)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Unbiased Outside Agency Report for Nurse Practitioner Schools

PURPOSE: Work with the AMA to call for an unbiased outside agency survey and report of NP schools to provide recommendations for NP reform to improve the quality of NP education and to improve patient care.

FISCAL IMPACT: Budgeted AMA Section Council on Emergency Medicine and staff resources.

WHEREAS, Medical school education had a rapid proliferation of schools in the early 1900s; and

WHEREAS, Medical education was not nationally standardized, which led to the decrease in quality of physicians, decrease in quality of patient care, and decrease in confidence patients had for physicians; and

WHEREAS, The AMA created the Council on Medical Education in 1904, which contracted with an outside agency, the Carnegie Foundation for the Advancement of Teaching, which chose an unbiased surveyor Abraham Flexner to evaluate all medical schools and provide recommendations for medical school reform; and

WHEREAS, The Flexner Report recommended that American medical schools enact higher admission and graduation standards, and higher standards for medical school teachers and teaching facilities; and

WHEREAS, The Flexner Report recommendations helped standardize medical school education for the United States, and improved the quality of medical education and patient care; and

WHEREAS, Nurse practitioner education has had a significant proliferation of schools, including online programs; and

WHEREAS, Nurse practitioner schools do not have national standards for admissions and graduation; and

WHEREAS, Nurse practitioner schools do not have national standards for clinical education, clinical preceptors, and clinical locations; and

WHEREAS, ACEP has joined the AMA Scope of Practice Partnership (SOPP); therefore be it

RESOLVED, That ACEP work with the American Medical Association and call for an unbiased outside agency survey and report of nurse practitioner schools to provide recommendations for nurse practitioner reform to improve the quality of nurse practitioner education and to improve patient care.

Background

This resolution calls for the College to work with the American Medical Association (AMA) to call for an independent agency to review and make recommendations for standards for the education of Nurse Practitioners (NPs).

There has been tremendous growth in the use of NPs in the emergency department (ED). According to Medicare claims data, the numbers of NPs submitting emergency medicine (EM) claims each year increased 99 percent between the years 2012 and 2018. It is estimated that EDs employ between 14,000-16,000 NPs. Currently, 24 states have granted NPs independent practice, which is also known as “full practice authority.” This growth has been even more dramatic in rural

settings where NPs may see patients without an onsite physician.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" states unequivocally that NPs and PAs should not practice independently in the ED.

> *"ACEP believes that PAs and NPs should not perform independent, unsupervised care in the ED.*

The policy further states that the gold standard for care in the ED is the emergency physician as defined by ACEP:

> *"Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency 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) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine."*

When the role of NPs was originally envisioned in the 1960s, it was designed to fill the void in primary care. However, now NPs practice in a variety of clinical settings. NPs must choose a population to focus on – family, adult, pediatrics, psychiatry, or women's health – each with different credentialling bodies. Family NPs (FNP) is the most common pathway to emergency medicine as it provides exposure to a wide range of age groups; however, the training is focused mostly on outpatient primary care. NPs graduate with either a master's degree or doctorate of nursing practice. There is no standard around education or population focus required to work in the ED. While many NP programs call for 500-1000 hours of post bachelor's healthcare experience, this is not a standardized requirement. There are NP programs that allow direct entry without any prior nursing experience. NPs can be hired to work in the ED immediately upon completion of schooling, as opposed to physicians who require an additional 3-4 years of residency training in emergency medicine after medical school. NP schools typically require 500 clinical hours as opposed to the 5,000 hours of medical school and 10,000 hours of EM residency.[1] There is currently a pathway to emergency NP (ENP) certification based on training in FNP. As of September 2021, only 1,514 NPs are certified as ENPs, meaning that about 90% of NPs working in EDs are not certified.

A recent study by Lavin, et al, analyzed the education of NPs practicing in the ED and found wide variation in training. Further, there no uniform consensus over education and certification standards. There are multiple accrediting bodies for NP programs, each with different standards and requirements. Students graduating from FNP programs are able to choose two different accrediting bodies to sit for certification. Often programs lack alignment between education and future scope of practice.[3]

When it comes to licensure, each state has its own legal scope of practice. In some states, NPs have the authority to diagnose, order, and interpret diagnostic tests, manage treatments, and prescribe medications, while other states place restrictions on these activities, requiring either collaborative agreements or delegation/supervision from other health care professionals.

Independent review of current training, educational, standards, certification, and scope of practice for nurse practitioners would help identify strengths, weaknesses, and inconsistencies in preparation for practice in the ED setting and provide useful information to ACEP members involved in training, hiring, supervising, or evaluating ED nurse practioners.

Background References

1. Chekijian SA, Elia TR, Horton JL, Baccari BM, Temin ES. A Review of Interprofessional Variation in Education: Challenges and Considerations in the Growth of Advanced Practice Providers in Emergency Medicine. AEM Educ Train. 2020 Jul 10;5(2):e10469. doi: 10.1002/aet2.10469. PMID: 33796808; PMCID: PMC7995928.
2. Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments
3. Lavin RP, Veenema TG, Sasnett L, Schneider-Firestone S, Thornton PT, Saenz D, Cobb S, Shahid M, Peacock M, Couig M.

Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments. Journal of Nursing Regulation Volume 12, Issue 4, January 2022, 50-62

ACEP Strategic Plan

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Objective 4 – Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Fiscal Impact

Budgeted AMA Section Council on Emergency Medicine and staff resources.

Prior Council Action

Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants referred to the Board of Directors. The resolution sought to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement by removing "offsite" supervision and for ACEP to oppose staffing of emergency departments with physician assistants and nurse practitioners without onsite emergency physician supervision.

Resolution 71(21) Emergency Medicine Workforce by Non-Physician Practitioners not adopted. The resolution called 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.

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; and 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. Requested that ACEP develop a policy statement recommending that NPs and PAs working in EDs or urgent care settings obtain 25 CME credits in emergency care annually.

Referred Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners adopted. 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. This resolution called for ACEP to work with NP and PA organizations on the development of curriculum and clinically-based ED education training and encourage certification bodies to develop certifying exams for competencies in emergency care.

Prior Board Action

March 2022, approved "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." Revised June 2020, 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 2022, discussed Referred Resolution 73(21) Offsite Supervision of Nurse Practitioners and Physician Assistants and appointed a Board workgroup to revise the "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" policy statement.

June 2020, filed the final report of the Emergency PA/NP Utilization Task Force.

June 2012, reviewed the information paper "Physician Assistants and Nurse Practitioners in Emergency Medicine."

June 2011, approved the recommendation of the Emergency Medicine Practice Committee to take to take 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.

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.

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.

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.

May 2001, discussed the recommendations of the Staffing Task Force.

September 1999, the MLP/EMS Task Force recommendations were presented to the Board. The Board approved dissemination of the survey results.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 48(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: ED Staffing at Critical Access Hospitals, Rural Emergency Hospitals, Outpatient EDs

PURPOSE: Endorse that PAs or NPs have a minimum of 5-years experience working in an ED with onsite supervision before working in a Critical Access Hospital (CAH), Rural Emergency Hospital (REH), or Outpatient Emergency Department (OED).

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, ACEP 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; 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 the patients. 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 believes that all patients who present to emergency departments (EDs) deserve to have access to high quality, patient-centric, care delivered by emergency physician-led care teams; and

WHEREAS, The 2021 ACEP EM Physician Workforce of the Future Report suggested a looming surplus of emergency physicians; and

WHEREAS, Currently, there are workforce limitations to providing the gold standard of care in certain rural or frontier areas; and

WHEREAS, Critical Access Hospitals (CAHs), Rural Emergency Hospitals (REHs) and Outpatient Emergency Departments (OEDs) have provided emergency service care to patients in rural and frontier areas; and

WHEREAS, ACEP has a policy statement "Guidelines on the Role of Physician Assistants and Advanced Practice Registered Nurses in the Emergency Department" most recently approved March 2022; therefore be it

RESOLVED, That ACEP endorse that before a physician assistant or nurse practitioner can work in a Critical Access Hospital (CAH), Rural Emergency Hospital (REH) or Outpatient Emergency Department (OED) that they have a minimum of five years of experience working in an emergency department with onsite supervision.

References

1. https://www.acep.org/globalassets/new-pdfs/policy-statements/guidelines-reg-the-role-of-physician-assistants-and-nurse-practitioners-in-the-ed.pdf
2. https://www.acep.org/patient-care/policy-statements/emergency-physician-rights-and-responsibilities/
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.health.pa.gov/topics/kDocuments/Facilities%20and%20Licensing/Hospital%20Guidance%20to%20Implement%20an%20OED.pdf
6. https://tigerweb.geo.census.gov/tigerweb2020/

Background

This resolution asks ACEP to endorse as a standard that physician assistants (PAs) or nurse practitioners (NPs) have a minimum of five years experience working in an emergency department with onsite supervision before they can work in a Critical Access Hospital (CAH), Rural Emergency Hospital (REH), or Outpatient Emergency Department (OED).

A CAH is a designation by CMS to provide essential access to high-quality healthcare in rural communities. A REH is a new classification established by the Consolidated Appropriations Act 2020 that allows a CAH to convert to REH. Under this designation, REH would provide emergency services, observation care, and additional medical and health outpatient services vital to the rural community. An OED is an outpatient location of a hospital that offers only emergency services and is not located on the grounds of a main licensed hospital. OEDs are governed at the state level and generally restricted to underserved areas and rural settings.

CAH, REH, and OEDs function in rural environments where there is a shortage of qualified emergency physicians. Rural EDs represent 53% of all hospitals in the U.S. and 24% of total ED patient volume. Only 8% of all EPs (not necessarily ABEM/AOBEM certified) work in rural EDs and only about 2% work in very low volume ED's.[1]

ACEP's Rural Emergency Care Task Force Report in 2020 highlighted some important challenges facing rural emergency medicine. The task force recognized the discrepancies in the quality of care between urban and rural sites and work to encourage emergency medicine residency trained/emergency medicineboard certified physicians to migrate to those rural EDs. Despite a 28% increase in emergency medicine residency positions over the past 10 years, there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board certified physicians working in rural EDs. A survey conducted by the task force revealed that "31% of NPs and 45% of PAs reported that they work independently in their ED (no physician onsite and virtually no presence of a supervising physician)" The task force actions items included that ACEP "develop a recommended knowledge and experience base for PAs and NPs who are working in rural areas."

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" delineates the importance of real-time supervision of PAs and NPs and creates an allowance for qualified emergency physicians to provide supervision "Offsite" by telehealth in CAHs and REHs. This policy also states "the ED Medical Director should have the authority to approve both departmental credentialing and for the granting of clinical privileges for PAs and NPs working in the ED."

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.[2]

ACEP's ED Accreditation Task Force completed the first phase of their work in June 2022. Their recommendations to the Board of Directors were to initiate an ED Accreditation Program with several standards based upon ACEP policy. These recommended standards included the requirement for there to be a physician medical director and for that medical director to be an emergency physician as defined in ACEP policy, "Definition of an Emergency Physician." ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states "the ED medical director shall be certified by ABEM, AOBEM, or possess comparable qualifications. An operational task force has been appointed to further explore the recommendations, identify other issues, and develop a business plan that would be required for implementation of the ED Accreditation Task Force's recommendations.

Background References

[1] https://www.acep.org/rural/rural-newsroom/rural-news-articles/january-2021/rural-task-force-summary/
[2] 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

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Develop and implement an ongoing, two-way system to identify and address the issues that hinder wellness and career satisfaction for emergency physicians and allow for members to be heard in more meaningful and effective ways.
- Position ACEP as the standard bearer for well workplaces in emergency medicine to increase job security for all emergency physicians and improve access and outcomes for patients.
- Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

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; and 4) Develop strategies, including legislative solutions, to require onsite supervision of non-physicians by an emergency physician.

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; 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.

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. Called for the College to develop a report or information paper supporting the use of freestanding emergency centers as a replacement for EDs in critical access and rural hospitals that are closing or at-risk of closing.

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 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.

Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments.

Prior Board Action

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

March 2022, approved "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." Revised June 2020 and June 2013; 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).

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

October 2020, filed the Rural Emergency Care Task Force report and referred the recommendations to staff for implementation in the context of the Strategic Plan and the budgetary requirements needed.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted.

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 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

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

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 2012, reviewed the information paper "Physician Assistants and Nurse Practitioners in Emergency Medicine."

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.

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.

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.

April 2006, reviewed the survey responses from NP and PA organizations regarding developing a curriculum for NPs and PAs in emergency care.

Amended Resolution 37(05) Rural Emergency Medicine Workforce adopted.

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.

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.

May 2001, accepted the report of the Staffing Task Force.

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: Kelly Peasley
ED Pain & Addiction Management Accreditation Manager
Staff Liaison, Rural Emergency Medicine Section

Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 49(22)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Enhancing Rural Emergency Medicine Patient Care

PURPOSE: 1) support initiatives to encourage placement of emergency medicine-trained and board certified medical directors in all U.S. EDs, whether in person or virtual; 2) support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and 3) support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-boarded physicians, physician assistants, and nurse practitioners already working in rural EDs.

FISCAL IMPACT: Budgeted staff resources for committee or task force support. Unbudgeted expenses of $20,000-$30,000 for an in-person meeting if needed.

WHEREAS, Patients in many rural emergency departments (EDs) are not afforded care provided by an emergency medicine (EM)-trained/boarded physician; and

WHEREAS, The national standard outside ACEP has already been determined to allow for non-boarded emergency medicine physicians to serve in rural facilities; and

WHEREAS, Patients in rural EDs deserve care that is consistent with emergency care provided in urban counterparts (or locations with 24/7 board-certified emergency medicine coverage); 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,[1-7]; and

WHEREAS, Current technology exists to support opportunities to provide a virtual emergency medicine evaluation by a board-certified emergency medicine physician; and

WHEREAS, The current threshold for credentialing privileges to work in a rural ED, for physicians, physician assistants, and nurse practitioners, commonly consists of simply holding certifications in ACLS, ATLS, and PALS; therefore be it

RESOLVED, That ACEP support initiatives that encourage the placement of emergency medicine-trained and board certified medical directors in all U.S. EDs, whether in person or virtual; and be it further

RESOLVED, That ACEP support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and be it further

RESOLVED, That ACEP support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-emergency medicine physicians, physician assistants, and nurse practitioners already working in rural EDs.

References

1. 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.
2. 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.

3. 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.
4. Heaton J, Kohn MD. EMS Inter-Facility Transport. 2020 Sep 27. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan–. PMID: 32310376.
5. (EMS Workforce for the 21st Century: A National Assessment EMSWorkforceReport_June2008.pdf)
6. (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))
7. 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.

Background

This resolution asks the College to:

1. Support initiatives that encourage the placement of emergency medicine-trained and board-certified medical directors in all U.S. EDs, whether in person or virtual.
2. Support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board-certified physicians.
3. Support the creation of a minimum standard for training partnered with emergency medicine trained and board certified local or virtual bedside support for all non-boarded physicians, physician assistants, and nurse practitioners already working in rural EDs.

ACEPs policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" addresses the first resolved. It states:

- EDs should have a Medical Director 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) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine." It also states that care by an emergency physician is the "gold standard."

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" addresses the second resolved. It states:

- ACEP believes that PAs and NPs should not perform independent, unsupervised care in the ED.
- The supervising emergency physician for a PA or NP must have the real-time opportunity to be involved in the contemporaneous care of any patient presenting to the ED and seen by a PA or NP, whether the supervision is provided "Onsite" or "Offsite" as defined below.
- While there are ongoing efforts to achieve the gold standard of all ED care being provided by an emergency physician, ACEP believes that there are, at the present time, workforce limitations to specific types of CMS-designated facilities located in rural or frontier areas where emergency physicians may provide supervision of an PA/NP in an ED through telehealth means.
- The only CMS-designated facility types in which supervision of a PA or NP by an emergency physician may be provided "Offsite" by telehealth means are as follows:
  - Critical Access Hospitals (CAHs)
  - Rural Emergency Hospitals (REHs).

ACEP has had three separate task forces in the past several years to address the issue of attracting emergency physicians to practice in a rural area. They have identified several strategies, including rural rotations for emergency medicine residents and loan forgiveness programs. However, a survey of emergency medicine residency graduates, conducted by Ed Salsberg, PhD, at George Washington showed that few, if any, of those who answered the survey took jobs in the rural area, despite the fact that those jobs paid an average of $100,000 more in compensation and included loan forgiveness programs. Though they were not asked directly why they did not take rural positions, they

were asked the major factors for their decision. The most common responses were spouse job needs and to be near family.

ACEP's ED Accreditation Task Force completed the first phase of their work in June 2022. Their recommendations to the Board of Directors were to initiate an ED Accreditation Program with several standards based upon ACEP policy. These recommended standards included the requirement for there to be a physician medical director and for that medical director to be an emergency physician as defined in ACEP policy, "Definition of an Emergency Physician." ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states "the ED medical director shall be certified by ABEM, AOBEM, or possess comparable qualifications. An operational task force has been appointed to further explore the recommendations, identify other issues, and develop a business plan that would be required for implementation of the ED Accreditation Task Force's recommendations.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Provide resources, roadmaps, education, and networks to assist members in identify8ing career opportunities and having career fulfillment based on different interests or at different life stages.
- Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Fiscal Impact

Budgeted staff resources for committee or task force support. Unbudgeted expenses of $20,000-$30,000 for an in-person meeting if needed.

Prior Council Action

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

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; 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.

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. Called for the College to develop a report or information paper supporting the use of freestanding emergency centers as a replacement for EDs in critical access and rural hospitals that are closing or at-risk of closing.

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

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved: 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

June 2022, approved the revised policy statement "Rural Emergency Medical Care;" originally approved June 2017 titled "Definition of Rural Emergency Medicine."

March 2022, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2020 with the current title; revised and 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 two policy statements "Guidelines on the Role of Physician Assistants in the Emergency Department" and "Guidelines on the Role of Nurse Practitioners in the Emergency Department."

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

April 2021, approved the revised policy statement "Emergency Department Planning and Resource Guidelines;" revised April 2014, October 2007, June 2004, June 2001 with the current title, and June 1991; reaffirmed September 1996; originally approved December 1985 titled "Emergency Care Guidelines."

October 2020, filed the Rural Emergency Care Task Force report and referred the recommendations to staff for implementation in the context of the Strategic Plan and the budgetary requirements needed.

February 2020, revised the policy statement "Emergency Medicine Telehealth," originally approved January 2016.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board 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.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

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.

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 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: Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 50(22)

SUBMITTED BY: Rural Emergency Medicine Section

SUBJECT: Supporting Emergency Physicians to Work Rural

PURPOSE: 1) support and encourage emergency medicine trained and board-certified emergency physicians to work in rural EDs; 2) work with CORD to establish a training program for EM residents with an interest to work rural; and 3) ACEP work with the ACGME to increase resident exposure to rural EM.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Emergency medicine (EM) workforce is saturated in urban and suburban EDs; and

WHEREAS, EM trained and board certified physicians are under-represented in rural EDs; and

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, Many rural EDs have unique care challenges that may not be part of standard EM residency training (e.g., inpatient care, labor and delivery care, neonatal resuscitation, emergency medicine observation care); and

WHEREAS Delays in transfer of EM patients (EMS limitations, hub site capacity, workforce shortages) require prolonged and extended care in the ED; therefore be it

RESOLVED, That ACEP support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; and be it further

RESOLVED, That ACEP help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work rural; and be it further

RESOLVED, That ACEP support working with the Accreditation Council for Graduate Medical Education to increase resident exposure to rural emergency medicine.

Resolution 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.)

Background

This resolution calls for ACEP to encourage emergency trained and board-certified emergency physicians to work in rural EDs; work with the Council of Residency Directors in Emergency Medicine (CORD) to establish a training program for emergency medicine residents with interests to work in rural areas; and work with the Acreditation Council for Graduate Medical Education (ACGME) to increase resident exposure to rural emergency medicine.

Attracting emergency physicians to a rural area is an ongoing concern. In 2020, the Rural Emergency Care Task Force Report highlighted the important challenges facing rural emergency medicine. Rural EDs represent 53% of all hospitals in the U.S. and 24% of total ED patient volume. Only 8% of all emergency physicians (not necessarily ABEM/AOBEM certified) work in rural EDs and only about 2% work in very low volume EDs.[1] The task force recognized the discrepancies in quality of care between urban and rural sites and the existing work to encourage emergency medicine residency trained/emergency medicine board certified physicians to practice in rural EDs.

Despite the rapid growth in emergency medicine residency programs, and the need for emergency medicine trained physicians in rural areas, a recent analysis shows that the majority of new EM residency positions/programs were added to states where training programs already exist., Rural states continue to have limited, or even, no emergency medicine residencies.[2]

The multi-organizational Emergency Physician Workforce Task Force reported on a survey of residents and fellows completing their training in July 2019. At that time, this group related some difficulty finding employment. They also reported a larger number of positions in rural areas rather than in urban areas. Despite this fact, few, if any, of the graduates reported taking a job in a rural area, despite offers that were an average of approximately $100,000 per year more than in urban areas. Despite an increased supply of emergency physicians and higher salaries, in rural areas there has not been a corresponding increase in emergency medicine residency trained or emergency medicine board-certified physicians working in rural EDs.

The Rural Task Force actions items included a goal to "reduce barriers involving the credentials of a "supervising physician with the ACGME Review Committee for Emergency Medicine (RC-EM)" and to "collaborate with CORD and EMRA to increase the options for rural ED rotations." A recent multi-organization emergency medicine work group led by ACEP to raise the bar on ACGME emergency medicine program requirements also recommended residencies should provide exposure/training in rural emergency medicine and an opportunity for a rural elective.

ACEP's ED Accreditation Task Force completed the first phase of their work in June 2022. Their recommendations to the Board of Directors were to initiate an ED Accreditation Program with several standards based upon ACEP policy. These recommended standards included the requirement for there to be a physician medical director and for that medical director to be an emergency physician as defined in ACEP policy, "Definition of an Emergency Physician." ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states "the ED medical director shall be certified by ABEM, AOBEM, or possess comparable qualifications. An operational task force has been appointed to further explore the recommendations, identify other issues, and develop a business plan that would be required for implementation of the ED Accreditation Task Force's recommendations.

Background References

[1]https://www.acep.org/rural/rural-newsroom/rural-news-articles/january-2021/rural-task-force-summary/
[2]Bennett CL, Clay CE, Espinola JA, et al. United States 2020 emergency medicine resident workforce analysis. *Ann Emerg Med*. 2022; 80(1):3-11.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Develop and implement an ongoing, two-way system to identify and address the issues that hinder wellness and career satisfaction for emergency physicians and allow for members to be heard in more meaningful and effective ways.

- Position ACEP as the standard bearer for well workplaces in emergency medicine to increase job security for all emergency physicians and improve access and outcomes for patients.
- Remain diligent in workforce solutions ensuring emergency physicians set the course for their practice and the specialty's future.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted. Directed that the ACEP ED Accreditation Task Force specifically consider the merits of a tiered ED classification based upon qualification of the clinician as part of the accreditation process with a report of findings to the Council by July 1, 2022.

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; 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.

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. Called for the College to develop a report or information paper supporting the use of freestanding emergency centers as a replacement for EDs in critical access and rural hospitals that are closing or at-risk of closing.

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.

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Amended Substitute Resolution 21(01) Rural Emergency Medicine Departments adopted. Directed ACEP to investigate the root causes related to the difficulty of securing board-certified emergency physician staffing for medically underserved and rural areas; the causes studies should include, but not be limited to, educational, financial, and resident candidate selection factors, and be it further resolved that ACEP investigate methods to improve educational opportunities in rural and underserved environments

Prior Board Action

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

June 2022, approved revised policy statement with revised title "Rural Emergency Medical Care," June 2017, originally approved policy statement titled "Definition of Rural Emergency Medicine."

March 2022, approved "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department." Revised June 2020, 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."

Substitute Resolution 28(21) Consumer Awareness Through Classification of Emergency Departments adopted.

October 2020, filed the Rural Emergency Care Task Force report and referred the recommendations to staff for implementation in the context of the Strategic Plan and the budgetary requirements needed.

February 2020, revised the policy statement "Emergency Medicine Telehealth," originally approved January 2016.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted.

June 2018, approved the revised policy statement "Resident Training for Practice in Non-Urban Underserved Areas." Reaffirmed in April 2012 and October 2006. Originally approved in June 2000

January 2018, assigned Referred Resolution 62(17) Freestanding Emergency Centers (FECs) as a Care Model for Maintaining Access to Emergency Care in Underserved, Rural, and Federally Declared Disaster Areas of the United States to the Federal Government Affairs Committee for action.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

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.

April 2017, Reaffirmed 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.

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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: Kelly Peasley
ED Pain & Addiction Management Accreditation Manager
Staff Liaison, Rural Emergency Medicine Section

Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 51(22)

SUBMITTED BY: Dennis Hsieh, MD, JD
Laura Janneck, MD, FACEP
Nikkole Turgeon, MD
Social Emergency Medicine Section

SUBJECT: Implementation of Social Determinants of Health Screening in the ED

PURPOSE: Support and encourage screening for social determinants of health with validated tools paired with feasible and appropriate responses.

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

WHEREAS, Social determinants of health (SDH) influence overall health outcomes to a greater degree than medical care alone[1,2]; and

WHEREAS, ACEP seeks 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[3]; and

WHEREAS Changes in reimbursement may incentivize emergency departments to implement screening tools for social determinants of health; 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; therefore be it

RESOLVED, That ACEP support screening for social determinants of health with validated tools; and be it further

RESOLVED, That ACEP encourage screening for social determinants of health to be paired with feasible and appropriate responses.

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. 2021 Council Resolution 57: Social Determinants of Health Screening in the Emergency Department. https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=C79FE36C-7F11-EC11-A9C7-B891C2BD0176 Accessed on June 17, 2022.

Background

This resolution calls for ACEP to support and encourage screening for social determinants of health with validated tools paired with feasible and appropriate responses.

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, grow, 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.

Some believe that emergency medicine is uniquely positioned to address SDH as emergency physicians handle more than 25% of all acute care encounters in the U.S. and more than half of such visits for the uninsured. The ED functions as society's "safety net," and thus, has been identified by some to be an ideal environment for identifying and intervening upon SDH that play a role in overall patient health. EDs are seeing a growing demand to better respond to patients with unmet social needs. The ICD-10-CM codes (Z55-Z65) include categories of potential health hazards related to a patient's socioeconomic or psychosocial environment, and other factors that can influence their health status. Despite the growing knowledge surrounding the health implications of unaddressed SDH and disparities in care, some in emergency medicine are concerned that increasing the focus on SDH could overburden already overwhelmed EDs and interfere with the ED's primary mission of caring for acute medical issues. Advocates for SDH screening inclusion argue that treating patients adequately without addressing SDH increases the likelihood that patients will return. However, many emergency physicians express concerns that screening will add costs, identify issues for which there is a lack of available follow up services, and the potential for a negative impact on ED throughput. One study of a SDH screening process found that while they were able to systematically screen and refer for needs, that an effective SDH screening program needed to ensure buy-in from staff as well as the availability of referral resources within the community.

EDs already do some screening for certain social determinants of health. For example, many nursing triage protocols include a screen for intimate partner violence. However, there is no widely accepted systematic screen for social determinants of health, nor consensus on what domains to screen for. Different screens over the years have examined different domains, including tobacco use, alcohol use, financial problems, and food insecurity and examples of these are Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE), HealthBegins Upstream Risks Screening Tool & Guide and the Health Leads Screening Toolkit.

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 also launched the educational module: "Determining What Matters: A Pragmatic Approach to Social Determinants of Health In and Outside of the ED" and microeducation: Social Determinants of Health.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

- Position ACEP as the standard bearer for well workplaces in emergency medicine to increase job security for all emergency physicians and improve access and outcomes for patients
- Provide resources, roadmaps, education, and networks to assist members in identifying career opportunities and having career fulfillment based on different interests or at different life stages.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

- Using a systematic approach, identify two or three viable career options for emergency physicians that expand the practice of acute, unscheduled care

Fiscal Impact

Budgeted committee, section, and staff resources.

Prior Council Action

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted. Directed ACEP to seek to improve the recognition of, and attention to, social determinants of health by supporting research of evidence-based SDH screening and interventions in the ED; advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and 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.

Amended Resolution 56 (21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted. Directed ACEP to 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, commit to educating ACEP members by denouncing the use of race-based calculators in clinical policies, and commit to not support research studies that utilize race-based calculations that are not supported by sound scientific evidence.

Resolution 20(21) Creation of the Social Emergency Medicine Association not adopted.

Amended Resolution 26 Addressing Systemic Racism as a Public Health Crisis adopted. The resolution 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 as an organization and support its members who seek to reform discriminatory systems and advocate for policies promoting the social determinants of health within historically disenfranchised communities at an institutional, local, state, and national level.

Amended Resolution 50(19) Social Work in the Emergency Department adopted. Directed ACEP 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.

Prior Board Action

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department was adopted.

Amended Resolution 56 (21) Race-Based Science and Detrimental Impact on Black, Indigenous, and People of Color Communities adopted.

Amended Resolution 26(20) Addressing Systemic Racism as a Public Health Crisis adopted.

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."

February 2020, approved the revised policy statement "Human Trafficking;" originally approved April 2016.

Amended Resolution 50(19) Social Work in the Emergency Department was adopted.

June 2019, approved the policy statement "Safe Discharge from the Emergency Department."

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 52(22)

SUBMITTED BY: Social Emergency Medicine Section

SUBJECT: Minimum Standards of Care for Health-Related Social Needs in the ED

PURPOSE: Appoint a task force or committee to identify minimum standards of care for health-related social complaints in the ED, acknowledging the standards are advisory in nature and must be reflective of standards that can be reasonably achieved in all ED, with particular attention given to the feasibility of recommended standards in low resource and/or rural settings, and submit a report to the 2023 Council.

FISCAL IMPACT: Unbudgeted travel expenses of $20,000 – $30,000 for in-person stakeholder/task force meeting depending on the size of the group. Unbudgeted resources for staff support and additional unknown and unbudgeted costs depending on the scope of work.

WHEREAS, The emergency department has, since its founding, been a critical element of the health care safety net; and

WHEREAS, The COVID-19 pandemic has highlighted the need to integrate care for health-related social needs in the emergency department; and

WHEREAS, There has recently been a growth in interest from hospitals and emergency departments in providing socially conscious care in the emergency department; and

WHEREAS, No standards of care addressing health-related social needs in the emergency department currently exist; therefore be it

RESOLVED, That ACEP appoint a task force or committee to identify minimum standards of care for health-related social complaints in the emergency department, acknowledging that these standards are only advisory in nature and must be reflective of standards that can be reasonably achieved in all emergency departments, with particular attention given to the feasibility of recommended standards in low resource and/or rural settings, and submit a report to the 2023 Council.

Background

This resolution asks ACEP to appoint a task force or committee to identify minimum standards of care for health-related social complaints in the ED, acknowledging the standards are advisory in nature and must be reflective of standards that can be reasonably achieved in all ED, with particular attention given to the feasibility of recommended standards in low resource and/or rural settings and submit a report to the 2023 Council

The health of a population depends upon several factors, including disease, public health initiatives, and the social determinants of health (SDH). As the only place in the US health care system where patients cannot be turned away for inability to pay, the emergency departments (EDs) see a disproportionate share of low-income and uninsured patients. These factors often converge in the ED where the impact of social conditions such as homelessness, low-literacy, and poverty lead to recidivism and may contribute to moral injury for emergency physicians and others in the health care continuum. Further, we know that physician moral injury is directly correlated to a personal sense of disempowerment to effect change in the work environment. However, questions remain about population-level SDH measurement and payment implications and about how to assess and address SDOH during health service delivery. The Institute of Medicine and the Center for Medicare and Medicaid Services have focused on identifying social needs and recommend that clinical systems screen for food and housing insecurity, financial strain, transportation,

childcare, education, employment, mental health needs, exposure to violence, and social isolation. Screening tools that include questions about social needs have predicted emergency department revisits and inpatient admissions after an emergency department visit. However, there could be improved guidance for clinicians about how to best integrate social needs assessment into clinical care and access to resources.

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "*Emergency departments (EDs) should possess the staff and resources necessary to evaluate all individuals presenting to the ED. The ED should have the capabilities to provide or arrange treatment necessary to stabilize patients who are found to have an emergency medical condition. Because of the unscheduled and episodic nature of health emergencies and acute illnesses, experienced and qualified physician, nursing, and ancillary personnel should be continuously available to meet those needs."*

EDs are beginning to take ownership of social determinants of health for their patients and there are examples of successful social emergency medicine interventions focusing on the development of coordinated care models providing ED patients in need with comprehensive medical and social services, however there are no current standards of care addressing health-related social needs in the emergency department currently exist. The first "standard" document for hospital standardization was adopted by the American College of Surgeons in 1919 and ultimately evolved into the Joint Commission on Accreditation of Hospitals in 1951, and the Joint Commission on Accreditation of Healthcare Organizations in 1987. In 2021, the WHO published the Classification and Minimum Standards for Emergency Medical Teams.

ACEP has not previously established minimum standards of care but there are multiple relevant policy statements that provide guidance on emergency department resource allocation, staffing, etc., such as:

- Emergency Department Planning and Resource Guidelines
- Freestanding Emergency Departments
- Geriatric Emergency Department Guidelines
- Pediatric Readiness in the Emergency Department
- Pediatric Readiness in Emergency Medical Services Systems

In June 2022, the Board of Directors approved moving forward with development of a business plan for an ED Accreditation program. The accreditation program will include tiers based on staffing levels and other criteria.

ACEP Strategic Plan Reference

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

Fiscal Impact

Unbudgeted travel expenses of $20,000 – $30,000 for in-person stakeholder meeting/task force depending on the size of the group. Unbudgeted resources for staff support and additional unknown and unbudgeted costs depending on the scope of work.

Prior Council Action

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted. Directed ACEP to seek to improve the recognition of, and attention to, social determinants of health by supporting research of evidence-based SDH screening and interventions in the ED; advocate for the allocation of private and public sector resources for identifying and addressing social determinants of health in the emergency department; and

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.

Resolution 35(21) Preserving Rural Emergency Care in Rural Critical Access Hospitals and Rural Emergency Hospitals adopted. Directed ACEP to support the rural critical access hospital program, including conversion of certain rural hospitals into rural emergency hospitals; and 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.

Amended Resolution 50(19) Social Work in the Emergency Department adopted. Directed ACEP 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.

Prior Board Action

June 2022, filed the report of the ED Accreditation Task Force and approved distributing it to the Council. Additionally, the Board approved: 1) funds of up to $50,000 to develop a business plan for an ED Accreditation Program; 2) the Emergency Department Accreditation Program will include tiers based on staffing levels; 3) emergency department accreditation may include care delivered by physicians who do not meet the ACEP definition of an emergency physician; 4) emergency department accreditation shall only be considered for sites where all care delivered by physician assistants and nurse practitioners is supervised in accordance with ACEP policy; and 5) all tiers for ED Accreditation Program must require an emergency physician (as defined by ACEP policy) to be the medical director.

Amended Resolution 57(21) Social Determinants of Health Screening in the Emergency Department adopted.

Resolution 35(21) Preserving Rural Emergency Care in Rural Critical Access Hospitals and Rural Emergency Hospitals adopted.

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 50(19) Social Work in the Emergency Department adopted.

Background Information Prepared by: Sam Shahid, MBBS, MPH
Practice Management Manager

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 53(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Law Enforcement and Intoxicated Patients in the ED

PURPOSE: Investigate alternative care models to evaluate patients in police custody, such as telehealth, to determine the need for an in-person evaluation and encourage law enforcement to remain with any patients brought to the ED for evaluation who are intoxicated, altered, agitated, or otherwise pose a risk to the safety of themselves or others until a disposition has been determined or the physician determines their assistance is no longer needed.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, ACEP believes that workplace violence is a preventable and significant public health problem, and that optimal patient care can be achieved only when patients, health care workers, and all other persons in the emergency department (ED) are protected against violent acts occurring within the department[1]; and

WHEREAS, Patients in police custody have been involved in 29% of shootings in emergency departments, with 11% occurring during escape attempts[2]; and

WHEREAS, Half of emergency physicians report than >50% of assaults against healthcare workers in the ED are committed by patients intoxicated from drugs and/or alcohol[3]; and

WHEREAS, Substance intoxication is a leading characteristic among perpetrators of workplace violence presenting with an altered mental state[2]; and

WHEREAS, >75% of emergency physicians report that violence in the emergency department has impacted patient care, including loss of productivity of staff, emotional trauma to staff, increased wait times as staff are otherwise occupied, less focus of staff after an incident, and other mechanisms[3]; and

WHEREAS, A large majority of emergency physicians report that violent patients have threatened to return and harm emergency department staff[3]; and

WHEREAS, Emergency physicians believe the largest contributing factor to violence in the emergency department is lack of adequate consequence or response to attackers[2];

WHEREAS, Patients in custody have rights to informed consent and refusal of medical interventions and rights to privacy and confidentiality that are similar to those of other patients[4]; therefore be it

RESOLVED, That ACEP investigate alternative care models to evaluate patients in police custody, such as telehealth, to determine necessity of an in-person evaluation; and be it further

RESOLVED, That ACEP encourage law enforcement to stay with any patient they choose to bring to the ED who are intoxicated, altered, agitated, or otherwise pose a risk to the safety of themselves or others until a disposition has been determined or the physician determines their assistance is no longer needed.

Resolution References

1. ACEP Policy Protection from Violence in the Emergency Department, April 2016. https://www.acep.org/patient-care/policy-statements/protection-from-violence-in-the-emergency-

department/#:~:text=The%20American%20College%20of%20Emergency%20Physicians%20%28ACEP%29%20believes,protected%20against%20violent%20acts%20occurring%20within%20the%20department Accessed June 23, 2022.
2. Phillips JP. Workplace Violence against Health Care Workers in the United States. *N Engl J Med*. 2016;374(17):1661-1669. doi:10.1056/NEJMra1501998
3. https://www.emergencyphysicians.org/globalassets/files/pdfs/2018acep-emergency-department-violence-pollresults-2.pdf Accessed June 9, 2022.
4. Law Enforcement and Emergency Medicine: An Ethical Analysis, May 2016. https://www.annemergmed.com/article/S0196-0644(16)00117-7/fulltext Accessed June 23, 2022.

Background

This resolution asks ACEP to explore alternative methods to evaluate patients in police custody, such as telehealth, to determine the need for an in-person evaluation and encourage law enforcement to remain with any patients brought to the ED for evaluation who are intoxicated, altered, agitated, or otherwise pose a risk to the safety of themselves or others until a disposition has been determined or the physician determines their assistance is no longer needed. The resolution authors ask that ACEP use available resources to investigate models currently being used around the country.

Violence in the ED is a serious and growing problem. According to surveys by ACEP and the Emergency Nurses Association (ENA), almost half of emergency physicians report being physically assaulted at work, while about 70 percent of emergency nurses report being hit and kicked while on the job.

ACEP's policy statement "Protection from Violence and the Threat of Violence in the Emergency Department" states:

> "The American College of Emergency Physicians (ACEP) believes that workplace violence is a preventable and significant public health problem, and that optimal patient care can be achieved only when patients, health care workers, and all other persons in the emergency department (ED) are protected against violent acts occurring within the department."

Law enforcement officers (LEO) will frequently escort subjects under arrest to emergency departments. Emergency department encounters with patients-in-custody may be for "medical clearance" exams, for evidence collection (such as blood alcohol testing prior to booking) or for treatment of illness/injuries sustained before, during or after being taken into custody. Patients-in-custody are also potentially in any of the various stages of the criminal justice process. For example, they may be pre-booking, booked and pending a bond hearing, held pending trial, or convicted/sentenced. Some who are early in the process may ultimately be released on bond or found not guilty. The status of a patient in custody (i.e.: are they eligible for bond or serving a long sentence) can have significant impact on the evaluation, disposition, and follow-up of the ED patient.

The ED environment is not designed to maintain staff /LEO safety and prisoner security in the same way as a detention facility. Additionally, the movement of a patient-in-custody through a community into the ED environment can pose unique risks to the patient, law enforcement officers, bystanders, and the ED staff These risks are potentially avoidable if the patient can be equally well cared for in an alternative care environment.

Alternative care models to care for intoxicated individuals have led to the creation of sobering centers in many cities and counties. These sobering centers provide a dedicated space for intoxicated adults to become sober while being monitored by trained staff. A study in *Annals of Emergency Medicine* by Smith-Bernardin, examined the 3-year experience at the San Francisco Sobering Center. There were 11,596 visits to the center. Less than 5% (506) were transferred to the ED.[1]

Telehealth and virtual care have emerged as alternative care models during the pandemic as both patients and health systems sought options in the location of health care services. The models were used for a wide variety of applications including screening patients with suspected COVID , urgent care, mental health, and follow up appointments after hospitalization or surgery. CMS approving payment for these types of models during the public health emergency.

Alternative care models such as telehealth have been utilized in detention facilities. A *JAMA* study by Khairat, outlined the use of telemedicine to provide specialty care for prisoners in North Carolina. Prisoners overall rating of satisfaction with the televisit was 4.29 on a 5-point scale. Physicians were slightly less satisfied with a 3.68 mean rating.[2]

Alternative care models for the evaluation of patients-in-custody have the potential of providing an equal level of care and may avoid some of the outlined safety risks if set up with careful consideration. All alternate care models for incarcerated patients must take into account that despite US Supreme Court and legislative precedents, incarcerated individuals may be at a greater risk of receiving a different level of treatment from the health care system due to the challenges unique to this population.

The second resolved clause addresses an additional safety factor. Law enforcement may initially accompany patients who are agitated, intoxicated, or are in an altered mental status to the emergency department. It is well documented that this category of patients (whether brought by LEO, EMS, or others) poses an increased risk of violence to ED staff. An article by Harada in *Annals of Emergency Medicine* in December 2021 stressed the importance of police presence in the ED for safety of staff.[3] Despite this, LEOs may "release" patients-in-custody on arrival to the ED. Whether this is on their own accord or due to departmental policies it can create new safety risks for the patient, staff, and other patients in the ED.

There are no standard guidelines for these scenarios. Resources in the ED could theoretically be expanded, and personnel made safer by the original LEO remaining with the patient-in-custody until the encounter is completed or the officer is no longer needed by the staff. Concerns could also be raised that continued presence of a LEO with a patient-in-custody could possibly interfere with the full evaluation of the patient and is a potential violation of patient privacy. Further research across this spectrum is needed to determine the best way to provide high quality care to patients-in-custody while preserving the safety of all of those that may encounter that patient.

Background References

[1] Smith-Bernardin SM, Kennel M, Yeh C. EMS Can Safely Transport Intoxicated Patients to a Sobering Center as an Alternate Destination. Ann Emerg Med. 2019 Jul;74(1):112-118. doi: 10.1016/j.annemergmed.2019.02.004. Epub 2019 Mar 27. PMID: 30926186

[2] Khairat S, Bohlmann A, Wallace E, et al. Implementation and Evaluation of a Telemedicine Program for Specialty Care in North Carolina Correctional Facilities. JAMA Netw Open. 2021;4(8): e2121102. doi:10.1001/jamanetworkopen.2021.21102

[3] Harada MY, Lara-Millán A, Chalwell LE. Policed Patients: How the Presence of Law Enforcement in the Emergency Department Impacts Medical Care. Ann Emerg Med. 2021 Dec;78(6):738-748. doi: 10.1016/j.annemergmed.2021.04.039. Epub 2021 Jul 29. PMID: 34332806.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 54(21) Understanding the Effects of Law Enforcement Presented in the Emergency Department adopted. Directed ACEP to support research, development, and adoption of best practices for emergency physicians regarding law enforcement and security personnel presence in the hospital environment and the ED and collaborate with other interested organizations to create toolkits outlining state specific policies and laws related to law enforcement presence in the hospital environment, including EDs.

Amended Resolution 52(21) Standardization of Medical Screening Exams of Arrested Persons Brought to the ED" adopted. Directed ACEP to work with interested chapters and other stakeholders to develop guidelines for the medical screening examination of individuals in law enforcement custody when the arresting agency requests a medical evaluation of the individual prior to processing into a detention center; and 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.

Resolution 51(21) Medical Bill of Rights for Detained and Incarcerated Persons While Receiving Emergency Medical Care referred to the Board. Called for ACEP to 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.

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.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted. It directed ACEP to work with appropriate governmental agencies to enact federal law, making it a felony to assault any emergency physician, on-call physician, or staff member working in a hospital's emergency department.

Amended Resolution 26(93) Violence in Emergency Departments adopted. It directed ACEP to develop training programs for EPs aimed at increasing their skills in detecting potential violence and defusing it, to develop recommendations for minimum training of ED security officers, to investigate the appropriateness of mandatory reporting and appropriate penalties for perpetrators of violence against emergency personnel, and to support legislation calling for mandatory risk assessments and follow up plans to address identified risks.

Amended Resolution 44(91) Health Care Worker Safety adopted. Directed ACEP to develop a policy statement promoting health care worker safety with respect to violence in or near the emergency department.

Prior Board Action

June 2022, approved the revised policy statement "Protection from Violence and the Threat of Violence in the Emergency Department;" revised April 2016 as "Protection from Violence in the Emergency Department;" revised June 2011 and April 2008 titled "Protection from Physical Violence in the Emergency Department Environment;" reaffirmed October 2001 and October 1997; originally approved January 1993 as "Protection from Physical Violence in the Emergency Department."

Amended Resolution 54(21) Understanding the Effects of Law Enforcement Presented in the Emergency Department adopted.

Amended Resolution 52(21) Standardization of Medical Screening Exams of Arrested Persons Brought to the ED" adopted.

Resolution 55(17) Workplace Violence adopted.

Amended Resolution 17(08) Felony Conviction for Assaulting Emergency Physicians adopted.

April 2006, reviewed the information paper "Recognizing the Needs of Incarcerated Patients in the Emergency Department."

Amended Resolution 26(93) Violence in Emergency Departments adopted.

Amended Resolution 44(91) Health Care Worker Safety adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 54(22)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Moral Injury Reporting and Tracking

PURPOSE: Assign a committee with developing a process to identify emergency medicine employers, quantify the degree of moral injury imposed by emergency medicine employers, and make the findings available to members.

FISCAL IMPACT: Budgeted committee, section, and staff resources for some tasks. Unbudgeted and unknown costs for conducting an environmental survey and analyzing results. The unbudgeted costs will vary based on the resources required and may include using consultants and other external resources.

WHEREAS, "Burnout" and moral injury are significant problems in emergency medicine; and

WHEREAS, Higher levels of "burnout" place patients and the healthcare system at risk; and

WHEREAS, The Surgeon General and National Academy of Medicine recently released reports with best practices and recommendations to promote wellness and reduce burnout; and

WHEREAS, Moral injury – a significant cause of "burnout" – is often perpetrated on employees by their employers; and

WHEREAS, Increasing consolidation and monopsony power leaves emergency physicians particularly vulnerable to moral injury; therefore, be it

RESOLVED, That, to safeguard the welfare of our membership and patients, ACEP task a committee with developing a process to identify employers of emergency physicians and quantify the degree of moral injury imposed by said employers on their emergency physician employees and further making these findings available to the general membership.

Background

This resolution asks ACEP to task a committee with developing a process to identify emergency medicine employers, quantify the degree of moral injury imposed upon emergency physicians by them, and make the findings available to the general membership.

The National Library of Medicine defines moral injury as an occurrence when one "perpetrates, bears witness to, or fails to prevent an act that transgresses our deeply held moral beliefs." The term moral injury was first used to describe soldiers' responses to their actions in war and application of the term in reference to physicians came soon thereafter. Although commonly regarded as *burnout*, it is important to distinguish the prevalence of physician distress as moral injury.

An ever-changing landscape in the administration of emergency departments, in addition to the expected stressors associated with being an emergency physician, have created what is akin to an epidemic of dysfunction in practice. Physicians navigate through overly regulated health care mandates, often compromising care to comply with seemingly detached administrative mandate.

Organizations and medical systems determine the bulk of physician well-being by the policies set at the executive ranks. Most physicians enter emergency medicine with a strong desire to help people with any concern, in any environment. The pressure of, and sometimes failure to, consistently meet patients' needs has a profound impact on physician wellbeing – the crux of consequent moral injury.

In an increasingly business-oriented and privatized health care environment, physicians must often consider a multitude of factors in addition to their patients' best interests when deciding on treatment. Financial considerations, whether hospitals, health care systems, insurers, patients, and sometimes of the physician himself or herself, lead to conflicts of interest. Electronic health record keeping distracts from patient connection and may serve as a centralized measure of productivity. Additionally, the threat of litigation may drive physicians to increase the number of testing and/or treatment modalities. Patient satisfaction scores and provider rating and review sites add additional complexities to the patient encounter. Business practices may alter referral patterns and can be an additional source of stress.

Finding balance among such intensely competing drivers is emotionally and morally exhausting. Routinely experiencing the loss of control in the different aspects of care can be frustrating and deeply painful. These are examples of "death by a thousand cuts."

Unsurprisingly, the onset of the pandemic exacerbated existing stressors, further compounding any moral injury experienced by physicians. While some health systems pledged to improve internal and administrative conditions to mitigate burnout, it is apparent that there is little to no standardization of ensuring physician well-being. Efforts to recognize systems that strive to dismantle burnout and moral injury are prevalent, such as the American Medical Association's "Joy in Medicine Health System Recognition Program." The ACEP Board of Directors approved creating the "Emergency Medicine Wellness Center of Excellence Award" in April 2019 to recognize excellence in promotion and identification of wellness and resiliency best practices in emergency medicine.

As of this writing, there are no comprehensive databases or reports available to indicate systems or employers with high levels of burnout, moral injury, and overall dissatisfaction by employed physicians. Burnout and moral injury are intensely multifactorial and it would be difficult to appropriately attribute the weight of each factor for any specific individual. No algorithm or system to accomplish this currently exists.

ACEP's policy statement "Physician Impairment" states:

> "ACEP recognizes the need for mental and physical health and well-being among emergency physicians, while assuring patient safety."
>
> "...emergency physician groups, employers, and residency programs should support physician wellness, facilitate physician resiliency, assist with physician burnout prevention, promote early recognition of and nonpunitive mechanisms for reporting potential physician impairment, and offer early intervention and treatment or other forms of assistance to help prevent or resolve physician impairment."

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted committee, section, and staff resources for some tasks. Unbudgeted and unknown costs for conducting an environmental survey and analyzing results. The unbudgeted costs will vary based on the resources required and may

include using consultants and other external resources.

Prior Council Action

None

Prior Board Action

February 2020, approved the revised policy statement "Physician Impairment;" revised and approved October 2013, October 2006, and April 1994; reaffirmed September 1999; originally approved September 1990.

April 2019, approved the "Emergency Medicine Wellness Center of Excellence Award" to recognize excellence in promotion and identification of wellness and resiliency best practices in emergency medicine.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Alyssa Ceniza
Wellness & Diversity Programs Manager

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 55(22)

SUBMITTED BY: Jennifer Conn, MD, FACEP
Kevin Conn, MD, FACEP
Rachel Levitan, MD
Anne Jennifer Richter, MD, FACEP

SUBJECT: Patients Leaving the ED Prior to Completion of Care Against Medical Advice

PURPOSE: Asks ACEP to affirm that patients leaving the ED against medical advice prior to completion of care will not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, all indicated consults, all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, Patients initiate an episode of care by presenting to the emergency department for evaluation of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part; and

WHEREAS, Patients without intent to harm themselves or others have the right to choose to leave the emergency department and sign out against medical advice at any point during their evaluation, workup, and management ending their episode of care; and

WHEREAS, Emergency providers manage multiple emergent patients simultaneously and may be unable to immediately avail themselves to the patient desiring to leave; and

WHEREAS, Leaving the emergency department against medical advice prior to completion of care does not allow the emergency provider to completely evaluate the patient, order indicated tests and imaging, review and act on results, discuss all results with the patient including incidental findings that require follow up, obtain appropriate consults, admit or transfer the patient, nor prepare a complete list of discharge diagnoses, prescriptions, instructions and referrals; and

WHEREAS, Emergency providers do not usually practice in a setting where they may schedule a follow up appointment with a patient; and

WHEREAS, The expectation of patients who utilize emergency departments expect their episodes of care and discharge paperwork to be complete; therefore be it

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department against medical advice prior to completion of care will not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, and all indicated consults; and be it further

RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department against medical advice prior to completion of care will not have all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure.

Background

This resolution asks ACEP to acknowledge that patients leaving the emergency department (ED) against medical advice (AMA) prior to completion of care will not have received a complete evaluation, results of all ancillary testing including incidental findings, all indicated therapies, all indicated consults, all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure. The CPT codes encompass these concepts but there are no ACEP documents that acknowledge these concepts or their potential impacts.

Patients who leave the ED do so for a variety of reasons including family obligations, pet care needs, financial responsibilities, being upset about the care provided, long waiting times, and ED crowding. The rates of AMA range from 0.1-2.7% of ED visits. Patients leaving AMA are at higher risk for bad outcomes and increased costs. Patients leaving AMA are 10 times more likely to initiate a litigation process against the emergency physician and the hospital than a typical ED patient with a rate of around 1 lawsuit per 300 AMA cases.[1,2]

Patients who leave AMA often leave with short notice or even walk out with no notice. They also may be leaving prior to completion of their evaluation and treatment. Given the lack of a complete ED work-up, these patients often leave without time for a complete discharge process. Patients who leave the ED AMA must have the decisional capacity, understand, and acknowledge the risks of leaving. By leaving prior to a complete ED evaluation, a patient will not have all medication recommendations and prescriptions, nor a complete list of discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure. There is significant medical-legal risk associated with the failure of the patient to receive complete discharge information and follow-up because they left prior to completion of treatment. The concern is that emergency physicians may be held to an expectation to provide a complete discharge process including treatment plans and referrals for follow up for patients who have left AMA. This expectation could expose emergency physicians to increased liability for failure to provide this information.

ACEP's policy statement "Interpretation of Diagnostic Imaging Tests" states:

> "Organizations should create service standards and operating procedures that clarify testing availability, timeliness, interpretation responsibility (including the role of residents), communication methods for preliminary and final results, as well as quality assurance, discrepancy follow-up, and incidental finding communication."
>
> "Organizations should provide clear guidance and support for the management of patient communication as it pertains to changes in findings, diagnosis, or need for further intervention, including the communication of incidental findings that were not available when the patient was in the ED."

Organizations should have policies and procedures in place delineating expectations and responsibilities for handling these communications for patients who leave AMA.

References

[1] Kazimi M, Niforatos JD, Yax JA, Raja AS. Discharges against medical advice from U.S. emergency departments. Am J Emerg Med. 2020 Jan;38(1):159-161. doi: 10.1016/j.ajem.2019.06.003. Epub 2019 Jun 3. PMID: 31208842.

[2] Sayed ME, Jabbour E, Maatouk A, Bachir R, Dagher GA. Discharge Against Medical Advice From the Emergency Department: Results From a Tertiary Care Hospital in Beirut, Lebanon. Medicine (Baltimore). 2016 Feb;95(6):e2788. doi: 10.1097/MD.0000000000002788. PMID: 26871837; PMCID: PMC4753933.

ACEP Strategic Plan Reference

Career Fulfillment – Goal: Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

None

Prior Board Action

June 2018, approved the revised policy statement "Interpretation of Diagnostic Imaging Tests;" revised and approved February 2013, and June 2006 with current title; reaffirmed October 2000; originally approved March 1990 titled "Interpretation of Diagnostic Studies."

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 56(22)

SUBMITTED BY: Brad Dreifuss, MD, FACEP
Robert McNamara, MD
Charles Pattavina, MD, FACEP

SUBJECT: Policy Statement on the Corporate Practice of Medicine

PURPOSE: Adopt a policy statement on the corporate practice of medicine based on the California Medical Board's guidance.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement. Unbudgeted costs of $25,000 – $30,000 for potentially obtaining a legal opinion.

WHEREAS, A significant number of the nation's emergency departments (EDs) are controlled by a staffing company with private equity backing or ownership; and

WHEREAS, Optum, a subsidiary of the United Healthcare, an insurer, through Sound Physicians has significant ownership of emergency medicine practices; and

WHEREAS, The Corporate Practice of Medicine (CPOM) doctrine exists in many states as a legal doctrine to keep the business interest out of the physician-patient relationship; and

WHEREAS, The CPOM doctrine has as its main purpose the protection of patients and the avoidance of the commercialization of the practice of medicine; and

WHEREAS, ACEP has filed an amicus brief in support of the American Academy of Emergency Medicine – Physician Group (AAEM-PG) litigation against Envision that addresses the CPOM doctrine in California and the California Medical Board's guidance on the CPOM; and

WHEREAS, ACEP, ACEP members, or other stakeholders may be called upon to be engaged in or offer amicus opinion in other CPOM matters in the future or to testify or opine in litigation, and having an existing policy statement will assist ACEP in those circumstances; and

WHEREAS, The membership of ACEP has a very negative view of the corporatization of emergency medicine based on the results of the 2021 ACEP Workforce Task Force survey and the collected experiences recently reported to the Department of Justice and the Federal Trade Commission by ACEP (letter to Lina Khan and Jonathan Kanter, April 20,2022); therefore be it

RESOLVED, That ACEP adopt the following policy statement based on the California Medical Board's guidance:

ACEP Policy Statement on the Corporate Practice of Medicine

ACEP strongly believes that the physician-patient relationship should be free of commercialization and undue influence by business interests. The corporate practice of medicine prohibition is intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment. The decisions described below are examples of some of the types of behaviors and subtle controls that the corporate practice doctrine is intended to prevent. The following health care decisions should be made by a licensed physician and would constitute the unlicensed practice of medicine if performed by an unlicensed person:

- Determining what diagnostic tests are appropriate for a particular condition.
- Determining the need for referrals to, or consultation with, another physician/specialist.
- Responsibility for the ultimate overall care of the patient, including treatment options available to the patient.
- Determining how many patients a physician must see in a given period of time or how many hours a physician must work.

In addition, the following "business" or "management" decisions and activities, resulting in control over the physician's practice of medicine, should be made by a licensed physician and not by an unlicensed person or entity:

- Ownership is an indicator of control of a patient's medical records, including determining the contents thereof, and should be retained by a licensed physician.
- Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff and medical assistants.
- Setting the parameters under which the physician will enter into contractual relationships with third-party payers.
- Decisions regarding coding and billing procedures for patient care services.
- Approving of the selection of medical equipment and medical supplies for the medical practice.

The types of decisions and activities described above cannot be delegated to an unlicensed person, including (for example) management service organizations. While a physician may consult with unlicensed persons in making the "business" or "management" decisions described above, the physician must retain the ultimate responsibility for, or approval of, those decisions.

The following types of medical practice ownership and operating structures also are prohibited:

- Non-physicians owning or operating a business that offers patient evaluation, diagnosis, care, or treatment.
- Management service organizations arranging for or providing medical services rather than only providing administrative staff and services for a physician's medical practice (non-physician exercising controls over a physician's medical practice, even where physicians own and operate the business).

In the examples above, non-physicians would be engaged in the unlicensed practice of medicine, and the physician may be aiding and abetting the unlicensed practice of medicine.

References

1. https://www.acep.org/globalassets/sites/acep/media/acep-newsroom-images/2022.03.25-filed-acep-amicus-brief.pdf.
2. https://www.acep.org/globalassets/acep-response-to-ftc-and-doj-rfi-on-merger-guidelines-04.20.22.pdf.
3. https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information/ (go to the section on Corporate Practice)

Background

This resolution requests the College to adopt a policy statement on the corporate practice of medicine based on the California Medical Board's guidance.

Laws regarding the corporate practice of medicine vary from state-to-state. Governmental agencies have authority to prohibit certain behavior from companies licensed to do business in their jurisdictions. ACEP, however, does not have equivalent authority over separate legal entities and as such, some prohibitory language included in the resolution may not be enforceable by the College.

Although ACEP does not have a specific policy statement on the corporate practice of medicine, in April 2022, the ACEP Board of Directors approved the "ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine" reaffirming ACEPs core beliefs and emphasizing the physician-patient relationship as the moral center of medicine that can never be compromised. The statement includes:

> *"Medical decisions must be made by physicians and any practice structure that threatens physician autonomy, the patient physician relationship, or the ability of the physician to place the needs of patients over profits should be opposed."*

The Emergency Medicine Group Ownership Task Force was created in response to Amended Resolution 58(19) Role of Private Equity in Emergency Medicine. The task force is currently preparing a report of its findings to address the effects of different ownership structures on the practice of emergency medicine and the impact on individual physicians.

ACEPs policy statement "Emergency Physician Rights and Responsibilities" 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."*

ACEPs policy statement "Emergency Physician Contractual Relationships" states:

> *"The emergency physician is individually responsible for the ethical provision of medical care within the physician-patient relationship, regardless of financial or contractual relationships."*
>
> *"Quality medical care is provided by emergency physicians organized under a wide variety of group configurations and with varying methods of compensation. ACEP does not endorse any single type of contractual arrangement between emergency physicians and the contracting vendor."*

The College also has existing policies "Compensation Arrangements for Emergency Physicians," "Definition of Democracy in Emergency Medicine Practice," and "Emergency Physician Compensation Transparency."

State law varies on the topic of corporate practice of medicine. Laws can be viewed by state at: https://silo.tips/download/corporate-practice-of-medicine-50-state-survey

Since this resolution is based on California law, a few excerpts from that law are:

> "Section 2052---Any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter, or without being authorized to perform such act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a misdemeanor."
>
> "Section 2400---Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Division of Licensing may, in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic."
>
> "Section 2052 of the California Medical Practice Act declares it to be illegal for any person to practice, attempt to practice or to advertise himself/herself out as practicing medicine in California without a valid certificate of licensure. For the purposed of the act the term "person" is limited in meaning to "a natural person" and with limited exception it declares corporations and other artificial

> entities to have "no professional rights, privileges or powers" thereunder. Accordingly, it has been stated as being settled that as a general rule a corporation may neither engage in the practice of medicine directly, nor may it do so indirectly by "engaging physicians to perform professional services for those with who the corporations contracts to furnish such services."

In Pacific Employers Ins. Co. V. Carpenter, 10 Cal.App.2d 595, 594 (1935). California courts have held that state medical licensure laws prohibit corporations from practicing medicine through licensed employees or independent contractors, and from realizing profits through the distributions of a physician's professional services. Whether or not an arrangement will be considered "unlawful practice of medicine" depends on the extent of control or influence a corporation has over the physician's practice. Indicia of unlawful physician control include employment, mandatory fee schedules, minimum office hour requirements, the selection of office sites, personnel or equipment, and other controls which singly or in combination may interfere with the ability of a physician to independently exercise his or her medical judgment. See, e.g., Cal. Ass'n of Disp. Opticians v. Pearle Vision, 143 Cal.App.3d 419 (1983) Lack of patient freedom of choice in the selection of his/her treating physician is also a factor that implies the existence of corporate practice of medicine. The corporate practice of medicine prohibition remains a significant factor in the structure of health care provider relationships. It is a criminal offense for any person or entity to practice or attempt to practice, or to advertise or hold itself out as practicing medicine, without having at that time a valid license, therefore. Penalties for the unlawful practice of medicine are significant and include: (1) criminal prosecution '(2) injunctive relief' (3) ouster in a quo warranto proceeding' and (4) exposure to civil lawsuits.

The general rule against the corporate practice of medicine is not absolute as exceptions to the California law permit the following types of corporations to practice medicine: (1) professional medical corporations, partnerships and group practices' (2) Knox-Keene Health Care Service Plans (i.e., HMOs)' (3) nonprofit corporations' (4) fraternal, religious, hospital, labor, education, and similar organizations may contract with physicians on an independent contractor basis in certain situations' (5) corporations having an interest in the health of its employees may contract with physicians to provide medical services for the corporation's employees at a reduced cost, and (6) certain licensed health care institutions may contract with physicians to provide medical services for the institution's employees at a reduced cost.

It is consistently recognized by the American Medical Association (AMA) and legal professionals that the adoption and enforcement of corporate practice of medicine doctrine is not just a matter of statutory law but as well a complex and living web of case law and attorneys general and regulatory agency opinions. An internet search yields several different types of state-level comprehensive reviews, albeit each limited in some way and nearly all cautioning about the complexities of this issue residing in of notoriously porous statutes and in a constant state of change.

ACEP currently works with our chapters to summarize or curate resources via our Legislative Information Clearinghouse. This is currently being used to monitor such issues as crowding, liability reform, reimbursement, and many more. Matters of CPOM are not one of the issues currently tracked as a state legislative issue. ACEP is working with state chapters to help create and track references on selected existing legal and regulatory resources related to the corporate practice of medicine in states.

In July 2021, ACEP's executive director discussed ACEP's concerns with the AMA's CEO regarding matters related to the corporate practice of medicine and interest in potentially collaborating with the AMA on an educational or needs assessment meeting. There was mutual interest in exploring this further, possibly through a virtual summit that could convene professional and state medical societies, as well as research organizations. Like ACEP has experienced, many of these research efforts are limited by a lack of transparency around ownership models and/or the inability to link ownership data to claims-based or other government database research, as well as published literature to study the CPOM landscape. At this time, ACEP and AMA staff continue working to develop the needs assessment.

ACEP began a campaign in March 2022 to collect stories that would help inform the Federal Trade Commission's (FTC) efforts to update its health care merger guidelines by expanding its evaluations on the impact of mergers and acquisitions to assess labor conditions rather than just competition. Stories were submitted through the ACEP website and other communications promoting the campaign were launched. The stories were reviewed to identify common themes and statistics and were used to create ACEP's response to a recent FTC/DOJ request for information. ACEP President Dr. Gillian Schmitz and ACEP Executive Director, Sue Sedory, provided public comments in a listening

session hosted by the FTC and DOJ on April 14, 2022, on the effects of mergers and acquisitions in the healthcare industry. In their comments, Dr. Schmitz and Ms. Sedory shared results from ACEP's story collection that showed numerous anti-competitive labor-related effects associated with mergers and acquisitions in emergency medicine including: reduced wages and/or non-cash benefits; infringement of due process rights; interference with physician autonomy to make independent medical decisions benefiting patients; inability to find a job or undue imposed restrictions on ability to switch jobs; and a shift to use of a less-skilled health care workforce jeopardizing patient care.

ACEP filed an amicus brief in the AAEMPG v. Envision case on March 25,2022, upholding the sanctity of a physician's duty to patients and the importance of allowing them to practice medicine without undue pressure from outside forces. Through this filing, ACEP is applying its might on behalf of our nearly 40,000 members in legal efforts to assert the physician's right to autonomy in medical decision-making. EMRA also filed a Declaration of Interest in support of the ACEP position.

Additionally, ACEP has been in communication with the Physicians Advocacy Institute to help inform a report they are developing that would address trends in emergency medicine regarding physician employment and acquisitions of medical practices.

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ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted committee and staff resources for development of a policy statement. Unbudgeted costs of $25,000 – $30,000 for potentially obtaining a legal opinion.

Prior Council Action

Amended Resolution 52(20) The Corporate Practice of Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) prepare a comprehensive review of the legal and regulatory matters related to the corporate practice of medicine and fee splitting in each state and the results of this review will be compiled into a resource and announced to members as an available electronic download; 2) adopt as policy: "ACEP, in concert with its relevant component state chapter, in those states where there are existing prohibitions on the corporate practice of medicine, will provide assistance to physician owned groups who are threatened with contract loss to a corporate entity or to hospital employed physicians whose site will be taken over by a corporate entity by providing, upon request, a written review of the legality of the corporation obtaining the contract for emergency services."; 3) in those states that are found to have existing prohibitions on the corporate practice of medicine, along with the relevant state chapter, petition the appropriate authorities in that state to examine the corporate practice of emergency medicine if such is believed to occur within that state and ACEP will reach out to the state professional societies to solicit the support of the state medical society; and 4) work with the American Medical Association to convene a meeting with representatives of physician professional associations representing specialties and other stakeholders affected by the corporate practice of medicine, to ensure the autonomy of physician owned groups or hospital employed physicians contracting with corporately-owned management service organizations.

Amended Resolution 58(19) Role of Private Equity in Emergency Medicine adopted. The resolution called for ACEP to study and report annually the market penetration of non-physician ownership of emergency medicine groups and the effects that these groups have on physicians and ACEP advocacy efforts. It further directed the College to advocate to preserve access to emergency care for patients and protect the careers of emergency physicians in the event of contract transitions, bankruptcies, or other adverse events of their employer/management company. Additionally, ACEP was directed to partner with other medical societies to determine the circumstances under which

corporate or private equity investment could lead to market effects that increase the cost of care without a commensurate increase in access or quality and to advocate for corrections to the market if such market effects should occur.

Prior Board Action

August 2022, reviewed the draft final report from the Emergency Medicine Group Ownership Task Force and referred the report back to the task force for additional information to be included in the report.

April 2022, the ACEP Board of Directors approved the ACEP Statement on Private Equity and Corporate Investment in Emergency Medicine,

January 2022, approved filing a brief in the AAEM-PG vs. Envision lawsuit.

April 2021, approved the revised policy statement "Compensation Arrangement for Emergency Physicians;" revised April 2015, April 2002, June 1997; reaffirmed October 2008, April 1992; originally approved June 1998.

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised 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 October 2015, April 20018, July 200; originally approved September 2000.

September 2021, approved actions regarding Referred Amended Resolution 52(20) The Corporate Practice of Medicine.

January 2021, approved the revised policy statement "Definition of Democracy in Emergency Medicine Practice;" reaffirmed April 2014; originally approved June 2008.

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

October 2019, Amended Resolutions 58(19) Role of Private Equity in Emergency Medicine adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

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American College of Emergency Physicians®
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RESOLUTION: 57(22)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Recognized Bodies for Emergency Physician Board Certification

PURPOSE: Amend the policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine" by adding additional language regarding alternate certifying boards affirm that board certification through the ABMS, AOA, or ABP are the only ACEP-recognized means for emergency physician board certification in the U.S.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, The American Board of Emergency Medicine (ABEM), the American Osteopathic Board of Emergency Medicine (AOBEM), and the American Board of Pediatrics (ABP) have historically provided board certification for emergency physicians; and

WHEREAS, Organizations such as the National Board of Physicians and Surgeons (NBPAS) hold themselves out as a "board" that provides a "board certification" credential to the lay public, physicians, hospitals, insurers, and legislators; and

WHEREAS, Organizations such as NBPAS provide verification of continuing medical education (CME) and verification of training but no ongoing assessment of competency and thus do not meet the definition of a certifying body as defined by the National Commission for Certifying Agencies (NCCA); and

WHEREAS, ACEP has previous policy recognizing certifying bodies for emergency physicians that limited the recognition of emergency medicine board certification through the American Board of Medical Specialties (ABMS) or through the American Osteopathic Association (AOA), with no restriction to certification by alternate organizations; and

WHEREAS, NBPAS offers "board certification" in emergency medicine in addition to other specialties; and

WHEREAS, Some physicians are advocating on a hospital, insurer, or state level to have organizations such as NBPAS recognized as "equivalent" to ABEM and AOBEM certification, including but not limited to medical staff privileges, hospital bylaws, and insurance reimbursement; and

WHEREAS, ACEP has previously opposed regulatory and legislative efforts to have NBPAS status as equivalent to ABEM and AOBEM certification; and

WHEREAS, Organizations that do not establish continuing competency through ongoing independent assessment are not equivalent to specialty-specific board certification as provided by ABEM, AOBEM, ABP, and recognized international medical organizations; and

WHEREAS, Multiple ACEP policies reference emergency board certification by ABEM and ABP under the ABMS or AOBEM under the AOA, but no ACEP policy addresses organizations that claim to provide "equivalent" board certification outside of the ABMS or the AOA; therefore, be it

RESOLVED, That ACEP amend its policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine" to reflect that alternate organizations that claim to provide "board certification" but that do not provide ongoing assessment of their diplomates, do not provide transparency about their certification process, do not provide transparency about the specialties and numbers of certified physicians, or merely verify continuing medical education

and training, are not recognized by ACEP as equivalent to board certification by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or the American Board of Pediatrics for any purpose; and

RESOLVED, That ACEP affirm that board certification through the American Board of Medical Specialties or the American Osteopathic Association are currently the only ACEP-recognized means for emergency physician board certification in the United States.

Background

This resolution calls for the College to amend its current policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine" by adding additional language to clarify that alternate organizations may provide "board certification" but fail to meet certain standards provided by the American Board of Medical Specialties (ABMS), the American Board of Emergency Medicine (ABEM) and/or the American Osteopathic Board of emergency Medicine (AOBEM). Included in that statement should be information that these organizations may lack ongoing assessment of their diplomates, transparency about their certification process, transparency about the specialties and numbers of certified physicians, or may merely verify continuing medical education and training. Also to be included is a statement that these organizations are not recognized by ACEP as equivalent to board certification by ABEM, AOBEM, or the American Board of Pediatrics (ABP) for any purpose. The resolution also calls for ACEP to affirm that board certification through the ABMS or the American Osteopathic Association (AOA) is currently the only ACEP-recognized means for emergency physician board certification in the United States.

ACEP's policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine" recognizes and supports ABEM as the sole ABMS certifying body for emergency medicine, recognizes AOBEM as a certifying body in emergency medicine under the jurisdiction of the AOA, and recognizes ABP as an ABMS certifying body in pediatrics providing subspecialty certification for pediatricians in the subspecialty of pediatric emergency medicine.

ACEP's policy statement "Definition of an Emergency Physician" states:

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

ACEPs recently revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" affirms that the gold standard for care in the ED is the emergency physician as defined by ACEP:

> *"Because of the nature of emergency medicine, in which patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions, the gold standard for emergency department care is that provided by an emergency 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) in Emergency Medicine or Pediatric Emergency Medicine or an equivalent international certifying body recognized by ABEM or AOBEM in Emergency Medicine or Pediatric Emergency Medicine.*"

In July 2022, The Joint Commission added the National Board of Physicians and Surgeons (NBPAS) as a credentialing body, deemed as a "Designated Equivalent Source Agency" and can now be used by hospitals and health systems for physician credentialing and privileging requirements.[1] However, the ABMS has stated their objection to this interpretation. https://www.abms.org/news-events/abms-response-to-nbpas-assertion-of-certifying-body-equivalency/

Currently, only a small list of hospitals accept NBPAS. According to the NBPAS website, candidates must be previously certified by an ABMS or AOA member board in the specialty being applied for through NBPAS.

Background Reference
[1] https://nbpas.org/tjc-press-release/

ACEP Strategic Plan

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy Action Plan – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Resolution 68(21) Patient's Right to Board Certified Emergency Physicians 24/7 (In-person or via Telehealth) not adopted. Called for ACEP to 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.

Substitute Resolution 66(21) ACEP Promotion of the Role of Emergency Physicians referred to the Board of Directors. Called for ACEP to approve and promote a policy explicitly stating that all patients presenting to an emergency department deserve to be assessed by an ABEM/AOBEM board certified emergency physician; that ACEP support the standard that board-certified/eligible emergency physicians are to be involved in every patient encounter presenting to an emergency department.

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.

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 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 adopted. 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

March 2022, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved June 2020 with the current title; revised and 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 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."

February 2020, approved the revised policy statement "ACEP Recognized Certifying Bodies in Emergency Medicine;" revised June 2014; reaffirmed April 2014, October 2008 and October 2002; originally approved March 1998.

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

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 33(93) Recognition of Certifying Bodies in Emergency Medicine adopted.

Amended Resolution 32(88) Recognition of the American Osteopathic Board of Emergency Medicine adopted.

November 1987, overruled Resolution 39(87) American Osteopathic Board of Emergency Medicine.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Sandra M. Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 58(22)

SUBMITTED BY: Emergency Medicine Residents' Association

SUBJECT: Removing Unnecessary and Invasive Medical Exams and Questionnaires from Employment Contracts

PURPOSE: Support cessation of invasive medical evaluation exams and questionnaires that may invade the privacy of emergency physicians seeking employment beyond what is necessary to confirm the ability to perform duties associated with the individual's role as hired.

FISCAL IMPACT: Budgeted committee and staff resources.

WHEREAS, In the course of employment many physicians discover that their employment is contingent upon completion of a post-offer/pre-employment medical evaluation, including physical examinations and questionnaires; and

WHEREAS, Some of the information requested may be considered sensitive by the physician in question seeking employment, for example, questions related to surgical history may incidentally disclose biopsies to rule out neoplasia, abortion care, procedures to assist with family planning, gender affirmation, and the like, as well as questions regarding medications, for example, may unnecessarily reveal chronic, auto-immune, or psychiatric complaints, among others including those related to hormone use or for cosmetic concerns; and

WHEREAS, Physician employees may wish to exert their right to privacy regarding conditions that do not cause impairment and have reasonable concern may color their professional or personal reputation; and

WHEREAS, Determining what information to provide to a medical screener (often a non-physician provider or nurse) places the physician in an ethical conundrum – whether to be honest or whether to obfuscate to protect one's professional and personal identity; falsification by omission to one's employer through mandated health exams may be cause for dissolution of contract, but revealing private health information may be deemed too invasive by the physician in question who is simply seeking to provide their skills in exchange for wages; and

WHEREAS, It is unclear why invasive medical screening exams are necessary to complete the hiring process for physicians who are not requesting or anticipating employer accommodations; therefore be it

RESOLVED, That ACEP support the cessation of invasive medical evaluation exams and questionnaires that may unduly and unnecessarily invade the privacy of emergency medicine physicians seeking employment beyond that which is necessary to confirm ability to perform duties associated with the individual's role as hired.

References

1. U.S. Equal Employment Opportunity Commission. Pre-Employment Inquiries and Medical Questions & Examinations. U.S. Equal Employment Opportunity Commission. [Online] June 14, 2022. https://www.eeoc.gov/pre-employment-inquiries-and-medical-questions-examinations.

Background

This resolution calls for ACEP to support the cessation of invasive medical evaluation exams and questionnaires that may invade the privacy of emergency physicians seeking employment beyond what is necessary to confirm the ability to perform duties associated with the individual's role as hired.

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

ACEP's policy statement "physician impairment" states:

> "The existence of a health problem in a physician is NOT synonymous with occupational impairment. Because of their training and dedication, most physicians with appropriately managed personal health problems and other stressors are able to function safely and effectively in the workplace."

In addition, the policy recommends that licensing and credentialing bodies use the FSMB language for questions about the physical or mental health of applicants. It further states that "licensing and credentialing bodies should not ask applicants and licensees about their past history of diagnosis or treatment for mental disorders, substance use disorders, physical disorders, and/or disabilities, focusing instead of current impairment."

The FSMB policy on "Policy on Physician Illness and Impairment" also support the distinction between illness and impairment.

> "It is important to distinguish illness from impairment. Illness, per se, does not constitute impairment. When functional impairment exists, it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of impairment may be prevented or resolved while the diagnosis of illness may remain."

State board licensing application questions about physician health vary. Recently, there has been renewed attention on destigmatizing mental health issues and removing questions about mental health. There has been less focus on removing questions about physical health. In June 2018, the AMA amended its policy on *Access to Confidential Health Services for Medical Students and Physicians* mostly addresses issues around mental health. The policy states in part, "Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept 'safe haven' non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety." The FSMB, in its policy *Physician Wellness and Burnout* adopted in April 2018, recommends that state medical boards consider whether it is necessary to include "probing questions about a physician applicant's mental health, addiction, or substance use on applications for medical licensure," noting also that these questions are likely to discourage treatment-seeking among applicants. It goes on to state that "Applications must not seek information about impairment that may have occurred in the distant past and state medical boards should limit the time window for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred." The FSMB recommends language such as: "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?" AMA Policy "Licensure Confidentiality" endorses this approach by the FSMB. An analysis of medical licensure application questions from 2018 found that a majority of states had questions that were unlikely to meet ADA standards. The table in the article shows the wide range in questions and approaches taken by states.

Amended Resolution 82(21) Defining the Job Description of an Emergency Physician directed ACEP to develop a job description that applies to all emergency physicians reflecting the true physical and cognitive demands of the specialty that can used in relation to disability claims. ACEP developed a letter with a description of emergency medicine work and describing the job requirements of an emergency physician. The letter can be used on behalf of a member's disability claim and can serve as the foundation for a future document. The Emergency Medicine Practice Committee is working on a policy statement and supporting documentation.

ACEP Strategic Plan Reference

Career Fulfillment – Members believe that ACEP confronts tough issues head on and feel supported in addressing their career frustrations and in finding avenues for greater career fulfillment.

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all landscapes and levels, including federal, state, and local.

Fiscal Impact

Budgeted committee and staff resources

Prior Council Action

Amended Resolution 82 (21) Defining the Job Description of an Emergency Physician adopted. Directed ACEP work with appropriate stakeholders and the insurance industry to develop ACEP policy defining an accurate job description that can apply to all emergency physicians and consider developing an accurate job description for emergency physicians that can be used to support appeals of long term disability claim denials, until an acceptable ACEP policy is created.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders adopted. Directed ACEP to: 1) promote awareness of current ACEP policy statement that supports decreasing the barriers, perceived or real, to physicians to feel safe seeking treatment for mental health, substance use, and other issues; 2) work with the American Medical Association, the Federation of State Medical Boards, and state medical societies to advocate for a change at state medical boards for protections for licensure for physicians to seek help and treatment for mental health, substance use, and other disorders; and 3) partner with appropriate stakeholders to investigate the effectiveness and quality of evidence of Physician Health Programs (PHPs) across the states and produce a white paper that reports on the findings.

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

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

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

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

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

actions related to the Wellness Working Group report.

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

Prior Board Action

Amended Resolution 82 (21) Defining the Job Description of an Emergency Physician adopted.

Amended Resolution 20(19) Supporting Physicians to Seek Care for Mental Health and Substance Use Disorders adopted.

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

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

February 2020, approved the revised policy statement "Physician Impairment;" revised and approved October 2013, October 2006; reaffirmed September 1999; revised and approved April 1994; originally approved September 1990.

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

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

Substitute Resolution 43(88) Emergency Physician Wellness adopted.

Amended Resolution 29(82) Physician Impairment adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce and Emergency Medicine Practice

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
Susan Sedory, MA, CAE, Council Secretary and Executive Director

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Late Resolution

RESOLUTION: 59(22)

SUBMITTED BY: Missouri College of Emergency Physicians

SUBJECT: In Memory of Brian Robb, DO, MBA, FACEP

WHEREAS, Brian Robb, DO, MBA, FACEP, was a long standing member of the Missouri College of Emergency Physicians (MOCEP); and

WHEREAS, Dr. Robb provided expert and compassionate emergency care to the people of western Missouri in a practice that spanned 38 years; and

WHEREAS, Dr. Robb served 28 years as President and Medical Director of Liberty Emergency Physicians Inc; and

WHEREAS, Dr. Robb served on the MOCEP Board of Directors for more than a decade; and

WHEREAS, Dr. Robb served MOCEP as Vice-President, President, and Past-President between 2008 and 2014; therefore be it

RESOLVED, That the American College of Emergency Physicians recognize and salute Brian Robb, DO, MBA, FACEP, and offer our heartfelt condolence to his wife of 43 years, Sharon, his three children, and many grandchildren.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 60(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of James R. Roberts, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a distinguished leader and pioneer when James R. Roberts, MD, FACMT, FAAEM, FACEP, passed away Friday, July 22, 2022, at the age of 76; and

WHEREAS, Dr. Roberts graduated Lafayette College and obtained his medical degree from Thomas Jefferson University in 1972. He completed his internship in 1973 at Highland General Hospital in Oakland, California, and his emergency medicine residency at the Medical College of Pennsylvania in 1975. Subsequently, he was a McNeil Scholar at Bellevue Hospital in New York City where he completed medical toxicology training; and

WHEREAS, Dr. Roberts was a trailblazer in the field of emergency medicine, and was one of the first board-certified emergency physicians and was a board-certified medical toxicologist; and

WHEREAS, Dr. Roberts served as Professor of Emergency Medicine, Vice Chair, Department of Emergency Medicine, and Senior Consultant, Division of Toxicology, at the Drexel University College of Medicine; and

WHEREAS, Dr. Roberts served as Chair of the Department of Emergency Medicine, Director, Division of Medical Toxicology, Mercy Catholic Medical Center, Philadelphia, Pennsylvania; and

WHEREAS, Dr. Roberts served as Chair of the editorial board for *Emergency Medicine News* magazine (Wolters Kluwer) for almost 40 years; and

WHEREAS, Dr. Roberts co-authored the book "Clinical Procedures in Emergency Medicine and Acute Care" (Elsevier) first published in 1983, now in its 7th edition, which defined the procedural scope of the practice of emergency medicine; and

WHEREAS, Dr. Roberts was named as one of the 30 most influential physicians in the history and development of American academic emergency medicine by the Emergency Medicine Residents' Association (EMRA); and

WHEREAS, Dr. Roberts was a founding member of EMRA and was the first resident representative to the American College of Emergency Physicians; and

WHEREAS, Dr. Roberts received ACEP's Judith Tintinalli Award for Outstanding Contribution in Education in 2016; and

WHEREAS, We owe a tremendous amount of gratitude to him for his commitment to the education of the next generation of emergency physicians and to the specialty as a whole; and

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

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of James R. Roberts, MD, FACMT, FAAEM, 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 extend to his partner Lydia (Forte) to whom he was married for over 40 years, daughter Martha, son Matthew, his grandchildren Eleanor Cronin and Liam Roberts, his brother George Roberts, his sister Mary Peterlin, nieces, nephews, and family-in-law gratitude for his tremendous service as one of the pillars of emergency medicine, a consummate clinician and educator, as well as for his dedication and commitment to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Late Resolution

RESOLUTION: 61(22)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Douglas D. Rockacy, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a valued teacher and iconic emergency physician when Douglas D. Rockacy MD, FACEP, passed away tragically on July 16, 2022, at the age of 47; and

WHEREAS, Dr. Rockacy completed medical school at the University of North Carolina in 2000 and his residency in emergency medicine at the University of Pittsburgh in 2003; and

WHEREAS, Dr. Rockacy has been a key faculty member within the University of Pittsburgh Emergency Medicine Residency for the past 19 years; and

WHEREAS, Dr. Rockacy has been a mentor for countless medical students and residents reflected in his receiving the Faculty Teaching Award from the University of Pittsburgh Emergency Medicine Residency multiple times; and

WHEREAS, Dr. Rockacy has been a long standing nocturnist at the UPMC-Mercy ED for more than 15 years, averaging greater than 200 overnight shifts per year; and

WHEREAS, Dr. Rockacy embodied and exemplified the mission and values of the American College of Emergency Physicians, and

WHEREAS, Dr. Rockacy has been emphatically admired by patients, families, EMS partners, and staff; and

WHEREAS, Dr. Rockacy was a universally loved proud father, husband, uncle, and friend; therefore be it

RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of Douglas D. Rockacy, MD, FACEP, who dedicated himself to his patients, to his trainees, 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 extend to his wife Wendy, daughter Claire, and son Russell gratitude for his tremendous service as one of the finest emergency physicians the University of Pittsburgh has ever seen, as well as for his dedication and commitment to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Late Resolution

RESOLUTION: 62(22)

SUBMITTED BY: Hawaii Chapter

SUBJECT: In Memory of Robert J. Teichman, MD, PhD

WHEREAS, With the death of Robert J. Teichman, MD, PhD, on March 9, 2022, at the age of 78, ACEP and the State of Hawaii lost a devoted physician and teacher; and

WHEREAS, Dr. Teichman served as the senior lecturer and course coordinator for gross anatomy at the University of Hawaii John A Burns School of Medicine (JABSOM) in Honolulu, Hawaii from 1969 to 1975; and

WHEREAS, Dr. Teichman received his medical degree from JABSOM in 1978; and

WHEREAS, Dr. Teichman began work in the emergency department at Wilcox Hospital on the Island of Kaua'i in 1980; and

WHEREAS, Dr. Teichman received his Diplomate from the American Board of Emergency Medicine in 1990; and

WHEREAS, Dr. Teichman loved to teach and continued to serve as a Clinical Assistant Professor for the University of Hawaii at Manoa School of Nursing for most of the years he worked as a physician on Kaua'i; and

WHEREAS, Dr. Teichman will be missed by his friends and colleagues who were privileged to know him for his strength of character and a dedication to the practice of 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, Robert J. Teichman, MD, PhD, and extends condolences and gratitude to his wife, Geri Young, MD, of Kapa'a, Kaua'i, and his sons Kurt Teichman of Brooklyn, NY and Grant Teichman of Honolulu, Hawaii, and other family members for his service to the community, his patients, his students, and the specialty of emergency medicine.

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American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Late Resolution

RESOLUTION: 63(22)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: In Memory of Jason M. White, MD, FACEP

WHEREAS, Emergency medicine lost a beloved physician leader of our specialty in the passing of Jason M White MD, FACEP, who died July 10, 2022; and

WHEREAS, Dr. White earned his medical degree from the University of Michigan in Ann Arbor, MI and completed his residency training in emergency medicine at Henry Ford Hospital in Detroit, Michigan; and

WHEREAS, Dr. White established and served as the president of Timberline Emergency Physicians, P.C. for almost 20 years; and

WHEREAS Dr. White was a recognized leader in the field of emergency medicine on a regional level, having served as president of the Michigan College of Emergency Physicians and received the MCEP Ronald L. Krome Meritorious Service Award in 1998; and

WHEREAS, During his 38 years at Ascension St. Mary's of Michigan in Saginaw, MI, he served many patients in an underserved population and served as medical director of the emergency department, chair of many committees, and chief of staff of the hospital and was a generous supporter of the Ascension St. Mary's Foundation; and

WHEREAS, Dr. White helped establish the emergency medicine residency program in Saginaw, and with his exceptional dedication to physician education, leadership, and professional development, he changed the trajectory of many physicians; and

WHEREAS Dr. White's commitment and dedication to professional and personal development while providing high quality care was a priority and he demonstrated this by seeking his Master's in Medical Management at the University of Southern California and though his work serving as chief medical officer; and

WHEREAS Dr. White's passion for teaching had no limit and he was known not only for his bedside clinical teaching of residents and students, but also for his ability to give lectures while bringing in history, everyday experiences, and humor to his presentations; and

WHEREAS, Dr. .White received stellar evaluations from the students, and he was not only an advocate for education, but a role model demonstrating professionalism and compassion for his learners; and

WHEREAS Dr. White created a sense of family for the emergency medicine community and made it a priority to get to know people, not only his patients but also his colleagues and the relationships, both professional and personal, that developed out of these activities lasted many years; and

WHEREAS Dr. White's legacy as an innovative leader and mentor of our specialty who integrated education into his culture and personal commitments will be most remembered because of his willingness to serve and his supportive mentorship which he combined with his wonderful, witty sense of humor; therefore be it

RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions of Jason M White, MD, FACEP, to the specialty of emergency medicine and extends the College's condolences to his wife of almost 40 years, Carol, and also to their sons and daughters, Ken, Christopher, Brittany, and Allison, and grandchildren Olivia, Finn, Rosalyn, Easton, and Cassius.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2022 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: 64(22)

SUBMITTED BY: Government Services Chapter

SUBJECT: In Memory of J. David, Barry, MD, FACEP

WHEREAS, The specialty of emergency medicine lost a compassionate physician, dedicated educator, mentor, pioneer, military officer, and colleague in J. David Barry, MD, FACEP, who passed away on September 2, 2022; and

WHEREAS, Dr. Barry graduated from the Uniformed Services University and completed his residency training at the Brooke Army Medical Center (BAMC) in emergency medicine (EM) and his fellowship in medical toxicology at UC San Diego; and

WHEREAS, Dr. Barry served in the U.S. Army and retired as a Colonel after 25 years of service to his country with multiple wartime deployments; and

WHEREAS, Dr. Barry trained and mentored hundreds of EM residents and medical students serving as an Associate Program Director at BAMC, the Program Director at Naval Center Portsmouth, and Director of the Board Review Course for the American College of Medical Toxicology; and

WHEREAS, Dr. Barry became the Assistant Chief of Emergency Medicine at the Long Beach VA Medical Center and a Professor in the Department of Emergency Medicine at University of California, Irvine after his military retirement; and

WHEREAS, Dr. Barry was a leader in the Government Services Chapter, serving as President from 2012-2013, Chair of the Awards Committee, and was actively involved in the ACEP Council for over a decade; and

WHEREAS, Dr. Barry was elected to the American Board of Emergency Medicine Board of Directors in 2020 and was the Chair of the Continuing Certification Committee, liaison to the Medical Toxicology Subboard, and co-editor for MyEMCert where he served with affability, thoughtfulness, and an unwavering commitment to excellence; and

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

RESOLVED, That the American College of Emergency Physicians remembers with gratitude the many contributions made by J. David Barry, MD, FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further

RESOLVED, That the American College of Emergency Physicians extends to the family of J. David Barry MD, FACEP, his friends, and his colleagues our condolences and gratitude for his tremendous service to his country, the specialty of emergency medicine, and to the patients and physicians of the Department of Defense, Veteran's Affairs, and the United States.