American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

INTRODUCTION

2023 Annual Council Meeting
Friday Evening, October 6, 2023 through Sunday, October 8, 2023
Philadelphia Marriott and Philadelphia Convention Center

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 upon adoption by the Council.

Asynchronous testimony will open on September 8 for all resolutions assigned to a Reference Committee. An announcement with the link to the 2023 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 of the resolution 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 Philadelphia. Opinions posted elsewhere (including Council engagED) will not be considered in the Reference Committee deliberations. 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.** Just as the in-person Reference Committee hearings during the 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 Wednesday, September 27. 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 Monday, October 2 and will be the starting point for the live Reference Committee debate during the Council meeting in Philadelphia on Saturday, October 7.

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, Council Speaker and Council Vice Speaker 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 Philadelphia!

Your Council Officers,

Kelly Gray-Eurom, MD, MMM, FACEP Speaker	Melissa W. Costello, MD, FACEP Vice Speaker

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

2023 Council Meeting
Reference Committees

Reference Committee A – Governance, Membership, & Other Issues
Resolutions 15-26

Scott H. Pasichow, MD, MPH, FACEP (IL) – Chair
William D. Falco, MD, FACEP (WI)
Gregory Gafni-Pappas, DO, FACEP (MI)
Catherine A. Marco, MD, FACEP (PA)
Laura Oh, MD, FACEP (GA)
Stephen C. Viel, MD, FACEP (FL)

Maude Surprenant Hancock, CAE
Laura Lang, JD

Reference Committee B – Advocacy & Public Policy
Resolutions 27-42

Diana Nordlund, DO, JD, FACEP (MI) – Chair
Lisa M. Bundy, MD, FACEP (MS)
Puneet Gupta, MD, FACEP (CA)
Joshua S. da Silva, MD (GS)
Torree M. McGowan, MD, FACEP (GS)
Michael Ruzek, DO, FACEP (NJ)

Erin Grossman
Ryan McBride, MPP

Reference Committee C – Emergency Medicine Practice
Resolutions 43-55

Daniel Freess, MD, FACEP (CT) – Chair
Angela P. Cornelius, MD, FACEP (TX)
Joshua R. Frank, MD, FACEP (WA)
Kenneth L. Holbert, MD, FACEP (TN)
Jeffrey F. Linzer, Sr., MD, FACEP (GA)
Jennifer L. Savino, DO, FACEP (PA)

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

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

2023 Council Resolutions

Resolution #	Subject/Submitted by	Reference Committee
1	Commendation for Patrick Elmes, EMT-P *Jeffrey Jarvis, MD, FACEP* *Disaster Medicine Section* *EMS-Prehospital Care Section* *Tactical & Law Enforcement Medicine Section*	
2	Commendation for Kelly Gray-Eurom, MD, MMM, FACEP *Florida College of Emergency Physicians*	
3	Commendation for Russell H. Harris, MD, FACEP *New Jersey Chapter*	
4	Commendation for Rick Murray, EMT-P, FAEMS *Angela Cornelius, MD, MA, FACEP* *Richard C. Hunt, MD, FACEP* *Jeffrey Jarvis, MD, FACEP* *Jon Krohmer, MD, FACEP* *Disaster Medicine Section* *EMS-Prehospital Care Section* *Event Medicine Section* *Tactical &Law Enforcement Medicine Section*	
5	Commendation for Gillian R. Schmitz, MD, FACEP *Government Services Chapter*	
6	Commendation for JoAnne Tarantelli *New York Chapter*	
7	In Memory of Clifford Findeiss, MD *Florida College of Emergency Physicians*	
8	In Memory of Scott A. Hall, MD *Kansas Chapter* *Missouri Chapter*	
9	In Memory of Gene W. Kallsen, MD *Alicia Mikolaycik Gonzalez, MD, FACEP* *Susanne Spano, MD, FACEP* *California Chapter*	
10	In Memory of Michael Kleinman, DO *Pennsylvania College of Emergency Physicians*	
11	In Memory of Gloria J. Kuhn, DO, PhD *Michigan College of Emergency Physicians*	
12	In Memory of Richard M. Nowak, MD, MBA, FACEP Michigan College of Emergency Physicians	

Resolution #	Subject/Submitted by	Reference Committee
13	In Memory of Barbara W. Trainor *Valerie Norton, MD, FACEP* *Lori Winston MD, FACEP* *California Chapter*	
14	In Memory of Lori Weichenthal, MD, FACEP *Alicia Mikolaycik Gonzalez, MD, FACEP* *Susanne Spano, MD, FACEP* *California Chapter* *Wellness Section* *Wilderness Medicine Section*	
15	Additional Vice President Position on the ACEP Board of Directors – Bylaws Amendment *Board of Directors*	A
16	Council Quorum – Defining "Present" – Housekeeping Bylaws Amendment *Bylaws Committee* *Board of Directors*	A
17	Establishing the Position and Succession of a Speaker-Elect for the Council -Bylaws Amendment *Marco Coppola, DO FACEP* *Melissa Costello, MD, MS, FACEP* *Gary Katz, MD, MBA, FACEP* *Arlo Weltge, MD, MPH, FACEP*	A
18	Referred Resolutions *Emergency Medicine Workforce Section*	A
19	Scientific Assembly Vendor Transparency *Emergency Medicine Workforce Section*	A
20	Emergency Medicine Research Mentorship Program *Kalev Freeman, MD, FACEP* *Antony Hsu, MD, FACEP* *James Paxton, MD, MBA, FACEP* *Nicholas Vasquez, MD, FACEP*	A
21	Mitigation of Competition for Procedures Between Emergency Medicine Resident Physicians and Other Learners *Emergency Medicine Residents' Association*	A
22	Supporting Three-Year and Four-Year Emergency Medicine Residency Program Accreditation *Emergency Medicine Residents' Association*	A
23	Opposing Sale-Leaseback Transactions by Health Systems *Pennsylvania College of Emergency Physicians*	A
24	Addressing the Growing Epidemic of Pediatric Cannabis Exposure *Pennsylvania College of Emergency Physicians*	A
25	Compassionate Access to Medical Cannabis Act – "Ryan's Law" *Larry Bedard, MD, FACEP* *Dan Morhaim, DO, FACEP*	A

Resolution #	Subject/Submitted by	Reference Committee
26	Decriminalization of All Illicit Drugs *Larry Bedard, MD, FACEP* *Dan Morhaim, DO, FACEP*	A
27	Addressing Interhospital Transfer Challenges for Rural EDs *Rural Emergency Medicine Section* *Social Emergency Medicine Section* *Arizona Chapter* *Colorado Chapter* *New Mexico Chapter* *Oklahoma Chapter* *Vermont Chapter* *Washington Chapter*	B
28	Facilitating EMTALA Interhospital Transfers *Andrew Fenton, MD, FACEP* *Roneet Lev, MD, FACEP* *Aimee Moulin, MD, FACEP* *California Chapter*	B
29	Addressing Pediatric Mental Health Boarding in Emergency Departments *Pennsylvania College of Emergency Physicians* *Pediatric Emergency Medicine Section*	B
30	Advocating for Increased Funding for EMS *Pennsylvania College of Emergency Physicians*	B
31	Combating Mental Health Stigma in Insurance Policies *New York Chapter*	B
32	Healthcare Insurers Waive Network Considerations During Declarations of Emergency *Gary Gaddis, MD, PhD, FACEP* *David Schriger, MD, MPH, FACEP*	B
33	Ban on Weapons Intended for Military or Law Enforcement Use *Kathy Staats, MD, FACEP* *Niki Thran, MD, FACEP* *California Chapter*	B
34	White Paper on Weapons Intended for Military or Law Enforcement Use *Kathy Staats, MD, FACEP* *Niki Thran, MD, FACEP* *California Chapter*	B
35	Declaring Firearm Violence a Public Health Crisis *District of Columbia Chapter*	
36	Mandatory Waiting Period for Firearm Purchases *California Chapter* *Leslie Mukau, MD, FACEP* *Valerie Norton, MD, FACEP* *Bing Pao, MD, FACEP* *Scott Pasichow, MD, MPH, FACEP* *Katherine Staats, MD, FACEP* *Niki Thran, MD, FACEP* *Randall Young, MD, FACEP*	B

Resolution #	Subject/Submitted by	Reference Committee
37	Support for Child-Protective Safety Firearm Safety and Storage Systems *Leslie Mukau, MD, FACEP* *Valerie Norton, MD, FACEP* *Bing Pao, MD, FACEP* *Katherine Staats, MD, FACEP* *Niki Thran, MD, FACEP* *Randall Young, MD, FACEP* *California Chapter*	B
38	Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals *Pennsylvania College of Emergency Physicians*	B
39	Medicaid Reimbursement for Emergency Services *Bing Pao, MD. FACEP* *Thomas Sugarman, MD, FACEP* *California Chapter*	B
40	Support for Reimbursement of Geriatric ED Care Processes *Dual Training Section* *Geriatric Emergency Medicine Section* *Observation Medicine Section* *Maryland Chapter*	B
41	Use of Medical Coders in Payment Arbitration *Michigan College of Emergency Physicians*	B
42	On-Site Physician Staffing in Emergency Departments *Indiana Chapter*	B
43	Adopt Terminology "Unsupervised practice of Medicine" *Emergency Medicine Workforce Section*	C
44	Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss *Emily Ager, MD* *Kimberly Chernoby, MD* *Kelly Quinley, MD* *Rachel Solnick, MD* *Katherine Wegman, MD* *American Association of Women Emergency Physicians Section*	C
45	Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss American Association of Women Emergency Physicians Section Social Emergency Medicine Section	C
46	Consensus with ACOG on the Care of Pregnant Individuals with Substance Use Disorder *Emily Ager, MD* *Kimberly Chernoby, MD* *James Feldman, MD, FACEP* *Kelly Quinley, MD* *Rachel Solnick, MD* *Katherine Wegman, MD* *Social Emergency Medicine Section*	C

Resolution #	Subject/Submitted by	Reference Committee
47	Clarification of and Taking a Position Against Use of Excited Delirium Syndrome *Kevin Durgun MD* *Adam Kruse, MD* *Brooks Walsh MD* *District of Columbia Chapter* *Social Emergency Medicine Section* *EMS-Prehospital Care Section*	C
48	Medical Malpractice Certificate of Merit *New York Chapter*	C
49	Patients Leaving the ED Prior to Completion of Care Against Medical Advice *Jennifer Conn, MD, FACEP* *Olga Gokova, MD, FACEP* *Rachel Levitan, MD* *Anne Richter, MD, FACEP* *Arizona College of Emergency Physicians*	C
50	Metric Shaming *American Association of Women Emergency Physicians Section* *Government Services Chapter*	C
51	Quality Measures and Patient Satisfaction Scores *Ohio Chapter*	C
52	Summit & New Tools for Transforming Acute Care *New York Chapter*	C
53	Treating Physician Determines Patient Stability *Andrew Fenton, MD, FACEP* *Roneet Lev, MD, FACEP* *Aimee Moulin, MD, FACEP* *California Chapter*	C
54	Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions *Michigan College of Emergency Physicians*	C
55	Uncompensated Required Training *American Association of Women Emergency Physicians Section* *Government Services Chapter*	C

Late Resolutions

56	In Memory of William A. Nice, MD *Indiana Chapter*	
57	Commendation for Raymond L. Fowler MD, FACEP, FAEMS *Angela Cornelius MD, MA, FACEP* *D. Mark Courtney, MD, FACEP* *Angela F. Gardner, MD, FACEP* *Jeffrey M. Goodloe MD, FACEP* *Andrew Hogan, MD* *S. Marshal Isaacs, MD, FACEP* *Jeff Jarvis MD, MS, FACEP*	

Jeffery C. Metzger, MD, MBA, FACEP
Brian L. Miller MD, FACEP
Brandon Morshedi, MD, DPT, FACEP
Kathy Rinnert, MD, MPH, FACEP
John J. Rogers MD, FACEP
Gilberto A. Salazar, MD, FACEP
Robert E. Suter, DO, MHA, FACEP
Raymond E. Swienton, MD, FACEP
Dustin Williams, MD, FACEP
Georgia College of Emergency Physicians
Texas College of Emergency Physicians

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 1(23)

SUBMITTED BY: Angela Cornelius, MD, MA, FACEP
Jeffrey Jarvis, MD, FACEP
Disaster Medicine Section
EMS-Prehospital Care Section
Tactical & Law Enforcement Medicine Section

SUBJECT: Commendation for Patrick Elmes, EMT-P

1 WHEREAS, Patrick Elmes, EMT-P, was a dedicated ACEP staff member from June 6, 2011, through
2 February 3, 2023; and
3
4 WHEREAS, Mr. Elmes was an exceptional staff liaison to the Disaster Preparedness & Response Committee,
5 Air Medical Transport Section, and the Disaster Medicine Section and also provided support to other committees and
6 sections, such as the EMS Committee, EMS Section, and Event Medicine Section over the years; and
7
8 WHEREAS, Mr. Elmes ensured that EMS Week was a successful educational opportunity for ACEP
9 members and the paramedics that they oversee; and
10
11 WHEREAS, Mr. Elmes, served a critical role in managing multiple federally funded EMS and disaster
12 medicine-related grant projects ACEP was awarded during his tenure with the College; and
13
14 WHEREAS, Mr. Elmes assisted College members in their quest for subspecialty certification in Disaster
15 Medicine: and
16
17 WHEREAS, Mr. Elmes represented the College with complete professionalism with other national EMS
18 organizations, including federal government agencies, which strengthened the College's position as a recognized
19 leader in the EMS and disaster medicine communities; and
20
21 WHEREAS, Mr. Elmes served his community as a paramedic, providing essential prehospital care; therefore
22 be it
23
24 RESOLVED, That the American College of Emergency Physicians commends Pat Elmes, EMT-P, for his
25 outstanding service and commitment to the College and the specialty of emergency medicine.

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RESOLUTION: 2(23)

SUBMITTED BY: Florida College of Emergency Physicians

SUBJECT: Commendation for Kelly Gray-Eurom, MD, MMM, FACEP

1 WHEREAS, Kelly Gray-Eurom, MD, MMM, FACEP, has served the American College of Emergency
2 Physicians with dignity, distinction, and dedication as Council Vice Speaker 2019-21 and Council Speaker 2021-23;
3 and
4
5 WHEREAS, Dr. Gray-Eurom represented the Council at Board of Directors' meetings during her term as
6 Vice Speaker and Speaker and provided thoughtful discourse and comments on a variety of issues; and
7
8 WHEREAS, Dr. Gray-Eurom gracefully led the Council during debate of contentious issues with respect and
9 courtesy; and
10
11 WHEREAS, Dr. Gray-Eurom diligently devoted significant amounts of time, creativity, humor, and
12 enthusiasm to her duties as a Council officer; and
13
14 WHEREAS, Dr. Gray-Eurom welcomed and encouraged the participation of new councillors and alternate
15 councillors on Council committees and is respected for her integrity, objectivity, and mentorship she provided to
16 numerous councillors across all chapters of the College; and
17
18 WHEREAS, Dr. Gray-Eurom has demonstrated a long history of service to the Council including serving as
19 councillor and alternate councillor and on various Council committees; and
20
21 WHEREAS, Dr. Gray-Eurom has maintained an active presence in the Florida Chapter and served on the
22 Board of Directors 2006-13 and as President 2012-13; and
23
24 WHEREAS, Dr. Gray-Eurom has shown exemplary leadership and outstanding service with her participation
25 on several committees and task forces of the College; and
26
27 WHEREAS; Dr. Gray-Eurom is a visionary and influential leader with a distinguished career in emergency
28 medicine as a clinician, educator, mentor, and advocate for the specialty; and
29
30 WHEREAS, Dr. Gray-Eurom will continue to be involved and committed to the cause and mission of ACEP
31 and the specialty of emergency medicine; therefore be it
32
33 RESOLVED, That the American College of Emergency Physicians commends Kelly Gray-Eurom, MD,
34 MMM, FACEP, for her service as Council Speaker, Council Vice Speaker, and for her enthusiasm and commitment
35 to the specialty of emergency medicine and to the patients we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 3(23)

SUBMITTED BY: New Jersey Chapter

SUBJECT: Commendation for Russell H. Harris, MD, FACEP

1 WHEREAS, Russell H. Harris, MD, FACEP, has served the College and the specialty with skill and
2 dedication as a member of ACEP and the New Jersey Chapter for more than 40 years; and
3
4 WHEREAS, During his time with the chapter and ACEP, he ensured an ever rising level of professionalism
5 and dedication to the chapter and emergency medicine; and
6
7 WHEREAS, He served on the New Jersey Chapter Board of Directors 1994-2000 and as the chapter president
8 1998-99; and
9
10 WHEREAS, His dedication to the chapter included serving as councillor from 1997-06, 2008-09, 2011-13
11 and as alternate councillor in 2001, 2007, and 2010; and
12
13 WHEREAS, Dr. Harris' level of dedication to the New Jersey Chapter included but was not limited to hosting
14 a yearly membership dinner at his home in which he welcomed all 900+ chapter members with open arms; and
15
16 WHEREAS, At the national level, Dr. Harris served on the Public Relations Committee from 1998-01, State
17 Legislative/Regulatory Committee 2001-17, and the Education Committee 2005-07; and
18
19 WHEREAS, Dr. Harris has served as a selfless mentor to many emergency physicians throughout his career;
20 and
21
22 WHEREAS, Dr. Harris has been a full-time emergency physician at Our Lady of Lourdes Medical Center in
23 Camden, New Jersey for more than 35 years; and
24
25 WHEREAS, Dr. Harris is a retired Navy Captain and was awarded two Navy achievement medals during
26 Operation Desert Storm; and
27
28 WHEREAS, Dr. Harris has advocated on behalf of emergency medicine at both a local and national level;
29 therefore be it
30
31 RESOLVED, That the American College of Emergency Physicians recognizes the scope, breadth, and lasting
32 impact of the contributions of Russell H. Harris, MD, FACEP, to the advancement of emergency medicine; and be it
33 further
34
35 RESOLVED, That the American College of Emergency Physicians commends Russell H. Harris, MD,
36 FACEP for his outstanding service, leadership, and commitment to the College and the specialty of emergency
37 medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 4(23)

SUBMITTED BY: Angela Cornelius, MD, MA, FACEP
Richard C. Hunt, MD, FACEP
Jeffrey Jarvis, MD, FACEP
Jon Krohmer, MD, FACEP
Disaster Medicine Section
EMS-Prehospital Care Section
Event Medicine Section
Tactical &Law Enforcement Medicine Section

SUBJECT: Commendation for Rick Murray, EMT-P, FAEMS

1 WHEREAS, Rick Murray, EMT-P, FAEMS, began his distinguished career with ACEP on August 12, 1996,
2 and it ended on June 30, 2023, almost 27 years later; and
3
4 WHEREAS, Mr. Murray worked tirelessly to build ACEP's role in EMS and by serving our members who
5 oversee and work hand-in-hand in the daily life-saving work of EMTs and paramedics; and
6
7 WHEREAS, Mr. Murray has been an exceptional staff liaison to the EMS Committee, EMS-Prehospital Care
8 Section, Event Medicine Section, and Tactical & Law Enforcement Medicine Section, and also provided support to
9 other related committees and sections over the years including the Disaster Preparedness & Response Committee, Air
10 Medical Transport Section, and the Disaster Medicine Section; and
11
12 WHEREAS, Mr. Murray was instrumental in the formation of the Section of Tactical Emergency Medicine in
13 2003 and his leadership led to the embrace of expansive medical support for police and corrections, reflected in the
14 revised name of the section to Tactical & Law Enforcement Medicine; and
15
16 WHEREAS, EMS became a subspecialty of emergency medicine – the largest subspecialty – and his efforts
17 in assisting members to achieve this milestone are laudable; and
18
19 WHEREAS, Under his leadership, ACEP's EMS Department supported the work of members involved with
20 EMS through specialized courses, pre-conferences during ACEP's annual Scientific Assembly, and webinars; and
21
22 WHEREAS, Mr. Murray was instrumental in the success of EMS Week by leading the initiative and seeking
23 and securing vital funding to ensure the program continued as a successful educational opportunity for our members
24 and the paramedics they oversee; and
25
26 WHEREAS, Through his expertise, leadership, dedication, many work hours, and contacts, he helped ACEP
27 secure more than $11 million dollars in federal, foundation, and corporate grants to support increased resources for
28 emergency physicians and EMS professionals to improve patient care, such as the CHDPA; Tale of Two Cities;
29 Terrorism Injuries Information Dissemination, and Exchange (TIIDE); and Until Help Arrives; and
30
31 WHEREAS, Mr. Murray's significant work on the Terrorism Injuries Information, Dissemination, and
32 Exchange (TIIDE) program grant from the Centers for Disease Control and Prevention, through coordination with
33 multiple professional organizations and those who led the medical response to terrorist injuries in other countries in
34 assimilating and disseminating new knowledge related to clinical care of bomb injuries, resulted in the U.S. and other
35 countries being far better prepared for a medical response to terrorist bombings and those materials remain some of
36 the most requested disaster-related materials from ACEP; and

37 WHEREAS, Mr. Murry was a true collaborator and had great relationships with many organizations and
38 agencies, including the Administration for Strategic Preparedness & Response, American College of Surgeons
39 Committee on Trauma, Centers for Disease Control and Prevention, Federal Emergency Management Agency,
40 National Association of EMS Physicians, National Highway Traffic Safety Administration, United States Department
41 of Health and Human Services, among many others, and he helped ACEP to develop and coordinate these beneficial
42 relationships; and
43
44 WHEREAS, Mr. Murray served his community as a paramedic, providing essential prehospital care, and as
45 an EMS educator and administrator; and
46
47 WHEREAS, Mr. Murray is widely respected in the emergency medicine, EMS, and trauma communities at
48 the local, state, national, and federal levels; and
49
50 WHEREAS, Mr. Murray is a titan in the EMS profession and in 2022 he was awarded the designation of
51 Fellow of the Academy of Emergency Medical Services (FAEMS) by the National Association of EMS Physicians;
52 therefore be it
53
54 RESOLVED, That the American College of Emergency Physicians commends Rick Murray, EMT-P,
55 FAEMS, for his outstanding service and commitment to the College, the specialty of emergency medicine, and the
56 subspecialty of emergency medical services.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 5(23)

SUBMITTED BY: Government Services Chapter

SUBJECT: Commendation for Gillian R. Schmitz, MD, FACEP

1 WHEREAS, Gillian R. Schmitz, MD, FACEP, has been an extraordinary and dedicated leader while serving
2 on the Board of Directors 2016-23 and in her roles as Vice President 2019-20, President-Elect 2020-21, President
3 2021-22, and Immediate Past President 2022-23; and
4
5 WHEREAS, During her term as President, Dr. Schmitz was committed to ACEP addressing ACGME
6 residency standards, private equity in emergency medicine, and workforce issues; and
7
8 WHEREAS, Dr. Schmitz maintained an active clinical schedule in a busy academic Level 1 Military
9 Treatment Facility while serving on the ACEP Board of Directors; and
10
11 WHEREAS, During her tenure on the ACEP Board of Directors and as President, she participated in
12 numerous visionary efforts, including Emergency Department Accreditation, and appointed many task forces to
13 address key issues affecting the practice of emergency physicians; and
14
15 WHEREAS, Dr. Schmitz has been a staunch advocate for preserving reimbursement for emergency
16 physicians and ensuring that the "No Surprises Act" protects both patients and physicians from surprise billing; and
17
18 WHEREAS, Dr. Schmitz has shown exemplary leadership and outstanding service with her tireless efforts
19 and expertise on various committees, task forces, sections, the Council, and Board of Directors; and
20
21 WHEREAS, Dr. Schmitz has exemplified her commitment to ACEP and its members by engaging virtually
22 with members during her informative town hall sessions and traveled around the country meeting members in person
23 and advocating for those on the frontlines; and
24
25 WHEREAS, In all of her meetings and travels, Dr. Schmitz represented the College and its members with
26 diplomacy, integrity, and honor and focused on unity and bringing members together; and
27
28 WHEREAS, Dr. Schmitz demonstrated leadership through chapter involvement and served on the
29 Government Services Chapter Board of Directors and as chapter President 2015-16 and has also been an active
30 member of the Texas College of Emergency Physicians; and
31
32 WHEREAS, Dr. Schmitz will continue to serve the College and be involved with the practice of emergency
33 medicine and dedicated to the mission of ACEP; therefore be it
34
35 RESOLVED, That the American College of Emergency Physicians commends Gillian R. Schmitz, MD,
36 FACEP, for her outstanding service, leadership, and commitment to the specialty of emergency medicine and to the
37 patients and communities we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 6(23)

SUBMITTED BY: New York Chapter

SUBJECT: Commendation for JoAnne Tarantelli

1 WHEREAS, JoAnne Tarantelli has served as the Executive Director of New York ACEP (NY ACEP) for
2 nearly four decades; and
3
4 WHEREAS, She has been dedicated to the growth and development of emergency medicine in New York
5 State and across the country through her tenure; and
6
7 WHEREAS, Her unwavering leadership has guided New York ACEP through decades of challenges; and
8
9 WHEREAS, Her awareness and communication of important issues has allowed New York ACEP to weather
10 and address challenges before they impacted emergency medicine practice or patient care; and
11
12 WHEREAS, Her support of physicians and their practice have undoubtedly improved emergency care
13 throughout New York State; and
14
15 WHEREAS, She has supported and developed decades of emergency physicians and leaders as a confidant,
16 counselor, and friend; therefore be it
17
18 RESOLVED, That the American College of Emergency Physicians commends and thanks JoAnne Tarantelli
19 for her outstanding career and decades of dedicated service, leadership, commitment to the College, the emergency
20 physicians of New York, the specialty of emergency medicine, and the patients that we serve.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 7(23)

SUBMITTED BY: Florida College of Emergency Physicians

SUBJECT: In Memory of Clifford Findeiss, MD

1 WHEREAS, J. Clifford "Cliff" Findeiss, MD, obtained both an MS in Pharmacology and MD from
2 Northwestern University Feinberg School of Medicine in 1968, completed a surgical internship at Jackson Memorial
3 Hospital in Miami, and then proudly served as a Lieutenant in the US Navy Medical Corps; and
4
5 WHEREAS, Dr. Findeiss was an active member of the American College of Emergency Physicians since
6 1971, is recognized as an early national leader in the new specialty of emergency medicine, and served on the
7 American College of Emergency Physicians' original exploratory Committee on Board Establishment, ultimately
8 becoming board certified himself in 1983 and maintaining the certification until his death on April 1, 2023; and
9
10 WHEREAS, Dr. Findeiss possessed the intelligence, confidence, and stamina to turn possibilities into reality,
11 always seeking to put his philosophy of "doing well by doing right" into practice, combining his analytic and creative
12 skills to change emergency medical care delivery; and
13
14 WHEREAS, Dr. Findeiss co-founded Emergency Medical Services Associates (EMSA), which gradually
15 established a new system of 24/7/365 physician on-site care in south Florida emergency departments, during which
16 time Dr. Findeiss also served as the first Medical Director of Miami-Dade County Fire Rescue and the Hialeah Fire
17 Department, initiating field care protocols for first responders; and
18
19 WHEREAS, Dr. Findeiss is renowned as one of the first to recognize that care provided in emergency
20 departments should be provided by full-time physicians who dedicate their skills to the practice of acute, unscheduled
21 care; and
22
23 WHEREAS, Dr. Findeiss actively recruited other physicians to support the specialty's development nationally
24 and in Florida traveling around the state, bringing emergency physicians together through the Florida Chapter of
25 ACEP; and
26
27 WHEREAS, Dr. Findeiss provided a lifetime of service to the Florida College of Emergency Physicians since
28 joining in 1973, having served as the sixth president in 1975-76, Chairman of the Florida Emergency Medicine
29 Foundation Board of Directors from 2011-15, and as a Foundation Board Member from 2007-21; and
30
31 WHEREAS, Dr. Findeiss' entrepreneurial approach to the practice of emergency medicine expanded
32 opportunities for emergency physicians to choose a professional practice model congruent to the needs of individual
33 physicians and their families; and
34
35 WHEREAS, Dr. Findeiss' visionary leadership, pioneering spirit, and tireless dedication to advancing the
36 specialty of emergency medicine over the last five decades have proven to be invaluable; and
37
38 WHEREAS; Dr. Findeiss was a role model and mentor leaving exponential and immeasurable impact among
39 his colleagues and future leaders in emergency medicine; and
40
41 WHEREAS; Dr. Findeiss was a dedicated and devoted husband, father, grandfather, colleague, mentor, and
42 friend who inspired all of those who knew him; therefore be it
43

44 RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the
45 contributions of a trailblazing pioneer, visionary leader, invaluable mentor, and outstanding emergency physician, J.
46 Clifford "Cliff" Findeiss, MD, and his selfless contributions to emergency medicine; and be it further
47
48 RESOLVED, That the American College of Emergency Physicians extends condolences and appreciation to
49 his wife Jean; his four sisters Marcia, Joan, Pat, and Michele; as well as his four children and his granddaughter in
50 whom his legacy lives on: Dr. Laura Findeiss, Craig Findeiss, Amanda (Findeiss) Rosillo, Allison Findeiss,
51 granddaughter Elizabeth (Lily) Rosillo; and to his family, friends, and colleagues for his remarkable service to the
52 specialty of emergency medicine, patient care, and the communities he served.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 8(23)

SUBMITTED BY: Kansas Chapter
Missouri Chapter

SUBJECT: In Memory of Scott A. Hall, MD

1 WHEREAS, With the untimely death of Scott A. Hall, MD, on July 4, 2023, Missouri lost a devoted
2 emergency physician and EMS leader; and
3
4 WHEREAS, Dr. Hall was passionate about rural EMS, serving as an EMT then paramedic for NTA Ambulance
5 district for years before and throughout medical school; and
6
7 WHEREAS, Dr. Hall received his medical degree and completed a residency in emergency medicine at the
8 University of Kansas Medical Center and served as Chief Resident; and
9
10 WHEREAS, Dr. Hall was a community leader in Northwest Missouri, serving as EMS Medical director for
11 Buchanan County and NTA Ambulance district, and as Medical Director for Mosaic Life Care – St. Joseph Emergency
12 Department, and Harrison County Community Hospital Emergency Department; therefore be it
13
14 RESOLVED, That the American College of Emergency Physicians remembers with honor and gratitude the
15 accomplishments of Scott A. Hall, MD, and offer our heartfelt condolence to his wife, daughter, and the entire Hall
16 family.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 9(23)

SUBMITTED BY: Alicia Mikolaycik Gonzalez, MD, FACEP
Susanne Spano, MD, FACEP
California Chapter

SUBJECT: In Memory of Gene W. Kallsen, MD

1 WHEREAS, The specialty of emergency medicine lost a longtime ACEP member, a beloved leader, and an
2 early pioneer of the specialty when Gene W. Kallsen, MD, passed away on March 4, 2023; and
3
4 WHEREAS, Dr. Kallsen started the University of Minnesota medical school in 1968, at the height of the
5 Vietnam War, and the same year that emergency medicine began with the formation of the American College of
6 Emergency Physicians; and
7
8 WHEREAS, After completing a transitional internship at the University of Washington, Dr. Kallsen joined
9 UCSF Fresno's emergency medicine program in 1977 – just three years after the founding of UCSF Fresno's
10 emergency medicine residency in 1974 – and at the time, emergency medicine had still not been officially recognized
11 as a specialty; and
12
13 WHEREAS, He completed his UCSF Fresno residency in 1979, the same year the American Board of
14 Emergency Medicine was approved, and that year, emergency medicine became the 23rd and youngest recognized
15 medical specialty; and
16
17 WHEREAS, Dr. Kallsen started on the ground floor of emergency medicine and quickly became an architect
18 and leader in the specialty and he was fondly known as the "father" of Emergency Medical Services in Fresno County
19 and served as the first EMS medical director in 1981; and
20
21 WHEREAS, He chaired the first statewide organization of EMS directors, serving as its representative on the
22 newly created EMS Commission, and helped develop the original EMS policies and protocols, many of which
23 continue to be used, and he fought to reform ambulance services in Fresno County, which resulted in faster response
24 times; and
25
26 WHEREAS, As chief of the UCSF Fresno Emergency Medicine Program for more than two decades, Dr.
27 Kallsen helped to establish the four-year ACGME-accredited residency into one of the most sought in the country and
28 it is estimated that he graduated between 200 and 300 emergency medicine residents; and
29
30 WHEREAS, Dr. Kallsen took great pride and joy in teaching young doctors, and to recognize his work and
31 service to UCSF, Dr. Kallsen was honored with professor emeritus title and his legacy lives on with the endowed
32 chair named in his honor; and
33
34 WHEREAS, Dr. Kallsen will be missed tremendously and his contributions to emergency medicine, EMS,
35 and his beloved UCSF Fresno community will always be remembered; therefore be it
36
37 RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to his
38 family gratitude for his tremendous service to emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 10(23)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: In Memory of Michael Kleinman, DO

1 WHEREAS, The specialty of emergency medicine lost an exceptional emergency physician when Michael
2 Kleinman, DO, passed away on June 17, 2023, surrounded by his loving family, at the age of 68; and

3 WHEREAS, Dr. Kleinman completed medical school education at the Des Moines University College of
4 Osteopathic Medicine in 1979 and completed his internship and residency training in emergency medicine at
5 Memorial Hospital of York in 1984; and

6 WHEREAS, Dr. M. Kleinman was a founding faculty member for the emergency medicine residency at
7 WellSpan York Hospital in 1989 and he was a long-time emergency physician, faculty member, leader, and mentor;
8 and

9 WHEREAS, Dr. M. Kleinman served in a variety of leadership positions at WellSpan York Hospital including
10 Chair of the Department, member of the Medical Executive Committee, and Residency Program Director; and
11
12 WHEREAS, Dr. M. Kleinman was aptly known locally as "The Wizard" for his ability to always make the right
13 diagnosis at the right time and to orchestrate the complex actions needed to care for the many ill and injured patients
14 he helped over the years as he faithfully served as a staff emergency physician and faculty member until his passing;
15 and
16
17 WHEREAS, Dr. M. Kleinman's kindness, caring, and wisdom were legendary among his colleagues and his
18 skill and compassion has helped to shape the careers of hundreds of emergency medicine students, residents, and
19 fellows over the years; therefore be it
20
21 RESOLVED, That the American College of Emergency Physicians cherishes the memory and legacy of
22 Michael Kleinman, DO, who dedicated himself to his patients, his trainees, his profession, and his family; and be it
23 further

24 RESOLVED, That the American College of Emergency Physicians and the Pennsylvania College of Emergency
25 Physicians extends to his wife Jacklyn, his sons Dr. Steve Kleinman and David Kleinman, gratitude for his
26 tremendous service as an emergency physician at the WellSpan York Hospital, as well as for his dedication and
27 commitment to the specialty of emergency medicine.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 11(23)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: In Memory of Gloria J. Kuhn, DO, PhD

1 WHEREAS, Emergency medicine lost a pioneer in emergency medicine in Gloria J. Kuhn, DO, PhD,
2 a dedicated educator and mentor, and a staunch advocate for women leaders, who passed away on March 29, 2023;
3 and
4
5 WHEREAS, Dr. Kuhn was a member of the American College of Emergency Physicians 1977-2019; and
6
7 WHEREAS, Dr. Kuhn served on the Board of Directors of the Michigan College of Emergency Physicians;
8 and
9
10 WHEREAS, Dr. Kuhn founded the residency program at Mt. Carmel Hospital (now Sinai-Grace Hospital) in
11 Detroit in 1982 and served as its program director for 12 years; and
12
13 WHEREAS, Dr. Kuhn held the position of Professor and Vice-Chair of Academic Affairs, Department of
14 Emergency Medicine, Wayne State University, School of Medicine for 10 years; and
15
16 WHEREAS, Dr. Kuhn was recognized for her exemplary service to emergency medicine by receiving the
17 2013 Michigan College of Emergency Physicians John A. Rupke, MD, Lifetime Achievement Award; and
18
19 WHEREAS, Dr. Kuhn was committed to a lifetime of learning as demonstrated by obtaining her Doctorate in
20 Instructional Technology when she was 55; and
21
22 WHEREAS, Dr. Kuhn was recognized for her expertise in education by receiving the 2006 ACEP Award for
23 Outstanding Contribution in Education; and
24
25 WHEREAS, Dr. Kuhn firmly believed and was oft quoted: "*The decisions are made by those who show up to*
26 *the table; if you don't show up, you won't have a say.*"; and
27
28 WHEREAS, Dr. Kuhn was known for her commitment to the highest standards of resident education
29 balanced with a warm heart and willing ear if a patient case did not go well; and
30
31 WHEREAS, Dr. Kuhn embodied the idea that a residency program is a family, insisted on being called by her
32 first name, and hosted journal clubs at her home where spirited debate was only outdone by the excess of food and
33 dessert – always dessert; therefore be it
34
35 RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency
36 Physicians hereby expresses their enduring appreciation to Gloria J. Kuhn, DO, PhD, as a champion for emergency
37 medicine; and be it further
38
39 RESOLVED, That the American College of Emergency Physicians and the Michigan College of Emergency
40 Physicians extends to the family of Gloria J. Kuhn, DO, PhD, her colleagues, and former residents, our condolences
41 along with our profound gratitude for her lifetime of service to the specialty of emergency medicine, Michigan
42 emergency physicians, and patients, who will never fully know her impact, across the United States of America and
43 likely beyond.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 12(23)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: In Memory of Richard M. Nowak, MD, MBA, FACEP

1 WHEREAS, Emergency medicine lost a beloved physician leader in the passing of Richard M. Nowak, MD,
2 MBA, FACEP, who died January 26, 2023; and
3
4 WHEREAS, Dr. Nowak earned his medical degree from the University of Toronto School of Medicine,
5 completed residency at Montreal General Hospital, and a research fellowship at the University of Toronto prior to
6 joining the Henry Ford Medical Group, Detroit, MI, in 1975; and
7
8 WHEREAS, Dr. Nowak's legacy in emergency medicine is reflected by his almost 50-year relationship with
9 Henry Ford Hospital (HFH) where he provided innovative emergency care to innumerable patients in a highly
10 underserved population; and
11
12 WHEREAS, Dr. Nowak completed his MBA from Michigan State University and was a founding member
13 and Chairman of the HFH Department of Emergency Medicine and his contributions to the clinical and academic
14 mission of the department were immense; and
15
16 WHEREAS, Dr. Nowak founded the HFH emergency medicine residency program in 1976, prior to its
17 approval as a recognized specialty and when few emergency medicine residencies existed; and
18
19 WHEREAS, Dr. Nowak's commitment to teaching was boundless and he always demonstrated a sincere
20 interest in his patients and possessing an unbridled enthusiasm, he was renowned for his bedside teaching; and
21
22 WHEREAS, With an unparalleled sense of curiosity, humor, compassion, and collegiality, Dr. Nowak served
23 as a role model for students, residents, fellows, and colleagues, and his many life-long relationships with students are
24 a testament to his rare talent as an educator; and
25
26 WHEREAS, Dr. Nowak served as a representative in the Association of American Medical Colleges where he
27 assisted in the creation of our specialty in the house of medicine in 1979; and
28
29 WHEREAS, Dr. Nowak's commitment to leadership is further demonstrated by his commendable activity in
30 the Michigan College of Emergency Physicians (MCEP), including representing the College as a councillor and as
31 MCEP President in 1987; and
32
33 WHEREAS, Dr. Nowak was also enormously influential in education nationally, serving as an examiner for
34 the American Board of Emergency Medicine, on the Board of Directors of the Society of Teachers in Emergency
35 Medicine, and as President of the University Association for Emergency Medical Services, which is now the Society
36 for Academic Emergency Medicine (SAEM), and he later served on the SAEM Board of Directors; and
37
38 WHEREAS, Dr. Nowak was a nationally recognized presenter at countless local, national, and international
39 conferences and his lectures were always timely with just the right amount of history, humor, and personal anecdotes;
40 and
41
42 WHEREAS, Dr. Nowak's lifelong curiosity made him a staunch research advocate who established a world-
43 class research program, and by diversifying his areas of research activities he fostered interdisciplinary relationships

44 worldwide and pioneered advances in cardiopulmonary resuscitation, including the first use cardiopulmonary bypass
45 in the ED, cardiac biomarker development, and spirometry use for asthma that precipitated hand-held peak flow
46 meters; and
47
48 WHEREAS, Dr. Nowak embraced "bench to bedside" research decades before the term was coined and he
49 was a reviewer for numerous specialty journals; and
50
51 WHEREAS, He had more than 90 grant submissions, wrote numerous textbook chapters, more than 300
52 scientific papers, and 250 other publications, including a book on resuscitation, and he has served on numerous
53 international editorial boards in academic emergency medicine and cardiology and was recognized across the globe
54 with honors and awards; and
55
56 WHEREAS, In 1987, he received ACEP's Award for Outstanding Contribution in Research; and
57
58 WHEREAS, Dr. Nowak devoted his entire professional career to emergency medicine and he always
59 promoted and took time for a life outside of medicine, evidenced by his love and involvement in sports, music,
60 automobiles, travel, hockey, and theater; however, his family, was the pride of his life and were always included in
61 lectures and on his travels and they were well known to his HFH family and to his colleagues around the world;
62 therefore be it
63
64 RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions
65 of Richard M. Nowak, MD, MBA, FACEP, to the specialty of emergency medicine as a clinician, educator,
66 researcher, scholar, and leader; and be it further
67
68 RESOLVED, That the College extends condolences to his wife, Deborah, and children, Michael and Kathryn,
69 and he will forever endure in the minds of all who had the great opportunity to interact with him.

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RESOLUTION: 13(23)

SUBMITTED BY: Valerie Norton, MD, FACEP
Lori Winston MD, FACEP
California Chapter

SUBJECT: In Memory of Barbara W. Trainor

1 WHEREAS, The specialty of emergency medicine lost a longtime champion and advocate when
2 Barbara Wallace Trainor passed away on December 23, 2022; and

3 WHEREAS, Mrs. Trainor was the California Chapter President Dr. Michael P. Trainor's widow and
4 dedicated her time and talents to the chapter and the specialty both during his life and for many years after; and

5 WHEREAS, In recognition of Mrs. Trainor's lifetime of dedication she received honorary membership in the
6 College in 2013; and

7 WHEREAS, Mrs. Trainor served on the Emergency Medical Research and Education Foundation Board of
8 Trustees and the California Medical Association Alliance Foundation Board, and as President of the Orange County
9 Medical Association Alliance, State President of the California Medical Associations Alliance, as president of the
10 Western Coalition of the American Medical Association Alliance, and tirelessly contributed to numerous other
11 organizations throughout her life; and

12 WHEREAS, Mrs. Trainor served as chair of the Trainor Lectureship given at the California Chapter's
13 Scientific Assembly from 1993 to 2010; and

14 WHERAS, Mrs. Trainor was committed to the specialty of emergency medicine and determinedly promoted
15 and improved the work of the College and the California Chapter; and

16 WHEREAS, Mrs. Trainor will be missed tremendously and her contributions to emergency medicine, both
17 while her husband was alive and after he passed away, will always be remembered; therefore be it
18
19 RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to her
20 daughter Karyn Trainor and son William Trainor and his partner Patrice Pineda, her brothers David Wallace and
21 Doug Wallace, and sisters Carolyn Wallace Dee and Melanie Wallace, and the many others she impacted, gratitude
22 for her tremendous service to emergency medicine.

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RESOLUTION: 14(23)

SUBMITTED BY: Alicia Mikolaycik Gonzalez, MD, FACEP
Susanne Spano, MD, FACEP
California Chapter
Wellness Section
Wilderness Medicine Section

SUBJECT: In Memory of Lori Weichenthal, MD, FACEP

1 WHEREAS, The specialty of emergency medicine lost a devoted ACEP member, a beloved trailblazer, and
2 leader in wilderness medicine and wellness when Lori Weichenthal, MD, FACEP, passed away; and
3
4 WHEREAS, Dr. Weichenthal attended the University of California, San Diego for her undergraduate
5 degree, completed her medical degree at the UCSF School of Medicine in San Francisco, and her emergency
6 medicine residency at UCSF Fresno; and
7
8 WHEREAS, Dr. Weichenthal was a pioneer in the field, one of only two women in the UCSF Fresno
9 Department of Emergency Medicine when she began her residency in 1995, serving as a guiding star for the
10 women who have followed, and in 1998 she joined the emergency medicine faculty as a clinical instructor,
11 quickly rising to UCSF assistant clinical professor, associate clinical professor, and in 2014 to UCSF
12 professor; and
13
14 WHEREAS, Her interest in wilderness medicine led her to create the Emergency Medicine Wilderness
15 Medicine Fellowship in 2008, serving as program director in its first years while developing the curriculum
16 and most recently working with other fellowships nationwide to create a standardized curriculum for
17 wilderness medicine; and
18
19 WHEREAS, Dr. Weichenthal started UCSF Fresno emergency medicine's role as Medical Director for
20 the Two Cities Marathon, which still occurs today, and about a decade ago, started the UCSF High Sierra
21 Wilderness Medicine CME Conference which is held annually; and
22
23 WHEREAS, In 2019, the Fresno-Madera Medical Society honored Dr. Weichenthal as one of three
24 Women Trailblazers and in the society's Winter 2019 "Central Valley Physicians" magazine, her colleagues
25 praised her achievements and the calm and caring way in which she solved problems and attained goals; and
26
27 WHEREAS, Her leadership included starting a Women in Academic Medicine group at UCSF Fresno
28 about five years ago to help address the disparities that exist between men and women in academic medicine;
29 and
30
31 WHEREAS, In 2018, to help better understand the culture at UCSF Fresno around diversity and
32 inclusion, Dr. Weichenthal founded a committee on Diversity, Equity, and Inclusion (DEI) and was
33 instrumental in the appointment of the first campus DEI director in 2021; and
34
35 WHEREAS, Dr. Weichenthal developed a wellness curriculum for residents and extensively
36 researched wellness in residency training, becoming a nationwide voice for the importance of physician
37 wellness programs; and
38
39 WHEEAS, She conducted research looking at burnout rates in emergency medicine residents and at

40 whether a wellness curriculum might decrease burnout and compassion fatigue; and recently completed a
41 study on the impact of a mindfulness meditation course on trainee and faculty wellness; and
42
43 WHEREAS, As part of her commitment to wellness, Dr. Weichenthal helped lead yoga sessions at
44 UCSF Fresno, and over the years she taught yoga to community classes and to youth with disabilities and
45 weight issues; and
46
47 WHEREAS, Dr. Weichenthal received numerous awards and honors throughout her career, including
48 being inducted into the UCSF Academy of Medical Educators, receiving an Excellence in Teaching Award in
49 Medical Education from the Haile T. Debas Academy of Medical Educators, a Kaiser Award nominee, faculty
50 and research awards, a Letter of Distinction from ACEP, mentoring distinctions from UCSF and Women in
51 Academic Emergency Medicine, a Lifetime Achievement Award from the Fresno-Madera Medical Society,
52 and a host of other honors and recognitions; and
53
54 WHEREAS, She was held in the highest esteem for her unwavering commitment to the teaching and
55 training of residents, fellows, and medical students – and to their wellness; and
56
57 WHEREAS, Dr. Weichenthal was a skilled clinician and expert academic instrumental in resident and
58 medical student education at UCSF Fresno, first being appointed as Assistant Dean for Graduate Medical
59 Education in 2016 to provide oversight to the residency and fellowship programs and in November 2021,
60 named Associate Dean for GME and Clinical Affairs, while also in 2020 having taken on the role of
61 Designated Institutional Officer (DIO) and at the same time she remained deeply involved in the emergency
62 medicine residency program as Associate Residency Director; and
63
64 WHEREAS, Dr. Weichenthal served on the ACEP Well-Being Committee, served as chair of the
65 ACEP Wellness Section, and as chair of the ACEP Wilderness Medicine Section; therefore be it
66
67 RESOLVED, That the American College of Emergency Physicians, the California Chapter, and the Wellness
68 and Wilderness Medicine Sections hereby acknowledge the many contributions made by Lori Weichenthal, MD,
69 FACEP, as one of the leaders in emergency medicine and the greater medical community; and be it further
70
71 RESOLVED, That the American College of Emergency Physicians and the California Chapter extends to her
72 family gratitude for her tremendous service to emergency medicine.

2023 Council Meeting
Reference Committee Members

Reference Committee A – Governance, Membership, & Other Issues
Resolutions 15-26

Scott H. Pasichow, MD, FACEP (IL) – Chair
William D. Falco, MD, FACEP (WI)
Gregory Gafni-Pappas, DO, FACEP (MI)
Catherine Marco, MD, FACEP (PA)
Laura Oh, MD, FACEP (GA)
Stephen C. Viel, MD, FACEP (FL)

Maude Surprenant Hancock, CAE
Laura Lang, JD

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Bylaws Amendment

RESOLUTION: 15(23)

SUBMITTED BY: Board of Directors

SUBJECT: Additional Vice President Position on the ACEP Board of Directors

PURPOSE: Amends the Bylaws to add a second vice president officer position on the Board of Directors.

FISCAL IMPACT: Additional funds of $24,682 annually pending recommendation of the Compensation Committee and approval by the Board of Directors.

WHEREAS, The Board of Directors continuously seeks to optimally and efficiently serve members of the College, fostering ACEP becoming even stronger in advocacy for member emergency physicians and in fiscal ability, to provide additional products and services for member emergency physicians; and

WHEREAS, The last change in Board of Directors composition occurred in 2005, with creation of the officer position of Chair of the Board of Directors, at which time the College had only 23,559 members compared with today's approximately 38,000 members, and at which time the College offered less products and services; and

WHEREAS, A multitude of communications technologies and formats continue to be created and to evolve, thereby also creating choices and challenges in most effectively communicating ACEP advocacy, products, services, and involvement opportunities for members, which then create increasing duty among the Board of Directors in strategically directing resources and content; and

WHEREAS, Effectively maintaining and growing College membership is critical to the future successes of ACEP for benefits for member emergency physicians, requiring additional focused strategy today, directed by the Board of Directors, with ongoing leadership to effect that desired growth; and

WHEREAS, The Board of Directors believes the College leadership costs are best conserved by focusing Board of Directors duties among the current number of members on the Board of Directors; therefore be it

RESOLVED, That the ACEP Bylaws Article X – Officers/Executive Director, Section 1 – Officers, Section 2 – Election of Officers, and Section 7 – Vice President, and Article XI – Committees, Section 2 – Executive Committee, be revised to read:

ARTICLE X – OFFICERS/EXECUTIVE DIRECTOR

Section 1 – Officers

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

Section 2 — Election of Officers

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

Section 7 — Vice President**s**

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

ARTICLE XI – COMMITTEES

Section 2 — Executive Committee

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

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

Background

This resolution seeks to amend the Bylaws to add a second vice president officer position on the Board of Directors.

A subcommittee of the Board was appointed in January 2023 with the following objectives:

- Review the Board member and officer roles, including the current election process, and whether they continue to best serve the Board, individual Board members, and the College as a whole.
- Review the activities that Board members should be doing that would be most valuable to the College and to the individual Board members.

The subcommittee reviewed the current vice president position description and recommended submitting a Bylaws amendment to create a second vice president position to better align the work of the Board with the needs of the membership and to create an additional officer leadership opportunity on the Board. The addition of another formal leadership role (vice president) will help enable the Board to be more facile in addressing member needs based on the expanding complexity of the healthcare landscape. The subcommittee recommended that one vice president position have a primary focus on membership and the second vice president position have a primary focus on internal and external communications. The Board reviewed the subcommittee's recommendation at their June 28-29, 2023, meeting and approved submitting a Bylaws amendment to the 2023 Council and approved the position descriptions (see Attachment A) of the two vice president positions contingent on the resolution being adopted by the Council.

The Board also discussed the need for the Compensation Committee to determine the stipend for both vice president positions if the Bylaws amendment is adopted. The Compensation Committee has been informed about the Bylaws amendment and the potential need to develop a stipend recommendation. The stipend for the second vice president is not included in the current fiscal year budget and would require a budget modification.

The basis for the Compensation Committee resides in the ACEP Bylaws, Article XI – Committees, Section 7 – Compensation Committee:

> "College officers and members of the Board of Directors may be compensated, the amount and manner of which shall be determined annually by the Compensation Committee. This committee shall be composed of the chair of the Finance Committee plus four members of the College who are currently neither officers nor members of the Board of Directors. The Compensation Committee

chair, the Finance Committee chair, plus one other member shall be presidential appointments and two members shall be appointed by the speaker. Members of this committee shall be appointed to staggered terms of not less than two (2) years.

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

If the resolution is adopted by the Council, and the Board adopts the resolution at their October 12, 2023, meeting, the Bylaws amendment would be effective on that date and the two vice president positions would be eligible for election at that meeting.

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.

Resources and Accountability – ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

Fiscal Impact

The current annual stipend for the vice president is $35,736 and $11,054 for a non-officer Board member. The Compensation Committee has the responsibility, as delineated in the Bylaws, to determine the stipends for the Board of Directors and officers and would need to determine the stipend amount for both vice president positions. The total fiscal impact for FY 2023-24, if the Compensation Committee recommends the same stipend amount for the second vice president position, would be $16,455 for November 1, 2023 – June 30, 2024. ($35,756 current vice president stipend, less $11,054 current non-officer Board member stipend = $24,682 divided by 12 = $2056.83 x 8 months = $16,454.64).

Prior Council Action

None that is specific to adding a second vice president officer position.

Prior Board Action

June 2023, approved submitting a Bylaws amendment to the 2023 Council and approved the position descriptions of the two vice president positions contingent on the resolutions being adopted by the Council.

September 2022, approved the revised position description of the vice president.

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

Attachment A

VICE PRESIDENT – MEMBERSHIP POSITION DESCRIPTION

Basic Functions: Represent the College at chapter meetings, emergency medicine residencies, media briefings, legislative hearings, and meetings of other organizations, as requested by the president. Support and defend policies and programs adopted by the Board of Directors.

Characteristic Duties and Responsibilities:

1. Serve as Board liaison to the Membership Committee, Emergency Medicine Residents' Association, Young Physicians Section, and other committees and sections as appointed by the president.

2. Serve as Board representative to staff in membership issues, with specific focus on recruitment and retention of members.

3. Update the Board of Directors on issues pertaining to membership in coordination with staff.

4. Complete special assignments upon request of the president.

5. Serve as a member of the Executive Committee.

VICE PRESIDENT – COMMUNICATIONS POSITION DESCRIPTION

Basic Functions: Represent the College at chapter meetings, emergency medicine residencies, media briefings, legislative hearings, and meetings of other organizations, as requested by the president. Support and defend policies and programs adopted by the Board of Directors.

Characteristic Duties and Responsibilities:

1. Serve as Board liaison to College communications including, but not limited to, *ACEPNow*, *EM Today*, and the ACEP Annual Report and excluding *Annals of Emergency Medicine* and *JACEP Open* unless appointed to such by the president.

2. Serve as Board representative to the ACEP Rapid Response Team to College social media monitoring and strategy and to staff regarding communication issues, with specific focus on methods that effectively communicate College products, services, advocacy, and leadership actions with present and potential College members.

3. Serve as Board liaison to the Communications Committee and other committees and sections as appointed by the president.

4. Update the Board of Directors on issues pertaining to College communications in coordination with staff.

5. Complete special assignments upon request of the president.

6. Serve as a member of the Executive Committee.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Bylaws Amendment

RESOLUTION: 16(23)

SUBMITTED BY: Bylaws Committee
Board of Directors

SUBJECT: Council Quorum – Defining "Present" – Housekeeping Bylaws Amendment

PURPOSE: Amends the Bylaws to define the term "present" to determine a quorum whether voting in person or by remote communication technology.

FISCAL IMPACT: Budgeted staff resources to update the Bylaws.

1 WHEREAS, The term "present" in the American College of Emergency Physicians (ACEP) Bylaws is not
2 clearly defined; and

3 WHEREAS, The term "present" in the ACEP Bylaws, should be defined as either "in person" or
4 "participating by approved remote communication technology" to determine a quorum present; and

5 WHEREAS, A quorum always refers to the number of members present, not to the number voting[1]; therefore
6 be it

7 RESOLVED, That the ACEP Bylaws, Article VIII – Council, Section 4 – Quorum, of the ACEP Bylaws be
8 amended to read:
9 Article VIII - COUNCIL
10
11 Section 4 — Quorum
12
13 A majority of the number of councillors credentialed by the Tellers, Credentials, and Elections Committee
14 during each session of the Council meeting shall constitute a quorum for that session. The vote of a majority of
15 councillors voting in person or represented by proxy (if applicable) shall decide any question brought before such
16 meeting, unless the question is one upon which a different vote is required by law, the Articles of Incorporation, or
17 these Bylaws.

18 **Whenever the term "present" is used in these Bylaws to determine a quorum present, with respect to**
19 **councillor voting, "present" is defined as either in person or participating by approved remote communication**
20 **technology**.

Background

This resolution amends the Bylaws to define the term "present" to determine a quorum whether voting in person or by remote communication technology.

The 2020 Council meeting was conducted virtually and the 2021 Council meeting was a hybrid meeting including in-person and remote participation. Temporary Council Standing Rules were adopted in 2020 and 2021 to allow for remote participation. 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

[1] Sturgis, Alice. *The Standard Code of Parliamentary Procedure, 4th Edition* (p. 112). McGraw Hill LLC. Kindle Edition.

Standing Rules if the Council meeting is held virtually or as a hybrid meeting in future years. The Steering Committee supported continuing to use online voting technology instead of keypads so that the same voting system would be used whether the Council meeting is held in person, hybrid, or fully virtual. The Steering Committee submitted a resolution to the 2022 Council to amend the Council Standing Rules to specify that voting electronically includes remote communication and voting technology .

The Bylaws Committee was assigned an objective for the 2022-23 committee year to review the national ACEP Bylaws and identify any areas where revision may be appropriate and submit recommendations to the Board of Directors. The Bylaws Committee was specifically directed to review Article VIII – Council, Section 4 – Quorum to address voting by remote participation and potential clarifications regarding “present and voting” language throughout the Bylaws to address remote participation. The Bylaws Committee prepared the Bylaws amendment to define “present” to determine a quorum present with respect to councillor voting and to address “present and voting” throughout the College Bylaws regarding councillor participation by remote communication technology. The Board of Directors approved cosponsoring the resolution with the Bylaws Committee.

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.

Prior Council Action

Amended Resolution 15(22) Electronic Voting During the Council Meeting adopted. The resolution amended 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; points of order related to perceived or potential mass discrepancies in voting are in order; and that the chair of the Tellers, Credentials, & Elections Committee will monitor the voting to ensure there are no large discrepancies between votes.

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 an online platform for electronic voting.

Resolution 12(96) Qurom adopted. The resolution amended the Bylaws with a revised definition of a Council quorum.

Resolution 3(80) Council Meeting. The resolution amended the Bylaws to redefine a Council quorum as a majority of councillors present.

Prior Board Action

June 2023, approved cosponsoring a Bylaws Amendment with the Bylaws Committee to define the term “present” to determine a quorum whether voting in person or by remote communication technology.

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

Bylaws Amendment

RESOLUTION: 17(23)

SUBMITTED BY: Marco Coppola, DO FACEP
Melissa Costello, MD, MS, FACEP
Gary Katz, MD, MBA, FACEP
Arlo Weltge, MD, MPH, FACEP

SUBJECT: Establishing the Position and Succession of a Speaker-Elect for the Council

PURPOSE: Amends the Bylaws to create the position of "speaker-elect" to replace the current position of vice speaker, establishes an automatic transition from speaker-elect to speaker with each term being two years, and clarifies the procedures for filling a vacancy and automatic succession.

FISCAL IMPACT: Negligible use of budgeted staff resources to update the Bylaws and other administrative documents.

WHEREAS, The Council Speaker plays a critical role in the leadership and governance of ACEP, serving as the presiding officer of the Council; and

WHEREAS, The ACEP Council elects a new Speaker every two years and the election introduces uncertainty and potential disruption to the continuity of leadership within ACEP; and

WHEREAS, A seamless transition to the role of Speaker from without an additional election after a fixed period of time enhances stability, efficiency, and effectiveness of leadership within the organization; and

WHEREAS, The naming convention within the College for elected positions that move automatically into the next office at the end of a previous term is "-elect"; and

WHEREAS, An automatic transition to the role Speaker after two years would allow the incoming Speaker to build upon the experience and knowledge gained during the preceding term without restrictions on activities created by nomination for election; therefore be it

RESOLVED, That the ACEP Bylaws be amended to read:

ARTICLE VIII — COUNCIL

Section 8 — Board of Directors Action on Resolutions (paragraph 3)

The ACEP Council Speaker and ~~Vice Speaker~~ **Speaker-Elect** 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.

ARTICLE X — OFFICERS/EXECUTIVE DIRECTOR

Section 1 – Officers

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

Section 2 — Election of Officers

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

Section 4.2 — President-Elect

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

Section 4.4 — Council Officers

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

In the event of a vacancy in the office of speaker, the ~~vice speaker~~ **speaker-elect** shall succeed to the office of speaker for the remainder of the unexpired term, and an interim ~~vice speaker~~ **speaker-elect** shall then be elected as described above. **Any time remaining in the unexpired term of the previous speaker will not abbreviate the term that the new speaker would have originally served prior to the occurrence of the vacancy.**

In the event that the offices of both speaker and ~~vice speaker~~ **speaker-elect** become vacant, the Steering Committee shall elect a speaker, **as outlined in paragraph one of Section 4.4**, to serve until the election of a new speaker and ~~vice speaker~~ **speaker-elect** at the next meeting of the Council. **This individual, having served as speaker following election by the Steering Committee, shall be eligible for nomination to serve the full terms of speaker or speaker-elect, provided that all other candidate eligibility criteria are met.**

Section 4.6 — Vacancy by Removal of a Council Officer

In the event of removal of ~~a Council officer, nominations for replacement shall be accepted from the floor of the Council, and election shall be by majority vote of the councillors present and voting at the Council meeting at which the removal occurs. In the event that~~ the speaker**,** ~~is removed and~~ the ~~vice speaker~~ **speaker-elect** ~~is elected~~ **shall succeed** to the office of speaker**. Any time remaining in the unexpired term of the previous speaker will not abbreviate the term that the new speaker would have originally served prior to the removal.**

In the event of removal of the speaker-elect, ~~the office of vice speaker~~ **nominations for replacement shall be accepted from the floor of the Council, and election shall be by majority vote of the councillors present and voting at the Council meeting at which the removal occurs** ~~shall then be filled by majority vote at that same meeting~~ , ~~from nominees from the floor of the Council~~. **The new speaker-elect will succeed to the office of speaker at the end of the unexpired term.**

Section 11 — Speaker

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

Section 12 — ~~Vice Speaker~~ **Speaker-Elect**

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

Background

This resolution amends the Bylaws to create the position of "speaker-elect" to replace the current position of vice speaker, establishes an automatic transition from speaker-elect to speaker with each term being two years, and clarifies the procedures for filling a vacancy and automatic succession. The resolution eliminates the need for a speaker election every two years and essentially codifies in the Bylaws what has occurred since 2001. Since 1983, all vice speakers nominated for speaker have been elected and since 2001 the current vice speaker has been unopposed as the candidate for speaker.

The speaker and vice speaker served one-year terms from 1974-76. The Bylaws were amended in 1976 to change the term to two years. Until 1991, the Bylaws were silent on the issue of multiple terms for the Council officers and the Bylaws were amended in 1991 to limit the speaker and vice speaker to two consecutive terms of two years each. Only two speakers and two vice speakers have served two consecutive terms (1989-1997). The Bylaws were amended in 2003 to limit the speaker and vice speaker to a single two-year term of office.

The Council has considered automatic succession of the vice speaker to speaker in the past. A Bylaws amendment was considered in 1984 to allow the vice speaker to succeed to the office of speaker at the conclusion of the speaker's two-year term and the resolution was not adopted. In 2001 a Council Issues Governance Task Force was appointed composed of members of the Board of Directors and the Council Steering Committee. The task force recommended that the term of the vice speaker and speaker be limited to a single two-year term with automatic progression from vice speaker to speaker. During the Leadership & Legislative Issues Conference, a roundtable discussion on governance was held. Several members participating in that discussion were not in agreement with the automatic progression. The Steering Committee discussed the issue again and agreed that the Council may prefer to have separate elections for each office. The Bylaws amendment submitted in 2003 focused solely on the single two-year term for the Council officers.

Eliminating the election of the speaker would allow the speaker-elect to assist the speaker in the annual elections process, including serving on the Nominating Committee and Candidate Forum Subcommittee, addressing questions from candidates regarding the Candidate Campaign Rules, and assisting the speaker in evaluating and addressing alleged Candidate Campaign Rule violations. Currently, as a candidate the vice speaker is excluded from participating

in these activities in the election year for speaker. However, if adopted, the resolution would also eliminate the possibility of a floor nominee for speaker and removes the ability for the Council to have a choice in the speaker election if the speaker-elect has real or perceived performance issues.

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.

Resources and Accountability – ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

Fiscal Impact

Negligible use of budgeted staff resources to update the Bylaws and other administrative documents.

Prior Council Action

Resolution 2(03) Council Officer Terms adopted. Amended the Bylaws to limit the speaker and vice speaker to a single two-year term of office.

Resolution 7(02) Council Officer Terms referred to the Council Steering Committee. The resolution sought to amend the Bylaws to limit the speaker and vice speaker to a single two-year term of office.

Resolution 4(91) Council Officer Terms adopted. Limited the speaker and vice speaker terms to no more than two consecutive terms.

Resolution 15(84) Councillor Officer Terms not adopted. The resolution sought to amend the Bylaws to allow the vice speaker to succeed to the office of speaker at the expiration of the speaker’s two-year term.

Resolution 15(80) Election of Officers not adopted. The resolution sought to amend the Bylaws to limit the speaker and vice speaker to no more than three consecutive two-year terms.

Resolution 9(76) Speaker and Vice Speaker adopted. Amended the Bylaws to elect the speaker and vice speaker for two-year terms.

Amended Resolution 6(73) Speaker and Vice Speaker Elections adopted. Amended the Bylaws to allow the Council to elect the speaker and vice speaker.

Prior Board Action

Resolution 2(03) Council Officer Terms adopted.

June 2002, approved cosponsoring a resolution with the Council Issues Governance Task Force to amend the Bylaws to limit the speaker and vice speaker to a single two-year term of office.

April 2002, accepted the reports of the Council Issues Governance Task Force and the Steering Committee Governance Task Force.

Amended Resolution 4(91) Council Officer Terms adopted.

Resolution 9(76) Speaker and Vice Speaker adopted.

Amended Resolution 6(73) Speaker and Vice Speaker Elections 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 18(23)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Referred Resolutions

PURPOSE: Create two separate "refer to the Board" options: "refer to the Board for decision" and "refer to the Board for report" and return the resolution to the Council for final decision.

FISCAL IMPACT: Budgeted committee and staff resources to develop Bylaws and Council Standing Rules amendments to be considered at the 2024 Council meeting.

1 WHEREAS, The Council currently has the options to decide on resolutions: Approve, Not Approve, or Refer
2 to the Board; and
3
4 WHEREAS, The Council may want a resolution to have further discussion and information by the Board, but
5 then to be returned to the Council for a final decision; therefore be it
6
7 RESOLVED, That ACEP create two separate "Refer to Board" options: "Refer to Board for Decision" and
8 "Refer to Board for Report" then return the resolution back to the Council for final decision.

Background

This resolution requests that ACEP create two separate "refer to the Board" options: 1) "refer to the Board for decision" and 2) "refer to the Board for report" and return the resolution to the Council for final decision. Adoption of this resolution would require amendments to the Bylaws and the Council Standing Rules to be submitted to the 2024 Council for consideration.

The options available to the Council regarding resolutions are: adopt, adopt as amended, not adopt, or refer. Resolutions can be referred 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

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." Written 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 1989 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."

As previously stated, adoption of this resolution would require amendments to the Bylaws and the Council Standing Rules to be submitted to the 2024 Council for consideration. It is unclear from the resolution as written whether the Board's decision on a referred resolution or the Board's report on a referred resolution would need to be assigned to a Reference Committee for deliberation or if the intent is for the Council to deliberate directly on the Board's decision or the Board's report. Subsequently, there is the potential for re-debate/re-vote/re-referral for each referred resolution from the prior year's Council meeting.

A resolution was submitted to the Council in 2022 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. The resolution was not adopted. Testimony regarding the proposed resolution reflected that there is an existing process for such actions to be taken and a referred resolution could be resubmitted if there is dissatisfaction with the Board's actions on a referred resolution.

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

Resources and Accountability – ACEP commits to financial discipline, modern processes and transparent stewardship of resources aligned with strategic priorities most relevant to members and essential for the future of emergency. medicine.

Fiscal Impact

Budgeted committee and staff resources to develop Bylaws and Council Standing Rules amendments to be considered at the 2024 Council meeting.

Prior Council Action

Resolution 12 (22) Council Approval of Board Actions on Referred Resolutions not adopted. The resolution sought 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.

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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 19(23)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Scientific Assembly Vendor Transparency

PURPOSE: Require staffing and recruitment companies exhibiting at Scientific Assembly to bring sample contracts for physicians to review and the contracts must include information regarding non-compete clauses, due process and policies on transparency in billing and collections.

FISCAL IMPACT: Potential reduction in outside funding support should groups be denied access to exhibit at Scientific Assembly as well as possible legal expenses to respond to complaints against ACEP for such actions.

1 WHEREAS, ACEP allows vendors to advertise and recruit members for potential employment during
2 Scientific Assembly; and
3
4 WHEREAS, ACEP members seeking employment deserve transparency in the recruitment and contract
5 process; therefore be it
6
7 RESOLVED, For transparency as part of the vendor contract, vendors recruiting emergency physicians for
8 employment be required to bring sample contracts for physicians to review during Scientific Assembly exhibits and
9 the sample contracts must include stipulations relating to non-compete clauses, due process, and policies on
10 transparency in billing/collections.

Background

This resolution calls for ACEP to require staffing and recruitment companies exhibiting at Scientific Assembly to bring sample contracts for physicians to review and the contracts must include information regarding non-compete clauses, due process and policies on transparency in billing and collections.

As part of the exhibitor application process, ACEP includes an employer profile survey for staffing and recruitment companies to complete. The survey, developed in consultation with outside counsel and approved by the ACEP Board of Directors, requests information regarding the group's governance structure, transparency of their billing practices, ownership model, attestation to ACEP's policies, as well as other non-competitive information. While companies are required to complete the survey, no questions are mandatory and no answers will prohibit a company from exhibiting.

Contracting and employment resources are available on the ACEP website to assist members. An employer database is being enhanced to improve transparency between 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. In an effort to better support all members as they face unprecedented challenges in employment, 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 push back on unfair business practices, regardless of employment model or practice type. The Medical-Legal Committee developed 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. ACEP members also receive a 20 percent discount on services from Resolve, a partner who offers contract review, compensation data and more. Members have exclusive access to a contract toolkit that includes an extensive list of frequently asked questions about the nuances of employment agreements.

ACEP's policy statement "Emergency Physician Contractual Relationships" includes the following provisions:

Contractual Rights:

- 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.

Billing Rights:

- The emergency physician is entitled to detailed itemized reports on what is billed and collected for his or her service on at least a semi-annual basis regardless of whether or not billing and collection is assigned to another entity within the limits of state and federal law. The emergency physician shall not be asked to waive access to this information.
- Hospitals should disclose to physicians and/or the contracting vendor which networks, plans, etc. the hospital is contracting with, ie, which networks consider the hospital to be "in-network."
- It is the right of an emergency physician contracting entity to make an independent decision regarding all contractual arrangements that involve insurers and to be represented by legal counsel.
- Health care facilities should provide confidential complete transparency to the emergency physician of all facility charges that are billed as part of an emergency visit.

The Nature of the Contract:

- Business relationships that include emergency physicians are best defined within a written contract.
- The contracting parties should be ethically bound to honor the terms of any contractual agreement to which it is a party and to relate to one another in an ethical manner. This applies even if prior to the initiation of employment or in the case of deferred/delayed employment such as that of a graduating resident or fellow.
- Physician disciplinary, quality of care or credentialing issues pertaining to medical care must be reviewed and affirmed by a licensed emergency physician.
- 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 resolution requires that language be added to the contracts of the vendors recruiting emergency physicians requiring them to provide sample employee contracts at their booth(s) in the exhibit hall and further specifies what elements must be in those employment contracts. Enforcement of the resolution could be an antitrust violation.

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 based on certain criteria, 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.

ACEP's General Counsel has engaged outside counsel previously to provide legal opinion on the antitrust risk to ACEP to implement Referred Amended Resolution 44(20) Due Process in Emergency Medicine that called for ACEP to exclude or limit certain competitors from participating in the ACEP Scientific Assembly. 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 counsel 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 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 professional.

Fiscal Impact

Potential reduction in outside funding support should groups be denied access to exhibit at Scientific Assembly as well as possible legal expenses to respond to complaints against ACEP for such actions.

Prior Council Action

Amended Resolution 19(22) Due Process and Interactions with ACEP adopted (second resolved). Directed ACEP to 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. The first resolved was not adopted. It requested 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."

Amended Resolution 44(20) Due Process in Emergency Medicine referred to the Board of Directors. The resolution requested that ACEP: 1) adopt a policy prohibiting members from denying another emergency physician the right to due process regarding their medical staff privileges and prohibits members from holding management positions at

entities that deny an emergency physician this right; 2) revise the policy statement "Emergency Physician Rights and Responsibilities;" 3) adopt a new policy requiring any entity that wants to advertise, exhibit, or provide other sponsorship of any ACEP activity to remove all restrictions on due process for emergency physicians.

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.

Prior Board Action

Amended Resolution 19(22) Due Process and Interactions with ACEP adopted (second resolved).

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

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

April 2021, approved the revised policy statement "Emergency Physician Contractual Relationships;" revised and approved June 2018, October 2012, January 2006, March 1999, 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.

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

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.

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

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.

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

Jana Nelson
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Jodi Talia
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Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
Melissa W. Costello, MD, FACEP, Vice Speaker
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PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

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RESOLUTION: 20(23)

SUBMITTED BY: Kalev Freeman, MD, FACEP
Antony Hsu, MD, FACEP
James Paxton, MD, MBA, FACEP
Nicholas Vasquez, MD, FACEP

SUBJECT: Emergency Medicine Research Mentorship Network

PURPOSE: 1) Establish a formal emergency medicine research mentorship program that promptly identifies and creates collaborative ACEP-staffed networks based on academic topics including, but not limited to, patient-centered social issues, racial and gender-identity concerns, rural and non-academic research mentorship networks; 2) not be limited to either virtually only or in-person only; 3) develop multiple emergency medicine research mentorship models with support by ACEP staff with an ACEP.org-based and aligned online structure; 4) resources include, but are not limited to, constructive surveys and ACEP-staff curated anonymized feedback with an ongoing mentor development track replete with recognition of contributions and standardized mentorship training opportunities.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other projects and an additional staff member dedicated to the project. Unbudgeted costs of approximately $150,000 for salary and benefits and additional estimated costs of $50,000 to create and track the mentorship network.

1 WHEREAS, ACEP has a significant investment in promoting emergency medicine research; and
2
3 WHEREAS, Many emergency medicine residents and fellows of ACEP present a broad range of research
4 projects and findings at ACEP Scientific Assembly every year; and
5
6 WHEREAS, ACEP has many emergency physician-researchers who pursue clinical research around the
7 world at early points in their training and career looking for mentors; and
8
9 WHEREAS, The emergency physician-researchers pipeline drops off dramatically during their careers; and
10
11 WHEREAS, The number of emergency physician-researchers who are minorities in race, gender-identity and
12 nonacademic—based practice sites comprise a significant proportion of ACEP membership; and
13
14 WHEREAS, The Society of Academic Emergency Medicine does not support a research mentorship program
15 at this time; and
16
17 WHEREAS, Emergency medicine researchers do not yet have an organization-supported ongoing program
18 for research mentorship; therefore be it
19
20 RESOLVED, That ACEP establish a formal emergency medicine research mentorship program that promptly
21 identifies and creates collaborative ACEP-staffed networks based on academic topics including, but not limited to,
22 patient-centered social issues, racial and gender-identity concerns, rural and non-academic research mentorship
23 networks; and be it further
24
25 RESOLVED, That ACEP's emergency medicine research mentorship program not be limited to either
26 virtually only or in-person only; and be it further

27 RESOLVED, That ACEP develop multiple emergency medicine research mentorship models with support by
28 ACEP staff with an ACEP.org-based and aligned online structure; and be it further
29
30 RESOLVED, That ACEP's emergency medicine research mentorship resources include, but are not limited
31 to, constructive surveys and ACEP-staff curated anonymized feedback with an ongoing mentor development track
32 replete with recognition of contributions and standardized mentorship training opportunities.

Background

This resolution requests ACEP to establish a formal emergency medicine research mentorship program of ACEP-staffed networks focused on diverse academic and non-academic topics; ; that the research mentorship program not be limited to either virtually only or in-person only; develop multiple emergency medicine research mentorship models with support by ACEP staff including an aligned online structure; and provide resources including, but not limited to, constructive surveys, ACEP-staff curated anonymized feedback, ongoing mentor development track. and recognition of contributions and standardized mentorship training opportunities.

The creation of a research mentorship network would require recruiting both mentors and mentees and supporting those interactions. New resources, materials, and tools to support researchers would need to be curated and adapted from existing sources or created de novo including IT support and software.

ACEP, together with the Emergency Medicine Foundation, is a leading supporter of emergency medicine research through: educational activities and nearly $1 million dollars in grants annually; hosting of the annual Research Forum; facilitation of the longest-running emergency medicine research training course, Emergency Medicine Basic Research Skills (EMBRS); ownership and support of two of the field's most preeminent emergency medicine journals (*Annals of Emergency Medicine* and *JACEP Open*); federal and state advocacy for research funding; training and application of research-to-practice; direct pursuit of and collaboration on research (encompassing millions of dollars annually in federal and foundation funding); support for the Research, Scholarly Activity, and Innovation (RSI) Section; and more. More recently, ACEP has also created one of the largest and most detailed registries of emergency care and related infrastructure through the Emergency Medicine Data Institute (EMDI), which will serve as an unparalleled data resource for the field. Currently, ACEP staff includes a Senior Research Fellow who is a doctoral and fellowship research-trained emergency physician to help guide and support the research mission of ACEP.

ACEP has directly supported formal and informal research mentorship for more than 20 years. EMBRS is a year-long, research training program including didactics and practical workshops on research study design, protocol development, statistical analysis, grant writing, manuscript publication, research management, and research career advancement. Participants are also eligible to receive an EMF/EMBRS grant based on their research grant application as a key deliverable of the training program. Informal mentorship opportunities are supported through the RSI Section, Research Committee, and through research related events, such as the Research Forum.

ACEP recognizes that increasing the number, longevity, and diversity of emergency medicine researchers is critical to advancing emergency medicine research and in turn has dedicated resources towards this purpose. The ultimate purpose of emergency medicine research is to increase the prominence of the field and pursue the quintuple aim (i.e., improved population health, decreased health care costs, improved care experience, well workforce, promotion of equity).

> Develop an evidence-based strategy and resources to promote interest in emergency medicine research among students, residents, and faculty with the goal of increasing research training, emergency medicine research fellows, and physician-scientists, for women and individuals of racial and ethnic minority backgrounds.

Promoting research-related mentorship and mentored exposure to research is foundational. Such experiences and relationships can begin and continue throughout a prospective researcher's career from secondary education through mid or late in independent practice. Additionally, while all those who receive such mentorship may not pursue research-oriented careers, it is likely that they decide to enter the field of emergency medicine at a higher rate; suggesting a secondary benefit that is relevant given recent recruitment challenges to the field. Furthermore,

developing more emergency physician researchers offers a path to expand career options in the context of workforce concerns and may provide for greater career longevity and job satisfaction. Most major academic institutions provide numerous resources, support, and infrastructure to develop researchers locally. This investment in developing and supporting researchers can benefit the institutions directly when the investigators receive federal funding since part of the award goes to the institution.

The NIH funds more than 60 academic medical centers around the country through a program called the Clinical and Translational Science Award (CTSA) administered by the National Center for Advancing Translational Sciences (NCATS).[3] The goal of the CTSA is to help institutions create an integrated academic home for clinical and translational science with the resources to support researchers and research teams working to apply new knowledge and techniques to patient care. This funding specifically focuses on providing the infrastructure and resources to support research separate from any research an institution/investigator might receive. The total budget for FY 2023 is over $800 million dollars.

The Society for Academic Emergency Medicine (SAEM) offers numerous research mentorship opportunities and resources for investigators. SAEM maintains and tracks lists of federal funding in emergency medicine and has a variety of educational offerings throughout the year and at their annual meeting. SAEM has developed extensive online resources for emergency medicine researchers, including a tool to help connect researchers with similar areas of focus called the SAEM Collaborator Connection. Collaboration between ACEP and SAEM would build complimentary resources and avoid duplication of effort.

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

Background References

[1]https://brimr.org/brimr-rankings-of-nih-funding-in-2022/
[2]Brown J. National Institutes of Health support for individual mentored career development grants in emergency medicine. Acad Emerg Med. 2014;21(11):1269–73 and Bessman SC, Agada NO, Ding R, et al. Comparing National Institutes of Health funding of emergency medicine to four medical specialties. Acad Emerg Med. 2011;18(9):1001–4.
[3]Brown J. National Institutes of Health support for individual mentored career development grants in emergency medicine. Acad Emerg Med. 2014;21(11):1269–73 and Bessman SC, Agada NO, Ding R, et al. Comparing National Institutes of Health funding of emergency medicine to four medical specialties. Acad Emerg Med. 2011;18(9):1001–4.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources from other projects and an additional staff member dedicated to the project. Unbudgeted costs of approximately $150,000 for salary and benefits and additional estimated costs of $50,000 to create and track the mentorship network.

Prior Council Action

None

Prior Board Action

January 2021, approved endorsing the 2030 National Institutes of Health Funding Goals for Emergency Medicine.

Background Information Prepared by: Martin Wegman, MD, PhD
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Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP, Speaker
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PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 21(23)

SUBMITTED BY: Emergency Medicine Residents' Association

SUBJECT: Mitigation of Competition for Procedures Between Emergency Medicine Resident Physicians and Other Learners

PURPOSE: Support EM residents right of first refusal over non-physicians, such as PAs and NPs, in performing ACGME-required procedures that are deemed medically necessary in EDs.

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

1 WHERAS, There are physicians, physician assistants, nurse practitioners, and other learners in emergency
2 departments; and
3
4 WHEREAS, Residency is an important time for resident training and procedural practice[1]; and
5
6 WHEREAS, Mastery of skills in residency is integral to developing clinical acumen[2]; and
7
8 WHEREAS, Residency training requires mastery of various procedures including airway management,
9 vascular access, laceration repair, invasive diagnostic procedures, among others[3]; and
10
11 WHEREAS, Emergency medicine residents are expected to perform a minimum required number of
12 procedures prior to graduation to be considered competent by the Accreditation Council for Graduate Medicine
13 Education (ACGME)[4]; and
14
15 WHEREAS, These procedural skills have and should continue to prioritize patient safety and be performed
16 with appropriate attending supervision; and
17
18 WHEREAS, There are an increasing number of non-physician professionals in the emergency department[5];
19 and
20
21 WHEREAS, There is a developing trend of fewer medically necessary procedures required in the emergency
22 department due to improvements in medical care and novel treatment options[5]; therefore be it
23
24 RESOLVED, That ACEP support emergency medicine resident physicians' right of first refusal over non-
25 physicians, such as physician assistants and nurse practitioners, in performing ACGME-required procedures that are
26 deemed medically necessary in emergency departments.

Resolution References

[1]Husted A, Rölfing JD, Ingeman ML, Paltved C, Ludwig M, Konge L, Nayahangan L, Jensen RD. Identifying technical skills and clinical procedures for simulation-based training in emergency medicine: A nationwide needs assessment. Am J Emerg Med. 2022 Dec;62:140-143. doi: 10.1016/j.ajem.2022.09.014. Epub 2022 Sep 15. PMID: 36167748.
[2]Tran V, Cobbett J, Brichko L. Procedural competency in emergency medicine training. Emerg Med Australas. 2018 Feb;30(1):103-106. doi: 10.1111/1742-6723.12925. Epub 2018 Jan 16. PMID: 29341458.
[3]Williams AL, Blomkalns AL, Gibler WB. Residency training in emergency medicine: the challenges of the 21st century. Keio J Med. 2004 Dec;53(4):203-9. doi: 10.2302/kjm.53.203. PMID: 15647626.
[4]Bucher, J.T., Bryczkowski, C., Wei, G. et al. Procedure rates performed by emergency medicine residents: a retrospective review. Int J Emerg Med 11, 7 (2018). https://doi.org/10.1186/s12245-018-0167-x

[5]Gisondi, Michael A. MD; Regan, Linda MD; Branzetti, Jeremy MD; Hopson, Laura R. MD. More Learners, Finite Resources, and the Changing Landscape of Procedural Training at the Bedside. Academic Medicine: May 2018 - Volume 93 - Issue 5 - p 699-704 doi: 10.1097/ACM.0000000000002062

EMRA Policy
EM resident physicians should be given priority, preference, and right of first refusal for medically necessary procedures over non-physician providers, to preserve the integrity of resident physician training.

Background

This resolution asks ACEP to adopt a position that emergency medicine residents have right of first refusal over non-physicians, such as physician assistants (PAs) and nurse practitioners (NPs) in performing ACGME-required procedures that are deemed medically necessary in emergency departments. Adopting such a position would align with EMRA's policy and current ACGME common program requirements.

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 2022-23 academic year, there are 13,066 accredited residency and fellowship programs in 182 specialties and subspecialties with 158,079 resident and fellows. Specialty-specific Review Committees create a uniform set of high standards for each accredited specialty and subspecialty applied across all accredited U.S. residency and fellowship programs educating and training physicians in those fields to ensure the highest quality physicians and patient care.[1] The ACGME does not have oversight of non-physician learners except as related to physician trainees. According to the ACGME Emergency Medicine Program Requirements[2]:

I.E. The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education. (Core)

I.E.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC). (Core)

Background and Intent:
The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.

IV.B.1.b).(2) Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.(Core)

IV.B.1.b).(2).(a) Residents must demonstrate competence in:

IV.B.1.b).(2).(a).(i) performing diagnostic and therapeutic procedures and emergency stabilization;

IV.B.1.b).(2).(a).(ii) managing critically-ill and injured patients who present to the emergency department, prioritizing critical initial stabilization action, mobilizing hospital support services in the resuscitation of critically-ill or injured patients and reassessing after a stabilizing intervention;(Core)

IV.B.1.b).(2).(a).(iii) properly sequencing critical actions for patient care and generating a differential diagnosis for an undifferentiated patient; (Core)

IV.B.1.b).(2).(a).(iv) mobilizing and managing necessary personnel and other hospital resources to meet critical needs of multiple patients; and, (Core)
IV.B.1.b).(2).(a).(v) performing invasive procedures, monitoring unstable patients, and directing major resuscitations of all types on all age groups.(Core)

IV.B.1.b).(2).(b) Residents must perform indicated procedures on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation, take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)

IV.B.1.b).(2).(c) Residents must demonstrate competence in performing the following key index procedures:
IV.B.1.b).(2).(c).(i) adult medical resuscitation; (Core)
IV.B.1.b).(2).(c).(ii) adult trauma resuscitation; (Core)
IV.B.1.b).(2).(c).(iii) anesthesia and pain management; (Core)
IV.B.1.b).(2).(c).(iv) cardiac pacing; (Core)
IV.B.1.b).(2).(c).(v) chest tubes; (Core)
IV.B.1.b).(2).(c).(vi) cricothyrotomy; (Core)
V.B.1.b).(2).(c).(vii) dislocation reduction; (Core)
IV.B.1.b).(2).(c).(viii) emergency department bedside ultrasound; (Core)
IV.B.1.b).(2).(c).(ix) intubations; (Core)
IV.B.1.b).(2).(c).(x) lumbar puncture; (Core)
IV.B.1.b).(2).(c).(xi) pediatric medical resuscitation; (Core)
IV.B.1.b).(2).(c).(xii) pediatric trauma resuscitation; (Core)
V.B.1.b).(2).(c).(xiii) pericardiocentesis; (Core)
IV.B.1.b).(2).(c).(xiv)procedural sedation; (Core)
IV.B.1.b).(2).(c).(xv) vaginal delivery; (Core)
IV.B.1.b).(2).(c).(xvi)vascular access; and (Core)
IV.B.1.b).(2).(c).(xvii) wound management. (Core)

Over the past few years there is increasing number of learners in EDs, including emergency medicine residents, off service residents, PAs, and NPs. Another development has been the creation of post graduate training programs in emergency medicine for both PAs and NPs. These programs are varied in location and format and often co-exist with emergency medicine residencies. Some of these programs have even referred to themselves as "residencies." While there may be abundance of certain procedures, other more critical procedures may be rarer. Additionally, some procedures such as transvenous pacing or pericardiocentesis have become rarer in the ED as the location they are being performed has shifted to the cardiac catheterization lab in some centers. All of these factors have led to increase competition for procedures among learners.[3]

A recent study published in the Western Journal of Emergency Medicine by Phillips et al. report the results of a survey of EM residents on the effects of Non-physician Practitioners (NPP) on emergency medicine physician resident education. The survey was distributed to 1,168 emergency medicine residents across the country and received 393 responses. 66.9% residents reported a detracting or greatly detracting impact on their education caused by NPP presence in training facilities. The survey also identified a significant loss of procedure opportunities, which was greatest at facilities that included postgraduate training programs for NPPs, where emergency physician residents reported a 14x increased loss of procedure opportunities. Even more concerning was the finding that, 33.5% residents reported feeling "not confident at all" in their ability to report concerns about NPPs to local leadership without retribution, and 65.2% reported feeling "not confident at all" regarding confidence in the Accreditation Council for Graduate Medical Education to satisfactorily address concerns about NPPs raised in the end-of-year survey.[4]

Background References

[1] https://www.acgme.org/about-us/overview/
[2] https://www.acgme.org/globalassets/pfassets/programrequirements/110_emergencymedicine_2022.pdf

[3] Gisondi MA, Regan L, Branzetti J, Hopson LR. More Learners, Finite Resources, and the Changing Landscape of Procedural Training at the Bedside. Acad Med. 2018 May;93(5):699-704. doi: 10.1097/ACM.0000000000002062. PMID: 29166352.
[4] Phillips AW, Sites JP, Quenzer FC, Lercher DM. Effects of Non-physician Practitioners on Emergency Medicine Physician Resident Education. West J Emerg Med. 2023 May 3;24(3):588-596. doi: 10.5811/westjem.58759. PMID: 37278773; PMCID: PMC10284528.

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 professional

Fiscal Impact

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

Prior Council Action

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistant adopted. The resolution called for ACEP to revise the current policy statement "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.

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 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. 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.

Substitute Resolution 43(91) Development of New Residency Programs adopted. The resolution directed ACEP to strongly encourage the Residency Review Committee for Emergency Medicine to consistently apply existing special

requirements used in reviewing prospective emergency medicine residency programs and meet with the ACGME to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted. Directed ACEP to promote the expansion of existing and the development of additional emergency medicine programs, particularly in those areas of emergency physician shortage.

Prior Board Action

June 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022; 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."

June 2023 approved the revised policy statement "Guidelines for Undergraduate Education in Emergency Medicine;" revised March 2022, June 2021, June 2015 and April 2008; reaffirmed October 2001; revised January 1997; originally approved September 1986.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistant adopted.

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.

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.

Amended Substitute Resolution 43(91) Development of New Residency Programs. The Board amended the substitute resolution adopted by the Council. The amended substitute resolution directed ACEP to meet with the Residency Review Committee for Emergency Medicine (RRC-EM) to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce & 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 22(23)

SUBMITTED BY: Emergency Medicine Residents' Association

SUBJECT: Supporting 3-Year and 4-Year Emergency Medicine Residency Program Accreditation

PURPOSE: Support continued accreditation of both three-year and four-year residency program training formats.

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

1 WHEREAS, Emergency Medicine residencies have included three-year and four-year programs since the
2 1980s[1]; and
3
4 WHEREAS, A 2023 ABEM study published in *JACEP Open* compared ACGME Milestones data and ABEM
5 test performance of emergency physicians completing three- and four-year residencies concluded the "results do not
6 provide sufficient evidence to make a confident determination of the superiority of one training duration compared
7 with the other"[2]; and
8
9 WHEREAS, A 2023 study in the *American Journal of Emergency Medicine* utilized data from over one
10 million patient encounters by three-year graduates, four-year graduates, and experienced new hires found similar
11 performance on "measures of clinical care and practice patterns related to efficiency, safety, and flow" among the
12 three groups; ultimately concluded the results did not support recommending one length of training over the other[3];
13 and
14
15 WHEREAS, There is no clear evidence from existing literature that either three- or four-year programs are
16 superior or noninferior to the other; and
17
18 WHEREAS, Any change to length of training requirements in emergency medicine should be evidence-
19 based; therefore be it
20
21 RESOLVED, That ACEP recognizes the value of choice in emergency medicine residency training formats
22 and supports the continued accreditation of both three-year and four-year emergency medicine residency programs.

References

1. Sloan EP, Strange GR, Jayne HA. United States emergency medicine residency length in 1986-87 and 1987-88. Ann Emerg Med 1987;16:862–6.
2. Beeson, MS, Barton, MA, Reisdorff, EJ, et al. Comparison of performance data between emergency medicine 1-3 and 1-4 program formats. JACEP Open. 2023; 4:e12991. https://doi.org/10.1002/emp2.12991
3. Nikolla DA, Zocchi MS, Pines JM, et al. Four- and three-year emergency medicine residency graduates perform similarly in their first year of practice compared to experienced physicians. Am J Emerg Med. Apr 15 2023;69:100-107.

EMRA Policy

EMRA recognizes the value of choice in emergency medicine residency training formats. EMRA urges the continued accreditation of three-year and four-year formats.

Background

This resolution calls for ACEP to support continued accreditation of three-year and four-year residency training program formats.

Currently, the Accreditation Council for Graduate Medical Education (ACGME), which accredits emergency medicine residency programs, has standards[1] that state:

> "Residency programs in emergency medicine are configured in 36-month and 48-month formats and must include a minimum of 36 months of clinical education."

The requirements additionally specify that:

> "Programs utilizing the 48-month format must ensure that all of the clinical, educational, and milestone elements contained in these Program Requirements are met and must provide additional in-depth experience in areas related to emergency medicine, such as medical education, clinical- or laboratory-based research, or global health. An educational justification describing the additional educational goals and outcomes to be achieved by residents in the incremental 12 months of education must be submitted to the Review Committee prior to implementation, and at each subsequent accreditation review of residency programs of 48 months' duration."

As of the academic year 2021-22 there were 276 programs and 80% of programs were three years in length. A review of the ACGME program requirements of the 27 primary specialties demonstrates that emergency medicine is one of the few specialties that has two different length of training formats. The ACGME is currently in the process of a major revision to the program requirements for Emergency Medicine which is a process that occurs every 10 years.[2]

A 2016 study surveyed emergency medicine program directors on their opinion of the ideal length of training for emergency medicine programs. The mean length of training was 41.5 months (SD = 5.5, range = 36 to 60 months).[3] A 2023 study by the American Board of Emergency Medicine (ABEM) examined performance of three-year versus four-year residents. ACGME Milestones and ABEM In-training Examination (ITE), Qualifying Examination (QE), Oral Certification Examination (OCE), and program extensions from three-year and four-year residency programs showed slight differences of uncertain significance.[4]

Measure	3-year Graduate	4-year graduate	P value
Milestones	3.51	3.67	<0.001
ITE Score	79.7	80.3	0.01
QE Score	83.5	83.0	<0.001
QE Pass Rate	93.1	90/8	<0.001
OE Score	5.65	5.67	0.03
OE Pass Rate	95.5	96.9	0.06
Program Extension	91.9	90.4	0.05

Another study examined more than one million encounters by 70 three-year graduates, 39 four-year graduates, and 476 experienced attendings found that measures of clinical care and practice patterns related to efficiency, safety, and flow. Length of stay, patients per hour, RVUs, and 72-hour returns were similar for all three groups although slight variations were found.[5]

In 2021, ACEP convened a workgroup of representatives from eight Emergency Medicine organizations (ACEP, AACEM, ACOEP, SAEM, CORD-EM, AAEM, EMRA, RAMS) to consider the optimal training and skills needed to prepare medical students entering the field of emergency medicine for future practice in the field. This was done in advance of the scheduled review and major revision of the emergency medicine program requirements according to ACGME timeline. Individuals reviewed the available formal and gray literature on selected topics both within and beyond emergency medicine, as appropriate as selected by the group. A detailed analysis was presented at biweekly virtual meetings over a six month period. At these sessions, each topic was thoroughly vetted by the entire group before a final consensus recommendation was developed. The individual recommendations were compiled and provided to the ACGME, Discussion of 3 year versus 4 year versus competency-based duration of training was robust and the committee did not reach a consensus recommendation for the optimal length of training. Instead, it was recommended that future length of training should be based on curriculum requirements for the future and time needed to achieve

competency in them. Passage of this resolution to support continuation of both 3 and 4 year formats would align with the multiorganizational report.

Emergency medicine has seen a dramatic rise in emergency medicine residencies in the past 10 years. The 2023 match also saw an unprecedented number of unfilled spots, with 554 of 3,010 (18.4%) PGY-1 positions at 131 of 276 (47%) emergency medicine programs going unfilled.[6] There has been speculation by some that moving to an all 4-year format will help address the rapid growth of emergency medicine residencies and workforce issues. Others speculate that an all 4-year format will tip the financial incentives in favor of further expansion of residencies. In an all 4-year model, CMS would be obligated to provide additional funding to cover the additional year of training. It is unclear whether programs would keep the same total number residents and spread them out over 4 years, meaning a smaller class size, or whether programs would add an additional year with the same class size. As such, the workforce impact of moving to an all 4-year format is unknown.

Background References

1. ACGME Program Requirements for Graduate Medical Education in Emergency Medicine https://www.acgme.org/globalassets/pfassets/programrequirements/110_emergencymedicine_2023.pdf accessed 8/14/2023
2. Shaping GME: The Future of Emergency Medicine https://www.acgme.org/globalassets/pfassets/reviewandcomment/emergencymedicinethemesinsights.pdf accessed 8/14/2023
3. Hopson L, Regan L, Gisondi MA, Cranford JA, Branzetti J. Program Director Opinion on the Ideal Length of Residency Training in Emergency Medicine. Acad Emerg Med. 2016 Jul;23(7):823-7. doi: 10.1111/acem.12968. Epub 2016 Jun 20. PMID: 26999762.
4. Beeson MS, Barton MA, Reisdorff EJ, et al. Comparison of performance data between emergency medicine 1-3 and 1-4 program formats. *J Am Coll Emerg Physicians Open*. Jun 2023;4(3):e12991.
5. Nikolla DA, Zocchi MS, Pines JM, et al. Four- and three-year emergency medicine residency graduates perform similarly in their first year of practice compared to experienced physicians. *Am J Emerg Med*. Apr 15 2023;69:100-107.
6. Preiksaitis C, Krzyzaniak S, Bowers K, Little A, Gottlieb M, Mannix A, Gisondi MA, Chan TM, Lin M. Characteristics of Emergency Medicine Residency Programs With Unfilled Positions in the 2023 Match. Ann Emerg Med. 2023 Jul 11:S0196-0644(23)00429-8. doi: 10.1016/j.annemergmed.2023.06.002. Epub ahead of print. PMID: 37436344.

ACEP Strategic Plan Reference

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

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

Prior Council Action

Resolution 48(20) Residency Program Expansion referred to the Board of Directors. Requested ACEP to engage the ACGME and other stakeholders to construct objective criteria for new residency accreditation considering workforce needs, competitive advantages and disadvantages, geographic distribution, and demand for physicians.

Amended Resolution 15(09) Emergency Medicine Workforce Solutions adopted. Directed ACEP to address workforce shortages and lobby for the removal of barriers to increasing the number of residency slots available in emergency medicine. Also directed ACEP to investigate broadening access to ACGME or AOA accredited emergency medicine residency programs to physicians who have previously trained in another specialty.

Amended Substitute Resolution 24(01) Work Force Shortage in Emergency Medicine adopted. Directed ACEP to work with other emergency medicine organizations to use existing workforce data to identify current and future needs for board certified emergency physicians, recommend strategies based on the projected need to ensure appropriate numbers of emergency medicine residency graduates meet the need, and advocate to eliminate barriers to create adequate numbers of emergency medicine residency positions and achieve optimal funding for those positions.

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted. Directed ACEP to continue long-range planning for projecting emergency physician needs based on patient visits and physician attrition and continue to

work toward preservation of adequate numbers of residency positions in emergency medicine, and to continue intensive lobbying efforts to preserve funding for adequate numbers of residency positions in emergency medicine.

Resolution 28(92) Emergency Medicine Residency Training Pilot Program not adopted. The resolution called on ACEP to facilitate, develop, and pilot a model training program in emergency medicine designed to allow practicing emergency physicians who completed training in other specialties to meet the requirements of the RRC-EM and become eligible for the ABEM exam. The pilot programs would be completed in a timely manner, through part-time and independent work, while in practice.

Substitute Resolution 43(91) Development of New Residency Programs adopted. The resolution directed ACEP to strongly encourage the Residency Review Committee for Emergency Medicine to consistently apply existing special requirements used in reviewing prospective emergency medicine residency programs and meet with the ACGME to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted. Directed ACEP to promote the expansion of existing and the development of additional emergency medicine programs, particularly in those areas of emergency physician shortage.

Prior Board Action

January 2021, appointed a multi-organization ACGME Emergency Medicine Requirements Consensus Task Force appointed to develop recommendations in response to Referred Resolution 48(20) Residency Program Expansion.

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

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

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

Amended Resolution 65(95) Residency Positions in Emergency Medicine adopted.

Amended Substitute Resolution 43(91) Development of New Residency Programs adopted. The Board amended the substitute resolution to meet with the Residency Review Committee for Emergency Medicine (RRC-EM) to explore effective means for facilitating new residency program accreditation.

Amended Resolution 17(90) Emergency Medicine Residency Training Programs adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce & 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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RESOLUTION: 23(23)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Opposing Sale-Leaseback Transactions by Health Systems

PURPOSE: Advocate for regulatory agencies and other entities, as appropriate, to closely monitor, discourage, and oppose sale-leaseback transactions involving health systems, ensuring transparency, accountability, and consideration of the long-term impact on patient care and health care infrastructure.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort.

1 WHEREAS, Health systems are increasingly engaging in sale-leaseback transactions, wherein they sell their
2 owned properties to third-party investors and then lease them back for continued use; and
3
4 WHEREAS, Sale-leaseback transactions by health systems are primarily driven by the desire to raise capital
5 quickly, resulting in a short-term financial gain for the health system while potentially compromising the long-term
6 stability and accessibility of health care services; and
7
8 WHEREAS, The sale-leaseback model often leads to increased operational costs for health care providers due
9 to the need to pay lease fees, potentially diverting resources away from patient care and other critical health care
10 investments; and
11
12 WHEREAS, Sale-leaseback transactions can limit the control and flexibility of health systems over their
13 facilities, as decisions regarding facility management and improvements are subject to the terms and conditions set by
14 the third-party investors; and
15
16 WHEREAS, The prioritization of financial gains through sale-leaseback transactions may incentivize health
17 systems to make decisions that are not aligned with the best interests of patients, potentially compromising the quality
18 and continuity of care provided; and
19
20 WHEREAS, The sale-leaseback model can negatively impact the stability and accessibility of health care
21 services, particularly in underserved communities where the closure or downsizing of health care facilities could
22 result in limited access to essential medical services; and
23
24 WHEREAS, The sale-leaseback of Hahnemann University Hospital, located within steps of this Council
25 meeting, was instrumental in the collapse of a health care institution that spanned three centuries; therefore be it
26
27 RESOLVED, That ACEP advocate for regulatory agencies and other entities, as appropriate, to closely
28 monitor, discourage, and oppose sale-leaseback transactions involving health systems, ensuring transparency,
29 accountability, and consideration of the long-term impact on patient care and health care infrastructure.

Background

This resolution directs ACEP to advocate for regulatory agencies and other entities, as appropriate, to closely monitor, discourage, and oppose sale-leaseback transactions involving health systems, ensuring transparency, accountability, and consideration of the long-term impact on patient care and health care infrastructure.

The sale and subsequent closing of Hahnemann University Hospital in Philadelphia, PA in 2019 resulted in the loss of a critical safety net hospital and created significant disruption in the training of more than 570 residents and fellows, including emergency physicians. Considered the "largest displacement of medical residents in a single event ever"[1], residency program slots and their associated funding was subsequently used by the hospital system and its debtors as an asset that could be traded or sold. Despite the Affordable Care Act (ACA) laying out the process for redistributing medical residency slots when a hospital closes, the disruption to current residents was unavoidable and significant.

The company that acquired Hahnemann, "Medical Properties Trust, Inc.(MPT), is a self-advised real estate investment trust formed in 2003 to acquire and develop net-leased hospital facilities. From its inception in Birmingham, AL, the company has grown to become one of the world's largest owners of hospitals with 444 facilities and roughly 47,000 licensed beds in nine countries and across four continents on a pro forma basis. MPT's financing model facilitates acquisitions and recapitalizations and allows operators of hospitals to unlock the value of their real estate assets to fund facility improvements, technology upgrades and other investments in operations." This worrisome trend puts innumerable health care facilities at risk for insolvency.

As a result of the closing of Hahnemann and other local hospitals with sale-leasebacks, Pennsylvania lawmakers plan to introduce legislation that would place a moratorium on private equity and other firms from buying hospitals in the state. Lawmakers would also prohibit owners from taking out dividends within two years of an acquisition and limit sale-leaseback transactions.

Several states have taken unprecedented legal actions to prevent hospital closure due to ownership changes. Rhode Island's attorney general was one of the first to conditionally approve a transaction that would allow a change in ownership of two safety net hospitals in 2021. Illinois introduced legislation to enforce monetary penalties for any critical access hospital that closes due to a failed sale-leaseback transaction by a health system.

Persistent labor shortages and inflation concerns over the past three years have left the majority of the 5,000+ hospitals in the U.S. unprofitable. As a result, leaseback of hospital buildings and infrastructure has been on the rise. Concerns about the potential diversion of resources away from patient care and limitations on the flexibility of for-profit health systems to make sustainable long-term financial decisions, still need to be addressed at the state and federal level.

This resolution asks for investment of ACEP resources in advocating for outside agencies to monitor and discourage and oppose hospital sale-leaseback transactions. There is not a specific ask related to emergency medicine specifically or even physicians in general. Additionally, this is an issue where many of ACEP's advocacy partners, including the American Medical Association (AMA) in collaboration with the Association of American Medical Colleges (AAMC)[1], American Association of Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council for Graduate Medical Education (ACGME), have existing policy and advocacy efforts that are ongoing and specific to their physician members and trainees.[2]

Backround References

[1] https://www.aamc.org/news/what-residents-need-know-about-hahnemann-university-hospital-closure
[2] https://www.ama-assn.org/press-center/press-releases/ama-statement-hahnemann-university-hospital-closure-settlement

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 professional.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources from other advocacy work to support this effort.

Prior Council Action

None

Prior Board Action

None

Background Information Prepared by: Adam Krushinskie
Director, State Government Relations

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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RESOLUTION: 24(23)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Addressing the Growing Epidemic of Pediatric Cannabis Exposure

PURPOSE: Advocate for changes in cannabis product packaging to prevent resemblance to non-cannabis products marketed towards children, while also appealing to regulatory bodies for labeling regulations to reduce accidental ingestion by young children and ensure clear dosing information and risk communication for cannabis products consumed by children.

FISCAL IMPACT: Cannabis labeling is not a current advocacy initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources for federal or state advocacy initiatives to support this effort.

1 WHEREAS, Recent studies have shown a rapid increase in unintentional cannabis exposures among young
2 children, posing significant toxicity risks and leading to a rising number of hospitalizations; and
3
4 WHEREAS, Pediatric cannabis exposure can have serious consequences for the health and well-being of
5 young children, necessitating proactive measures to prevent and mitigate such exposures; and
6
7 WHEREAS, Prioritizing prevention strategies is essential in reducing pediatric cannabis exposures; and
8
9 WHEREAS, ACEP plays a crucial role in promoting patient safety, public health, and advancing emergency
10 medicine; therefore be it
11
12 RESOLVED That ACEP advocate for changes in product packaging so as not to resemble non-cannabis
13 containing products, i.e., candy commonly marketed towards children; and be it further
14
15 RESOLVED, That ACEP appeal to regulatory bodies and public health agencies for labeling regulations to
16 reduce the likelihood of accidental ingestion by young children and clearly communicate dosing information as well
17 as the potential risks to children associated with cannabis products.

Background

This resolution calls for the College to push for changes in cannabis product packaging to avoid any resemblance to non-cannabis products, particularly those marketed towards children. Additionally, the resolution directs the College to appeal to regulatory bodies and public health agencies to implement labeling regulations to reduce the likelihood of accidental ingestion of cannabis products by young children and clearly communicate dosing information as well as the potential risks associated with cannabis products.

According to the National Conference of State Legislatures, as of April 24, 2023, medical use of cannabis is legalized in 38 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). As of June 1, 2023, recreational use of cannabis is legal in 23 states, the District of Columbia, the Northern Mariana Islands, and Guam; 27 states and D.C. have decriminalized small amounts of marijuana.

Although the use of cannabis remains illegal federally, some of its derivative compounds have been approved by the Food and Drug Administration (FDA) for prescription use. Cannabidiol derived from industrial hemp is legal at the federal level for non-prescription use, but legality and enforcement vary by state. A systematic review of the literature

shows that as cannabis legalization, availability, and potency increase so does the possibility of increasing unintentional pediatric cannabis intoxication and associated hospitalization.[1]

As cannabis continues to be prevalent in the United States, addressing the rise in pediatric cannabis exposure effectively remains a critical public health challenge. Recent studies have revealed increases in pediatric cannabis exposure incidents, resulting in significant toxicity risks and a subsequent rise in hospitalizations among this population.[2] Among various forms of marijuana, edible products containing cannabis extracts pose a unique risk to youth due to their attractive appearance, often closely resembling candies, cookies, and drinks. This resemblance to regular food items and lack the typical smell and visible smoke associated with inhaled marijuana makes them inconspicuous and appealing to adolescents. Greater accessibility and palatability have contributed to their growing popularity among young individuals. Moreover, manufacturers often design the packaging of edible products to closely resemble mainstream foods, further increasing the likelihood of accidental ingestion.

The effects of edible marijuana products take longer to manifest compared to inhaled forms. The cannabis compounds must be digested before entering the bloodstream, resulting in a delayed onset of effects. This delay can lead to unintentional overconsumption, as users may consume more, believing the product to be ineffective. The psychoactive compound in cannabis, delta-9-tetrahydrocannabinol (THC), can cause adverse effects, such as impaired motor function, respiratory distress, and even seizures in young children who accidentally consume these products.[3] In the first half of 2021, poison control centers have managed 2,158 cases related to cannabidiol. Some of these were related to additional drugs, or adulteration with a synthetic cannabinoid.[4] Between 2017 and 2018, Utah reported 52 cases of poisoning from ingestion of CBD oil that produced symptoms that included hallucinations, nausea, vomiting, seizures, and loss of consciousness.[5]

The increasing prevalence of cannabis use in the United States has brought attention to potential adverse effects, especially in children and adolescents. In 2023, the Centers for Disease Control and Prevention (CDC) conducted a study examining trends in cannabis-involved emergency department (ED) visits among individuals aged 25 years and younger, comparing the period before and during the COVID-19 pandemic.[6] The study analyzed data from the CDC's National Syndromic Surveillance Program covering the period from December 30, 2018, to January 1, 2023. The findings revealed a significant total of 539,106 cannabis-involved ED visits among individuals aged <25 years, highlighting an average rate of 64.9 visits per 10,000 ED visits. During the COVID-19 pandemic,[6] the study observed a spike in weekly cannabis-involved ED visits, particularly among children aged ≤10 years. The numbers ranged from 30.4 to 71.5 in the years 2020, 2021, and 2022, compared to 18.7 to 23.2 during the pre-pandemic period. This notable increase in visits points to a trend of heightened cannabis-related incidents among younger children during the pandemic, potentially influenced by changes in home environments and easier accessibility to cannabis products.

The study also uncovered patterns among youths aged 11-14 years, where cannabis-involved ED visits showed an upward trend starting in 2020. The peak of these visits (209.3) occurred during the second half of the 2021-22 school year. Another significant finding from the study was the sharp increase in cannabis-related ED visits among children under the age of 11, with a striking 214% rise on average from 2019 to 2022. This rise was primarily associated with accidental poisoning due to the ingestion of cannabis-infused edibles.

Some have suggested that strengthening labeling policies could play a role in reducing unintended ingestion incidents. Several states already require specific labeling and packaging requirements. These regulations vary substantially by state but generally involve specific warnings about potential harmful effects of cannabis and may include nutritional information. All states require THC content and manufacturer information, but common practices in more than 80 percent of states include providing a list of ingredients, batch number, production tracking, health warnings, and other information.[7] For instance, in Colorado, Washington, and Alaska, warning labels or accompanying material must indicate that cannabis has intoxicating effects (1 Colo. Code Regs. § 212-2, 2016; Wash. Admin. Code § 314-55-105, 2016; Alaska Admin. Code tit. 3, § 306.345, 2016).[9] Additionally, Colorado and Oregon mandate the inclusion of the state-designated universal symbol for cannabis on edibles labels (1 Colo. Code Regs. § 212-2; Or. Admin. R. 333-007-0070, 2016) and require a statement that intoxicating effects may not be felt for up to two hours after consumption (1 Colo. Code Regs. § 212-2; Or. Admin. R. 333-007-0070). Furthermore, Washington and Oregon either currently or will soon require that extra informational material be provided to buyers of edibles with each sale or displayed on posters in dispensaries (Wash. Admin. Code § 314-55-105; Or. Admin. R. 333-008-1500, 2016). In Washington State, this accompanying material must include warning statements about health risks, the importance of

keeping edibles out of reach of children, potential impaired judgment, delayed activation of effects, as well as disclosures of pesticides and extraction methods (Wash. Admin. Code § 314-55-105). Some packaging requirements include mandatory child-resistance measures (Alaska, Arizona, Colorado, Connecticut, Guam, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, the Northern Mariana Islands, Oregon, and Washington). Alaska, Colorado, Hawaii, Maryland, Massachusetts, New Mexico, the Northern Mariana Islands, and Oregon, require that containers housing cannabis must be opaque. Some states also require products to be labeled as "medical use only" if they are intended for medical patients (California, Delaware, the District of Columbia, Hawaii, Illinois, Minnesota, New Jersey, and Rhode Island).[8]

Additional standards and specifications are on the horizon as well. In July 2023, the National Conference on Weights and Measures (NCWM) met to finalize basic labeling requirements for cannabis products. State and federal regulators will use these guidelines set by the NCWM and created in coordination with the American Trade Association of Cannabis and Hemp (ATACH) as model standards for definitions, packaging and labeling requirements, and storage best practices. Under the guidelines, cannabis products must indicate whether the product "Contains 0.3% or less Total Delta-9 THC" or "Contains more than 0.3% Total Delta-9 THC." Additionally, the back or side panel of cannabis packaging must feature "a declaration of the labeled cannabinoid per serving or application," with the stipulation that "the cannabinoid quantity declaration must be in milligrams." This policy will become effective January 1, 2024.[7]

In 2021, 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.

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 and resources available on demand regarding ED presentations related to marijuana:

- Deadly Spice: A CME Now Case Study
- Legal and Legit? Vices of the Young:
- Still Dope: New on the Scene 2020:
- Marijuana Risks – patient handout
- THC Management – physician handout

Background References

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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 professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Cannabis labeling is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources for federal or state advocacy initiatives to support this effort.

Prior Council Action

The Council has discussed and adopted many resolutions about cannabis, although none have focused solely on pediatric cannabis exposure.

Amended Resolution 50 (21) Complications of Marijuana Use amended and adopted. Directed ACEP to develop practice guidelines on the treatment of complications of marijuana use as seen in emergency department presentations; 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 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.

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 recommendations regarding Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED and 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).

Background Information Prepared by: Fred Essis
Congressional Lobbyist

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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 25(23)

SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, DO, 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: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources for federal and state advocacy initiatives to support these efforts and potentially additional unbudgeted costs associated with assisting chapters.

WHEREAS, In 1996 California became the first state to legalize the use of medical cannabis when citizens passed the Compassionate Use Act; and

WHEREAS, 38 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,]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

37 WHEREAS, Ryan's Law allows any hospital investigated by the federal government for using a scheduled 1
38 drug to immediately prohibit the use of medical cannabis in the hospital; and
39
40 WHEREAS, Ryan's Law was signed into law in California by Governor Newson on September 28, 2021,
41 becoming effective January 1, 2022 (Ryan's Law applies to all CA health care facilities including acute care hospitals,
42 special hospitals, skilled nursing facilities, congregate living health facilities, or hospice providers, excluding
43 chemical dependency recovery hospitals, and state hospitals); and
44
45 WHEREAS, Marin Health Medical Center became one of the first hospitals in California to implement
46 Ryan's law; and
47
48 WHEREAS, The Ryan's Law team is advocating for a version of Ryan's Law in 14 other states and the
49 United States Congress and if approved these laws will also require health care facilities and hospitals to allow
50 terminally ill patients use of some types of medical cannabis; therefore be it
51
52 RESOLVED, That ACEP support allowing patients access to medical cannabis; and be it further
53
54 RESOLVED, That ACEP endorse and support the passage of Ryan's Law across the entire United States; and
55 be it further
56
57 RESOLVED, That ACEP endorse, support, and assist ACEP chapters in the passage of Ryan's Law
58 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. A similar resolution was submitted to the Council last year with the same three resolveds.

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 to ensure that hospitals and facilities are not forced to choose between complying with state law and not federal law (or vice versa), thus 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. According to the National Conference of State Legislatures, as of April 24, 2023, medical use of cannabis is legalized in 38 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). As of June 1, 2023, recreational use of cannabis is legal in 23 states, the District of Columbia, the Northern Mariana Islands, and Guam; 27 states and D.C. have decriminalized small amounts of marijuana.

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. Although the use of cannabis remains illegal federally, some of its derivative compounds have been approved by the Food and Drug Administration (FDA) for prescription use. Cannabidiol derived from industrial hemp is legal at the federal level for non-prescription use, but legality and enforcement vary by state.

In October 2022, President Joe Biden announced three initiatives his Administration was taking to address federal marijuana policy: 1) pardoning all prior federal offenses of simple marijuana possession; urging all state governors to do the same with regard to state offenses; and, 3) directing the Secretary of Health and Human Services and the Attorney General to initiate the administrative review process to review expeditiously how marijuana is scheduled under federal law. The Administration aims to finish that review before the end of 2023.

The 2021 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 began reviewing information on the conditions where there is evidence for an association between marijuana use and ED presentations: hyperemesis, psychosis, trauma, and, possibly, dysrhythmias. An initial literature search was performed to gain understanding of the scope of existing literature on the topic and found there was limited published data. The committee was also informed that the Society for Academic Emergency Medicine's "Guidelines for Reasonable and Appropriate Care" (GRACE) program is currently working on a practice guideline for cannabis-induced hyperemesis. ACEP's Clinical Policies Committee shifted its focus to developing a systematic review of the evidence for an association between marijuana use and specific ED presentations. The committee continues to work on developing a scientific article accompanied by a best practice document.

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 and resources available on demand regarding ED presentations related to marijuana:

- Deadly Spice: A CME Now Case Study
- Legal and Legit? Vices of the Young:
- Still Dope: New on the Scene 2020:
- Marijuana Risks – patient handout

- THC Management – physician handout

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. In the 117th Congress, ACEP advocated for the "Medical Marijuana and Cannabidiol Research Expansion Act," an updated version of the legislation that was successfully passed by both chambers of Congress and signed into law on December 2, 2022. The law removes the aforementioned barriers for research, ensures an adequate supply of research-grade marijuana, and promotes the development of FDA-approved drugs derived from CBD and marijuana.

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 professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources for federal and state advocacy initiatives to support these efforts and potentially additional unbudgeted costs associated with assisting chapters.

Prior Council Action

Resolution 30(22) Compassionate Access to Medical Cannabis Act – "Ryan's Law" not adopted. The resolution requested that ACEP 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.

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 recommendations regarding Referred Resolution 30(16) Treatment of Marijuana Intoxication in the ED and 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 26(23)

SUBMITTED BY: Larry Bedard, MD, FACEP
Dan Morhaim, DO ,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: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources for federal and state advocacy initiatives to support these efforts and additional unbudgeted costs of approximately $10,000 for legislative drafting or consulting for development of model legislation.

1 WHEREAS, In 2001 Portugal became the first country to decriminalize the personal possession and use of
2 small amounts of all illicit drugs; and
3
4 WHEREAS, Since it decriminalized all illicit drugs, Portugal has seen a dramatic drops in drops in
5 problematic drug use, HIV and hepatitis infection rates, overdose deaths, drug-related crime, and incarceration rates;
6 and
7
8 WHEREAS, The following countries have decriminalized drug use: Antigua + Barbuda, Argentina, Armenia,
9 Australian States: South Australia, Australian Capital Territory, Northern Australia, Belize, Bolivia, Chile, Colombia,
10 Costa Rica, Croatia, Czech Republic, Estonia, Germany, Italy, Jamaica, Mexico, Netherlands, Paraguay, Peru, Poland,
11 Portugal, Russian Federation, South Africa, Spain, Switzerland, Uruguay, U.S. Virgin Islands; and
12
13 WHEREAS, On Election Day 2020, Oregonians overwhelmingly passed Measure 110 that made the
14 possession of small amounts of cocaine, heroin, LSD, and methamphetamine, among other drugs, punishable by a
15 civil citation – akin to a parking ticket – and a $100 fine; and
16
17 WHEREAS, Alaska, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland,
18 Massachusetts, Nevada, New Hampshire, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington
19 DC have decriminalized to some degree the personal possession and use of illicit drugs; therefore be it
20
21 RESOLVED, That ACEP endorse and support the decriminalization of the personal possession and use of
22 small amounts of all illicit drugs in the United States; and be it further
23
24 RESOLVED, That ACEP endorse and support ACEP chapters to develop and introduce state legislation that
25 decriminalizes the personal possession and use of small amounts of all illicit drugs.

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 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. A similar resolution was submitted to the Council last year that was not adopted, however, that resolution included language in both resolveds to instead make personal possession and use of small amounts of

all illicit drugs in the U.S. 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 in the 117th Congress), 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 decriminalization."

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.

Most recently, an article published in the *Washington Post* on July 7, 2023, suggests that the country's initial progress may have stalled, and that decriminalization model may need to be reexamined in the wake of rising crime rates, significant increases in visible drug use in urban areas, long delays in access to state-funded rehabilitation treatment, lack of law enforcement engagement in registration of individuals with SUD, among others. The article further notes that, "[o]verdose rates have hit 12-year highs and almost doubled in Lisbon from 2019 to 2023." Some of these

challenges also appear to have been exacerbated by the effects of the COVID-19 pandemic. Overall, these issues have led even some pro-decriminalization advocates to push for some targeted reforms to address some of the more pressing public impacts, such as limited recriminalization in urban areas, or near schools and hospitals, though other decriminalization advocates oppose such changes. The piece also quotes João Goulão, Portugal's current national drug coordinator and the architect of the country's decriminalization and drug policy, who …"admitted to the local press in December that 'what we have today no longer serves as an example to anyone.' Rather than fault the policy, however, he blames a lack of funding."

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. Some have recently pointed to Portugal's recent experience, suggesting that decriminalization may lead to "normalization," and that the initial benefits of decriminalization may reverse course as time goes on.

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. These concerns appear to have manifested in practice, with civil fines or penalties ineffective, low engagement with available community support resources and limited voluntary treatment, a lack of grant funding, with Portland experiencing a 46 percent increase in overdoses this year. 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

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

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted committee and staff resources for federal and state advocacy initiatives to support these efforts and additional unbudgeted costs of approximately $10,000 for legislative drafting or consulting for development of model legislation.

Prior Council Action

Resolution 31(22) Decriminalization of All Illicit Drugs not adopted. The resolution called for ACEP to 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

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 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 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 27(14) National Decriminalization of Possession of Marijuana for Personal and Medical Use not adopted. Directed ACEP to adopt and support policy to decriminalize possession of marijuana for personal use, support medical marijuana programs, and encourage research into its efficacy, and have the AMA Section Council on EM submit a resolution for national action on decriminalization for possession of marijuana for personal and medical use.

Amended Resolution 19(14) Cannabis Recommendations by Emergency Physicians not adopted. The original resolution called for ACEP to support emergency physician rights to recommend medical marijuana where it is legal; object to any punishment or denial of rights and privileges at the state or federal level for emergency physicians who recommend medical marijuana; and support research for medical uses, risks, and benefits of marijuana. The amended resolution directed ACEP to support research into the medical uses, risks, and benefits of marijuana.

Resolution 23(13) Legalization and Taxation of Marijuana for both Adult and Medicinal Use not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 25(11) Regulate Marijuana Like Tobacco not adopted. This resolution would have revised ACEP policy on tobacco products to apply to marijuana or cannabis.

Resolution 20(10) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana.

Resolution 16(10) Classification Schedule of Marijuana as a Controlled Substance not adopted. The resolution requested ACEP to convene a Marijuana Technical Advisory Committee to advocate for change in the classification status of marijuana from a DEA Schedule I to a Schedule II drug.

Resolution 16(09) Legalization and Taxation of Marijuana not adopted. This resolution requested ACEP to support, endorse, and advocate for the legalization and taxation of marijuana and for a trust fund to be established using tax revenue from marijuana sales that would fund research and treatment of drugs and alcohol dependence.

Prior Board Action

June 2019, approved the policy statement "Medical Cannabis."

Amended Resolution 36(18) ACEP Policy Related to Medical Cannabis adopted.

June 2017, approved the Emergency Medicine Practice Committee's recommendation to take no further action on Resolveds 1, 2, and 4 and approved their recommendations for Resolved 3 (assign to the Tox Section or other body for additional work) and Resolved 5 (educate ED providers to document diagnosis of marijuana intoxication and subsequent efforts be made to correlate said diagnosis with concerning emergent presentations, including those in high-risk populations such as children, pregnant patients, and those with mental illness. Once that data is obtained, ACEP can then appropriately focus on determining what resources are needed to coordinate treatment of marijuana intoxication).

June 2017, adopted the recommendation of the Emergency Medicine Practice Committee, Medical-Legal Committee, and the Public Health & Injury Prevention Committees to take no further action on Referred Resolution 10(16) Criminal Justice Reform – National Decriminalization of Possession of Small Amounts of Marijuana for Personal Use.

Background Information Prepared by: 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

2023 Council Meeting
Reference Committee Members

Reference Committee B – Advocacy & Public Policy
Resolutions 27-42

Diana Nordlund, DO, JD, FACEP (MI) – Chair
Lisa M. Bundy, MD, FACEP (MS)
Puneet Gupta, MD, FACEP (CA)
Joshua S. da Silva, MD (GS)
Torree M. McGowan, MD, FACEP (GS)
Michael Ruzek, DO, FACEP (NJ)

Erin Grossman
Ryan McBride, MPP

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 27(23)

SUBMITTED BY: Rural Emergency Medicine Section
Social Emergency Medicine Section
Arizona Chapter
California Chapter
Colorado Chapter
New Mexico Chapter
Oklahoma Chapter
Vermont Chapter
Washington Chapter

SUBJECT: Addressing Interhospital Transfer Challenges for Rural EDs

PURPOSE: 1) Work with state and federal agencies to create state and regional transfer coordination centers; 2) advocate for state and federal requirements for tertiary centers to have a regional process for the rapid acceptance of patients from rural hospitals; 3) advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities; 4) support research to strengthen evidence-based rural hospital transfer processes; and 5) create a task force to examine current models and existing research yielding detailed recommendations for ACEP advocacy efforts.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources for federal and state advocacy initiatives to support these efforts. Additionally, it would require unbudgeted costs of $50,000 – $100,000 to collect and analyze data and conduct a comprehensive study, unbudgeted staff resources for supporting a task force, and unbudgeted funds of a minimum of $10,000 for convening an in-person task force meeting.

1 WHEREAS, Rural hospitals bear a great burden of transferring complex or critically ill patients, with up to
2 15% of Emergency Department (ED) visits to rural hospitals resulting in transfer; and

3 WHEREAS, Crowding and boarding at tertiary and academic EDs is an impediment to transfer of patients to
4 these hospitals which provide critical treatments and interventions for patients with time-sensitive conditions; and
5
6 WHEREAS, The current process of finding an accepting hospital for these patients is uncoordinated,
7 inefficient, and time-consuming, taking physicians away from their roles caring for other emergent patients; and
8
9 WHEREAS, Delays or failure to transfer rural patients can harm patients with time-sensitive conditions
10 because delay in access to life-saving interventions, which would otherwise reduce rural patient morbidity and
11 mortality, can violate the principle of justice; and
12
13 WHEREAS, There is no systematic data collected on transfers, which are critical to inform national and
14 regional policy on transfers and bed capacity, particularly during surges; and
15
16 WHEREAS, Several models exist to address this problem, which can be scaled regionally and nationally, in
17 particular, the Arizona REACH, Washington Medical Coordination Center, and the Office of the Administration for
18 Preparedness and Response (ASPR) Medical Operations Coordination Centers; therefore be it
19
20 RESOLVED, That ACEP work with state and federal agencies to create state and regional transfer
21 coordination centers to facilitate transfer of patients when normal transfer mechanisms are impaired by hospital and
22 ED capacity problems and to report their activities publicly; and be it further

23 RESOLVED, That ACEP advocate for state and federal requirements that tertiary centers have a regional
24 process for rapidly accepting patients from rural hospitals when the patient needs an emergency intervention not
25 available at the referring hospital, even when capacity is limited at the tertiary center; and be it further
26
27 RESOLVED, That ACEP advocate for regional dashboards with updated information on hospital specialty
28 service availability including procedural interventions and other treatment modalities (e.g., ERCP, ECMO, dialysis,
29 STEMI, interventional stroke, interventional PE, neurosurgery, acute oncologic disease) and in this region is defined
30 as patient catchment areas rather than jurisdictional boundaries; and be it further
31
32 RESOLVED, That ACEP support research to strengthen the evidence base regarding rural hospital transfer
33 processes including delays, administrative burden on sending hospitals, and clinical association with patient outcomes
34 and experience and include investigation of common challenges experienced by all small, non-networked hospitals;
35 and be it further
36
37 RESOLVED, That ACEP create a task force to examine current models and existing research yielding
38 detailed recommendations for ACEP advocacy efforts regarding interhospital transfer challenges for rural EDs and the
39 task force should:
40
41 • Examine existing and theoretical transfer models to identify best practices, including coordination of transfers
42 across state borders.
43 • Enumerate and endorse effective mechanisms to facilitate tertiary care hospitals' acceptance of patients in
44 transfer with time-sensitive conditions who are initially treated at EDs without needed services.
45 • Identify key capacity measures for public reporting of hospital capacity limitations, and propose mechanisms
46 to create and sustain appropriate state/regional dashboards.

Background

This resolution directs ACEP to work with state and federal agencies to create state and regional transfer coordination centers; advocate for state and federal requirements for tertiary centers to have a regional process for the rapid acceptance of patients from rural hospitals; advocate for regional dashboards with updated information on hospital specialty service availability including procedural interventions and other treatment modalities; support research to strengthen evidence-based rural hospital transfer processes; and create a task force to examine current models and existing research yielding detailed recommendations for ACEP advocacy efforts.

ACEP has had several rural health task forces over the past 20 years; however none specifically address rural hospital transfer processes to identify best practices. Furthermore, ACEP does not have comprehensive evidence-based data about rural EDs and has not conducted research as requested in the resolution. Since no such research has been previously conducted, and ACEP lacks access to this data, a third-party academic researcher would be required to collect this information on current and theoretical transfer models.

ACEP has advocated at the state and federal level for better coordination when transferring patients between facilities, however, the three models referenced in the resolution exist to address transfers (Arizona REACH, Washington Medical Coordination Center, and the ASPR Medical Operations Coordination Center).

ACEP's policy statement "Appropriate Interfacility Patient Transfer" addresses regional transfer policies:

> "When transfer of patients is part of a regional plan to provide optimal care at a specialized medical facility, written transfer protocols and interfacility agreements should be in place."

The policy statement does not examine existing and theoretical transfer models and does not identify best practices, including coordination of transfers across state lines.

ACEP's current legislative and regulatory priorities for the First Session of the 118th Congress include several rural emergency care initiatives although none that are specific to interhospital transfer challenges for 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.

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

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted resources for federal and state advocacy initiatives to support these efforts. Additionally it would require unbudgeted costs of $50,000 – $100,000 to collect and analyze data and conduct a comprehensive study, unbudgeted staff resources for supporting a task force, and unbudgeted funds of a minimum of $10,000 for convening an in-person task force meeting.

Prior Council Action

Amended Resolution 65(21) Rural Provider Support and a Call for Data adopted. Directed ACEP to: 1) recognize that patients presenting to rural emergency departments are a vulnerable ED patient population in the U.S. and deserve increased support; 2) support the Rural Section in collecting survey data from rural emergency departments to investigate volumes, clinician staffing patterns, and common barriers of care and staffing based on defined volumes; 3) recognize that ABEM/AOBEM-certified or eligible physicians are underrepresented in rural emergency departments and that very low volume EDs generally cannot support full-time ABEM/AOBEM-certified physicians; 4) encourage rural emergency departments to retain ABEM/AOBEM-certified physicians to serve as emergency department medical directors so there will be physician-led teams in all U.S. EDs; and 5) support and endorse rural-specific tools including telemedicine initiatives, the development of regional expedited transfer agreements, regional hub and spoke model integration, and rural specific educational tools.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to work with stakeholders within the College including the Rural Emergency Medicine Section and chapters to provide a regular mechanism to seek input from rural physicians in legislation that impacts rural communities; and seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Affairs Committee to reflect the fact that nearly half of all US EDs are located in rural areas.

Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine referred to Board. Directed ACEP to: 1) work with stakeholder groups to promote emergency medicine delivery models that increase quality and reduce costs in rural settings; 2) identify and promote existing training opportunities to help physicians and non-physicians in rural settings maintain their clinical skills; 3) develop a paper that identifies best practices and funding mechanisms to promote development of emergency medicine electives within emergency medicine residency programs; and 4) encourage research in rural emergency medicine by identifying funding sources to support research and cost savings in rural emergency medicine.

Substitute Resolution 19(08) Second Rural Workforce Task Force referred to the Board of Directors. The resolution called for the appointment of a second rural task force empowered to convene a second Rural Emergency Medicine Summit and develop recommendations for the ACEP Board.

Prior Board Action

February 2023, approved the legislative and regulatory priorities for the First Session of the 118th Congress that

include several initiatives related to rural emergency care.

June 2022, approved the revise policy statement "Rural Emergency Medical Care" with the current title; originally approved June 2017 titled "Definition of Rural Emergency Medicine."

January 2022, approved the revised policy statement, "Appropriate Interfacility Patient Transfer;" revised and approved January 2016 with current title; revised and approved February 2009, February 2002, June 1997, September 1992 titled, "Appropriate Inter-hospital Patient Transfer;" originally approved September 1989 as position statement "Principles of Appropriate Patient Transfer."

Amended Resolution 65(21) Rural Provider Support and a Call for Data 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.

January 2020, assigned Referred Resolution 40(19) Advancing Quality Care in Rural Emergency Medicine to the Rural Emergency Task Force to review and provide recommendations to the Board to address rural emergency medicine issues.

Substitute Resolution 41(19) Establish a Rural Emergency Care Advisory Board adopted. Directed ACEP to work with stakeholders within the College including the Rural Emergency Medicine Section and chapters to provide a regular mechanism to seek input from rural physicians on legislation that impacts rural communities; and to seek rural physician representation on the State Legislative/Regulatory Committee and the Federal Government Committee.

August 2017, reviewed the information paper "Delivery of Emergency Care in Rural Settings."

June 2015, accepted for information the report of the Rural Emergency Medicine Task Force.

June 2014, discussed the proposal from the Rural Emergency Medicine Section to support the Rural Emergency Medicine Education (REME) Program and appointed a Rural Emergency Medicine Task Force.

June 2009, took no further action on Referred Substitute Resolution 19(08) Second Rural Workforce Task Force because the intent of the resolution would be met by the Future of Emergency Medicine Summit.

September 2004, approved continuing the work of the Rural Task Force to complete their assigned tasks

September 2003, approved the recommendations by the Rural Emergency Summit

February 2003, approved the development of a Rural Emergency 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.

Background Information Prepared by: Adam Krushinskie
Director, State Government Relations

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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 28(23)

SUBMITTED BY: Andrew Fenton, MD, FACEP
Roneet Lev, MD, FACEP
Aimee Moulin, MD, FACEP
California Chapter

SUBJECT: Facilitating EMTALA Interhospital Transfers

PURPOSE: Work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA and support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

FISCAL IMPACT: No additional staff resources are required as the proposed action fits within currently budgeted and ongoing federal and state advocacy initiatives.

1 WHEREAS, ACEP recently wrote a letter to the White House ringing the alarm that emergency departments
2 (EDs) are in crisis: *"Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and*
3 *overwhelmed with patients waiting – waiting to be seen; waiting for admission to an inpatient bed in the hospital;*
4 *waiting to be transferred to psychiatric, skilled nursing, or other specialized facilities; or, waiting simply to return to*
5 *their nursing home,"*; and
6
7 WHEREAS, Contributing to the crisis is limited capacity at tertiary care centers and the lack of access to
8 specialist care leading to patients requiring transfer being boarded for hours or days in EDs who are unable to provide
9 definitive care; and
10
11 WHEREAS, EMTALA regulations require: "*A Medicare participating hospital that has specialized*
12 *capabilities or facilities…may not refuse to accept from a referring hospital within the boundaries of the United*
13 *States an appropriate transfer of an individual who requires such specialize capabilities or facilities if the receiving*
14 *hospital has the capacity to treat the individual." (42 CFR 489.24 (f)),"*; and
15
16 WHEREAS, ACEP's policy statement "Appropriate Interfacility Patient Transfer" states: "*When a patient*
17 *requires a higher level of care other than that provided or available at the transferring facility, a receiving facility*
18 *with the capability and capacity to provide a higher level of care may not refuse any request for transfer."*; and
19
20 WHEREAS, ACEP's policy statement *"*EMTALA and On-Call Responsibility for Emergency Department
21 Patients" states: "*All hospitals with specialized capabilities have a responsibility to accept transfer of patients when*
22 *such transfer is necessary to stabilize an emergency medical condition. Hospitals should have a means to*
23 *ensure medical staff responsibility for transfer acceptance and provision of specialized care.";*; and
24
25 WHEREAS, Because of financial and logistical issues, it is not uncommon that it is difficult to determine the
26 contact information and number for hospitals that may be able to provide higher level of care; and
27
28 WHEREAS, The California Chapter of ACEP wrote a letter to the state Department of Health Care Services
29 requesting the Department create and maintain a central list of transfer coordinator numbers for each Medicare
30 participating hospital bound by EMTALA; therefore be it
31
32 RESOLVED, That ACEP work with the American Hospital Association and appropriate agencies to compel

33 hospitals to make available to other hospitals transfer coordinator information, including contact numbers for
34 accepting transfers, for each Medicare participating hospital bound by EMTALA; and be it further
35
36 RESOLVED, That ACEP support state efforts to encourage state agencies to create and maintain a central list
37 of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare
38 participating hospital bound by EMTALA.

Background

The resolution calls for the College to work with the American Hospital Association and appropriate agencies to compel hospitals to make available to other hospitals transfer coordinator information, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA. It also directs the College to support state efforts to encourage state agencies to create and maintain a central list of transfer coordinator numbers for hospitals, including contact numbers for accepting transfers, for each Medicare participating hospital bound by EMTALA.

The resolution highlights the difficulties of determining appropriate contact information for hospitals that may be able to provide a higher, more specialized level of care based on financial and/or logistical issues. This is a particularly acute problem given the ongoing emergency department (ED) boarding crisis affecting EDs throughout the country, as well as one exacerbated throughout the COVID-19 pandemic response. The resolution cites a January 2023 letter sent by California ACEP to the California Department of Public Health, which notes:

> "…our members report difficulty determining who to contact at a given hospital to coordinate transfers. This opacity creates delays in care for the patient in need of transfer and sucks countless hours of emergency physician time into endless phone mazes diverting precious time from patients in the emergency department and stacked up waiting rooms."

The letter goes on to offer a suggested solution, proposing that the California Department of Public Health create and maintain a central list of transfer coordinator numbers for each Medicare participating hospital bound by EMTALA, ideally updated on a semi-annual basis.

Delays and inefficiencies in the transfer process may negatively affect patient outcomes and contribute to growing frustration and burnout for physicians and health care providers. A Becker's Hospital Review white paper (sponsored by Conduit Health Partners, an outsource organization whose services include patient transfer coordination) notes that, "[p]hysician frustration during the referral process can contribute to a poor patient experience, slower time to transfer, or patients leaving the organization…" Some hospitals employ dedicated call centers or patient transfer coordination partners to facilitate transfers and coordinate communications between physicians. Overall, there is limited information on interhospital transfers broadly and varying levels of effectiveness of dedicated call centers or related services.

Over the course of the past year, ACEP's federal advocacy has focused on raising awareness of the ED boarding crisis and developing both legislative and regulatory solutions to help ease this multifactorial challenge. Improving coordination between hospitals and health systems is a key component of this effort. One of the policy suggestions ACEP has proposed as an operational modification is a new Centers for Medicare & Medicaid Services (CMS) condition of participation (COP) that would require hospitals to develop contingency plans when inpatient occupancy exceeds 85 percent (or similar threshold as appropriate), including a load balancing plan and an identification and utilization plan of alternative space and staffing for inpatients when greater than a certain percentage of ED licensed bed capacity is occupied. As part of this continued initiative, ACEP is hosting an ED Boarding Summit on September 27, 2023, and stakeholder invitees include the American Hospital Association, America's Essential Hospitals, federal health care entities, and many others,

Additionally, similar efforts have been central to ACEP federal advocacy in response to the COVID-19 pandemic and related work to prepare for future pandemics, natural disasters, manmade disasters, and other mass casualty events

(such as the reauthorization of the Pandemic and All Hazards Preparedness Act, or PAHPA). ACEP has partnered with the American College of Surgeons Committee on Trauma (ACS-COT) in the development of a blueprint for a coordinated National Trauma and Emergency Preparedness System (NTEPS) that can provide awareness of resources and surge capacity throughout the health care system, as well as the ability to load balance the system to match patients with appropriate resources and specialty expertise. This would be operationalized on a framework of interconnected network of Regional Medical Operations Coordination Centers (RMOCCs) to improve regional care delivery by facilitating the most appropriate level of care based on individual patient acuity, while also maintaining patient safety and keeping patients in local facilities that are capable of providing high quality care. While this effort is designed around bolstering emergency/trauma response systems, the fundamental structures and improved coordination would also serve to strengthen everyday "normal" coordination and communication between hospitals and health systems in a given region.

ACEP has developed Emergency Department Boarding and Crowding resources on the website, including policy solutions to ED boarding, that include links to relevant information papers, policy statements, resources regarding state approaches, and other resources. ACEP's current legislative and regulatory priorities include:

- Develop and promote legislative efforts to address ED boarding and crowding crisis.
- Continue to advocate to CMS and other agencies for measures, reimbursement changes, and other regulatory strategies to help address the boarding and crowding crisis.
- Seek expansion of outpatient and inpatient psychiatric bed availability and services to reduce psychiatric boarding in the ED, improve coordination of care between EDs and mental health services within communities, and promote establishment of new and innovative models of care for acute psychiatric emergencies.
- Support innovative initiatives and models to reduce psychiatric boarding in the ED

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 professional.

Fiscal Impact

No additional staff resources are required as the proposed action fits within currently budgeted and ongoing federal and state advocacy initiatives.

Prior Council Action

Amended Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted. Directed ACEP to 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

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.

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

February 2023, approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department;" revised and approved June 2017, April 2011, April 2008, January 2007; originally approved October 2000.

January 2022, approved the revised policy statement, "Appropriate Interfacility Patient Transfer;" revised and approved January 2016 with current title; revised and approved February 2009, February 2002, June 1997, September 1992 titled, "Appropriate Inter-hospital Patient Transfer;" originally approved September 1989 as position statement "Principles of Appropriate Patient Transfer."

Amended Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted.

Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted.

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

January 2019, reaffirmed the policy statement "EMTALA and On-Call Responsibility for Emergency Department Patients;" revised and approved June 2013, April 2006 replacing "Hospital, Medical Staff, and Payer Responsibility for Emergency Department Patients" (1999),"Medical Staff Responsibility for Emergency Department Patients" (1997), and"Medical Staff Call Schedule."

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 29(23)

SUBMITTED BY: Pennsylvania College of Emergency Physicians
Pediatric Emergency Medicine Section

SUBJECT: Addressing Pediatric Mental Health Boarding in Emergency Departments

PURPOSE: Advocate for federal support to decrease ED boarding of pediatric mental health patients, and for tiered reimbursement for pediatric mental health admissions and a standard payment for boarding of children for whom there is no other medical necessity for hospital care.

FISCAL IMPACT: Budgeted resources for federal advocacy initiatives.

1 WHEREAS, Pediatric mental health boarding refers to the practice of keeping children and adolescents with
2 mental health conditions in emergency departments for extended periods due to the lack of appropriate mental health
3 care resources; and
4
5 WHEREAS, Pediatric mental health boarding is a systemic issue arising from the limited availability of
6 community-based mental health services, insufficient pediatric psychiatric beds, and inadequate coordination between
7 emergency departments, mental health providers, and other relevant stakeholders; and
8
9 WHEREAS, Pediatric mental health boarding can have detrimental effects on the well-being and
10 development of children, leading to increased anxiety, worsening of mental health symptoms, disruption of academic
11 progress, and potential escalation of crisis situations; and
12
13 WHEREAS, Emergency departments are ill-equipped to provide comprehensive mental health care, as they
14 primarily focus on acute medical conditions and lack the necessary staff, training, and resources to address the
15 specialized needs of pediatric mental health patients; and
16
17 WHEREAS, Current national legislative efforts, such as the "Improving Mental Health Access from the
18 Emergency Department Act" (S. 1346), offer workable solutions for emergency departments, these efforts do not
19 allocate specific resources/funds for pediatric patients; and
20
21 WHEREAS, The State of Massachusetts has successfully implemented a tiered payment structure for
22 pediatric mental health beds and other states (Delaware, Pennsylvania) are currently advocating for similar payment
23 structures to support current open pediatric mental health beds and encourage facilities to maintain these beds;
24 therefore, be it
25
26 RESOLVED, That ACEP advocate for federal support to decrease ED boarding of pediatric mental health
27 patients; and be it further
28
29 RESOLVED, That ACEP advocate for tiered reimbursement for pediatric mental health admissions and a
30 standard payment for boarding of children for whom there is no other medical necessity for hospital care.

Background

This resolution calls for the College to advocate for federal support to decrease ED boarding of pediatric mental health patients, and for tiered reimbursement for pediatric mental health admissions and a standard payment for boarding of children for whom there is no other medical necessity for hospital care.

Pediatric mental health boarding is an issue that arises when children and adolescents experiencing mental health crises are held in emergency departments (EDs) while awaiting appropriate psychiatric care or placement in a mental health facility. Psychiatric boarding has become a significant challenge in many emergency departments and health care systems, with detrimental effects on the overall mental health and well-being of young patients.

During the last decade, pediatric ED visits for mental health conditions have risen dramatically.[1] The COVID-19 pandemic led to a further acceleration of these visits, causing several pediatric health organizations to issue a national emergency for children's mental health in 2021 and the U.S. Surgeon General to release an advisory on mental health among youth. According to the CDC, one in five children and adolescents experience a mental health condition each year[2], with a staggering 50% of mental illnesses beginning by age 14 and 75% by age 24.[3] Another study revealed that during March–October 2020, among all ED visits, the proportion of mental health-related visits increased by 24 percent among U.S. children aged 5–11 years, compared to 2019 figures. That proportion also increased to 31 percent among adolescents aged 12–17 years, compared with 2019.[4] The problem of pediatric mental health is underscored by a 2021 CDC survey of American youth, which found:

- 42% of high school students felt sad or hopeless almost every day for at least two weeks.
- 29% of high school students reported experiencing poor mental health in the past 30 days.
- 1 in 5 high school students seriously contemplated suicide, and 1 in 10 made an attempt.

In the U.S. the growing demand for mental health services exceeds the available resources. Multiple studies show that pediatric patients with mental health conditions who are boarded are more likely to leave without being treated, and less likely to receive counseling or psychiatric medications.[5] The lack of specialized care during this critical period can also lead to an increased risk of self-harm, violence, and suicide attempts. Another study revealed that the primary barrier to disposition for mental health patients with prolonged ED stays was the lack of patient acceptance to inpatient psychiatric hospitals, community settings, or other housing.[6]

According to data from the 2013 National Pediatric Readiness Assessment, which was made available by the Health Resources & Services Administration (HRSA)-funded National Emergency Medical Services for Children (EMSC) Data Analysis Resource Center, only 47.2 percent of hospital emergency departments (EDs) reported having a policy specifically for children's mental health, and this percentage drops significantly to 33 percent in rural areas. Furthermore, although over half of all EDs have designated transfer guidelines for children with mental health issues, the figure decreases to 38 percent for rural and remote EDs.[7]

ACEP has been working on a study of ED boarding with the Emergency Department Benchmarking Alliance (EDBA). Preliminary results of this 2022 EDBA performance measures survey "…found a significant deterioration in patient processing due to inpatient boarding." 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.

Overall, addressing boarding and crowding have been longstanding priorities of the College There is active policy development, committee work, liaison work, and media outreach that is ongoing on this issue. Federal legislative and regulatory advocacy efforts continue as well. ACEP federal advocacy has focused on raising awareness of the ED boarding crisis and developing both legislative and regulatory solutions to help ease this multifactorial challenge. As part of this continued initiative, ACEP is hosting an ED Boarding Summit on September 27, 2023, and stakeholder invitees include the American Hospital Association, America's Essential Hospitals, federal health care entities, and many others. ACEP has reached out to both CMS and The Joint Commission to determine what federal action can be taken to address the issue.

Addressing mental health boarding and crowding have also been included as key priorities in communications with Congress during the 118th Congress as legislators in both the House and Senate develop legislative efforts to address the nation's mental health crisis. ACEP helped develop and supports the bipartisan Improving Mental Health Access from the Emergency Department Act (S.1346), which creates a grant program aimed at assisting emergency departments and communities in implementing innovative strategies to ensure continuity of care for patients who have

presented with acute mental health conditions. ACEP also supports the bipartisan Helping Kids Cope Act (H.R. 2412), introduced by Representatives Lisa Blunt Rochester (D-DE) and Brian Fitzpatrick (R-PA) which would provide funding to support necessary staffing, capacity increases, and infrastructure adjustments needed to alleviate pediatric boarding; maintaining initiatives to allow more children to access care outside of emergency departments; and addressing gaps in the continuum of care for children. ACEP staff continue to discuss potential solutions with legislators in both chambers and inform additional legislative efforts in development. Additionally, ED boarding, ED crowding, and mental health have been the central themes of the face-to-face advocacy efforts by our members who attend the ACEP Annual Leadership and Advocacy Conference for the last several years.

Emergency Department Boarding and Crowding resources are also available on the ACEP website, including Policy Solutions to Emergency Department Boarding.

Background References

[1]https://pubmed.ncbi.nlm.nih.gov/31175994/
[2]https://www.cdc.gov/childrensmentalhealth/features/kf-childrens-mental-health-report.html
[3]https://www.samhsa.gov/data/sites/default/files/report_1973/ShortReport-1973.html
[4]https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm#:~:text=During%20weeks%2012%E2%80%9342%2C%202020%2C%20the%20proportion%20of%20mental,years%20remained%20similar%20in%202020.
[5]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8762987/
[6]https://pubmed.ncbi.nlm.nih.gov/33279330/
[7]https://www.hrsa.gov/sites/default/files/hrsa/critical-crossroads/critical-crossroads-tool.pdf

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 professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted staff resources for federal advocacy initiatives.

Prior Council Action

Amended Resolution 38 (22) Focus on Emergency Department Patient Boarding as a Health Equity Issue adopted. Directed the College, through legislative venues and lobbying efforts, to 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; publish best practice action plans for hospitals to improve emergency department capacity; and, work to define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

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.

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

June 2023, filed the report of the ED Boarding Summit Task Force and approved convening an ED Boarding Summit within the next 12 months.

February 2023, approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department;" revised and approved June 2017, April 2011, April 2008, January 2007; originally approved October 2000.

Resolution 38(22) Focus on Emergency Department Patient Boarding as a Health Equity Issue

Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted.

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

September 2018, approved the revise policy statement "Boarding of Pediatric Patients in the Emergency Department;" originally approved January 2012.

September 2018, approved the revised policy statement "Definitionof Boarded Patient;" reaffirmed October 2017; originally approved January 2011.

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: Fred Essis
Congressional Lobbyist

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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 30(23)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Advocating for Increased Funding for EMS

PURPOSE: Advocate for: 1) increased funding for EMS services to address inadequacies in reimbursement rates; 2) increased funding for EMS services; 3) a premium rate for EMS reimbursement in rural areas; 4) EMS reimbursement rates for services and mileage to increase in line with Medicare rates based on changes to the consumer price index (CPI); 5) reimbursement of EMS based on the value of the care provided; and 6) reimbursement models that allow for "treatment-in-place" health care delivery

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives.

1 WHEREAS, EMS providers play a critical role in providing life-saving services to individuals covered by
2 Medicaid and Medicare; and
3
4 WHEREAS, EMS reimbursements for transporting Medicaid patients have received only two increases in the
5 last two decades, with the last increase occurring in 2018; and
6
7 WHEREAS, The current reimbursement rates for Advanced Life Support (ALS) and Basic Life Support
8 (BLS) services in Pennsylvania are significantly below Medicare and commercial insurance reimbursements; and
9
10 WHEREAS, There are often additional costs associated with providing EMS services in rural areas;
11
12 WHEREAS, Future reimbursement rates for services and mileage should increase in line with Medicare rates
13 based on changes to the CPI, ensuring that EMS agencies can keep pace with the increased cost of providing these
14 vital services; and
15
16 WHEREAS, EMS is reimbursed at a flat rate based on the level of care provided and on miles transported,
17 rather than the value of the care provided; and
18
19 WHEREAS, EMS is unable to collect financial reimbursement for valuable healthcare services provided to
20 Medicaid and Medicare patients that do not involve transport of a patient to an Emergency Department setting,
21 including, but not limited to, emergent scenarios such as cardiac arrest care involving field termination, non-emergent
22 mobile integrated health services and other "treatment-in-place" healthcare delivery models that allow for reduced
23 reliance on Emergency Departments; and
24
25 WHEREAS, Agencies throughout the nation are reporting that EMS units are facing financial collapse, a
26 crisis accelerated by COVID-19 and inflation; therefore be it
27
28 RESOLVED, That ACEP advocate for increased funding for EMS services to address the inadequacies in
29 reimbursement rates for EMS services and advocate for increased funding for EMS services recognizing the
30 importance of fair and adequate reimbursements to ensure the provision of high-quality emergency medical care for
31 patients and the sustainability of EMS services and be it further
32
33 RESOLVED, That ACEP advocate for a premium rate for EMS reimbursement in rural areas; and be it
34 further

35 RESOLVED, That ACEP advocate for EMS reimbursement rates for services and mileage to increase in line
36 with Medicare rates based on changes to the CPI, ensuring that EMS agencies can keep pace with the increased cost
37 of providing these vital services to our communities; and be it further
38
39 RESOLVED, That ACEP advocate for reimbursement of EMS based on the value of the care provided; and
40 be it further
41
42 RESOLVED, That ACEP actively advocate for reimbursement models for EMS that allow for “treatment-in-
43 place” health care delivery.

Background

This resolution calls on ACEP to advocate for: increased funding for EMS services to address inadequacies in reimbursement rates; increased funding for EMS services; a premium rate for EMS reimbursement in rural areas; EMS reimbursement rates for services and mileage to increase in line with Medicare rates based on changes to the consumer price index (CPI); reimbursement of EMS based on the value of the care provided; and reimbursement models that allow for “treatment-in-place” health care delivery.

EMS provides a critical role in providing life-saving services for Medicare and Medicaid recipients around the US. Despite this, EMS is reimbursed at a flat rate rather than based on the value, quality or efficiency of the care delivered. As such, EMS is unable to collect financial reimbursement for anyhealthcare services provided to Medicaid and Medicare patients that do not involve transport of a patient to an Emergency Department. This includes emergent scenarios such as cardiac arrest care terminated in the field, mobile integrated health services, patient navigation services, alternate destination programs, co-response with law enforcement and other “treatment-in-place” delivery models that reduce reliance on transport to Emergency Departments. Further complicating this issue is that EMS is deemed an essential service in only 11 states and not deemed an essential service at the federal level. The result is that EMS funding has been left to states and local governments, leading to a lack of national coordination and inconsistencies in EMS system design, training, qualifications, personnel requirements, and pay. For years, EMS agencies have struggled with these issues and increasing difficulty in retaining and supporting both volunteer and paid staff.. 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)have pushed many EMS systems to the breaking point.

ACEP’s policy statement “Definition of an Emergency Service” codifies that an emergency service is any health care service provided to evaluate and/or treat any medical condition for which a prudent layperson possessing an average knowledge of medicine and health, believes that immediate unscheduled medical care is required. Thus, advocacy for EMS falls under any ACEP policy that support reimbursement and fair payment for emergency services. In the “Fair Reimbursement when Services are Mandated” policy, any government agency, legislative body, insurance carrier, third party payer, or any other entity that mandates that a service or product be provided by emergency physicians or other health care professionals is called on to also mandate an adequate source of funding to ensure fair coverage for those services or products. Further, the “Emergency Medical Services Interfaces with Health Care Systems” asserts ACEP’s belief that EMS plays an essential role in the clinically effective, fiscally responsible regionalization of healthcare and therefore EMS systems must have significant involvement, funding, and leadership decision-making authority to best provide necessary out-of-hospital acute assessment and safe, timely care to patients. Current reimbursement and payment policies for EMS are not sufficient to keep EMS systems afloat. More and more patients will lose access to emergency services as systems fail.

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.

Prior Council Action

Amended Resolution 36(22) Emergency Medical Services are Essential Services adopted. Directed the College to advocate for EMS to be considered and funded as an essential service and work with the American Hospital Association, the National Association of EMS Physicians, and other stakeholder organizations to actively promote the inclusion of Emergency Medical Services among federally- and locally-funded essential services, including efforts to educate the public.

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

June 2023, approved the revised policy statement "Fair Reimbursement When Services are Mandated" with the current title; revised and approved April 2017 titled "Fair Coverage when Services are Mandated;" reaffirmed April 2011 and September 2005; originally approved June 1999 titled "Compensation when Services are Mandated."

Resolution 36(22) Emergency Medical Services are Essential Services adopted.

January 2021, reaffirmed the policy statement "Definition of an Emergency Service;" reaffirmed June 2015; revised and approved April 2009; reaffirmed October 2002, October 1998; revised January 1994 with the current title; originally approved October 1982 titled "Bona Fide Emergency Defined."

February 2018, approved the policy statement "Emergency Medical Services Interfaces with Health Care Systems" replacing 4 separate policy statements on EMS and ambulance care.

Resolution 26(01) Emergency Care as an Essential Public Service adopted.

Background Information Prepared by: Erin Grossmann
Regulatory & External Affairs 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 31(23)

SUBMITTED BY: New York Chapter

SUBJECT: Combating Mental Health Stigma in Insurance Policies

PURPOSE: 1) Advocate and commit resources for the elimination of discrimination against individuals with treated mental health conditions in insurance policies; and 2) work with other organizations to promote equitable access to insurance for all emergency physicians, regardless of their mental health status.

FISCAL IMPACT: Budgeted resources for federal advocacy initiatives. Unbudgeted staff and resources may be required for actions beyond federal advocacy.

1 WHEREAS, Mental health conditions such as depression and post-partum depression are common among
2 emergency physicians and can significantly impact their ability to work and perpetuate burn out; and
3
4 WHEREAS, Disability insurance can provide financial protection for emergency physicians in the event of a
5 disability that prevents them from working; and
6
7 WHEREAS, Some insurance companies may decline a disability insurance policy for an emergency physician
8 due to a previously diagnosed and treated mental health condition, such as depression and post-partum depression;
9 and
10
11 WHEREAS, The American College of Emergency Physicians (ACEP) has a responsibility to advocate for the
12 well-being and fair treatment of its members; therefore be it
13
14 RESOLVED, That ACEP advocate and commit resources for the elimination of discrimination against
15 individuals with treated mental health conditions in insurance policies; and be it further
16
17 RESOLVED, That ACEP work with other organizations to promote equitable access to insurance for all
18 emergency physicians, regardless of their mental health status.

Background

This resolution directs the College to advocate and commit resources for the elimination of discrimination against individuals with treated mental health conditions in insurance policies and work with other organizations to promote equitable access to insurance for all emergency physicians, regardless of their mental health status.

The resolution notes that some insurance companies may decline a disability insurance policy for an emergency physician due to a previously diagnosed and treated mental health condition, such as depression and post-partum depression. The resolution also notes that disability insurance may provide financial protection for emergency physicians in the event of a disability, such as a mental health condition, that prevents them from working.

Upwards of 65 percent of emergency physicians and emergency medicine resident physicians report experiencing burnout during their careers.[1] Approximately 15 to 17 percent of emergency physicians, and upwards of 20 percent of emergency medicine residents met the diagnostic criteria for PTSD in 2019. Other data indicates that, in the last year, as many as 6,000 emergency physicians have contemplated suicide and up to 400 have attempted to take their own life.

ACEP's current legislative and regulatory priorities include "Advocate for continued and increased funding for short, medium, and long-term efforts to improve mental health, reduce burnout, and prevent suicide for emergency physicians and other health care workers, and continue to develop new policy solutions."

ACEP helped inform, develop, and secure successful passage and enactment of the Dr. Lorna Breen Health Care Provider Protection Act (P.L. 117-105), which promotes mental and behavioral health support for physicians and health care providers, increases awareness and education about mental and behavioral health challenges for health care workers, and has funded dozens of grants totaling more than $100 million for organizations to develop programs and resources for frontline health care workers.

ACEP has advocated and continues to advocate at the federal level for both elimination of pre-existing conditions exclusions and for mental health parity in insurance plans, supporting legislative efforts that would provide the Department of Labor the ability to issue civil monetary penalties for violations of the Mental Health Parity and Addiction Equity Act. However, these laws and efforts focus on traditional health insurance – pre-existing conditions exclusions may still apply to certain types of life insurance or disability insurance.

ACEP's policy statement "Physician Impairment" states: "The existence of a health problem in a physician is NOT synonymous with occupational impairment..." and that most physicians with "appropriately managed personal health problems and other stressors are able to function safely and effectively in the workplace.

Background Reference

[1]Carbajal E. 29 physician specialties ranked by 2022 burnout rates. Becker's Hospital Review website. https://www.beckershospitalreview.com/hospital-physician-relationships/29-physician-specialties-ranked-by-2022-burnout-rates.html. Published February 1, 2023. Accessed August 31, 2023.

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 professional.

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 resources for federal advocacy initiatives. Unbudgeted staff and resources may be required for actions beyond federal advocacy.

Prior Council Action

Amended Resolution 41(22) Addressing Stigma in the Emergency Department adopted. Directed ACEP to develop an educational resource on identifying and addressing stigma in the emergency department that can be provided to emergency physicians and residency programs, highlighting the role of important practices such as person-first language.

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 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.

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.

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."

Prior Board Action

Amended Resolution 41(22) Addressing Stigma in the Emergency Department 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.

February 2020, "Physician Impairment;" revised and approved October 2013 and October 2006; reaffirmed September 1999; revised and approved April 1994; originally approved September 1990.

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.

Resolution 16(18) No More Emergency Physician Suicides adopted.

Substitute Resolution 41(05) Non-Discrimination adopted.

Amended Resolution 32(04) Disability in Emergency Physicians adopted.

Substitute Resolution 9(99) Federation of State Medical Boards adopted.

Background Information Prepared by: Fred Essis
Congressional Lobbyist

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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 32(23)

SUBMITTED BY: Gary Gaddis, MD, PhD, FACEP
David Schriger, MD, MPH, FACEP

SUBJECT: Health Care Insurers Waive Network Considerations During Declarations of Emergency

PURPOSE: 1) Advocate at the federal level and provide assistance to chapters for state lobbying efforts, urging the enactment of legislation and/or regulations that require health insurers to waive "network" rules and considerations for their insured patients during times at which a Declaration of Emergency has been declared and placed in force by a state governor or by the President of the United States, regardless of whether that state of emergency is the result of a natural disaster, an act of war, a pandemic, or other causative forces; and 2) Submit a resolution to the American Medical Association, requesting its House of Delegates to consider joining ACEP in seeking legislative or regulatory changes designed to compel health insurers to waive "network" considerations under the same circumstances.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Efforts pertaining to this issue would be prioritized with current committee and staff resources for federal and state advocacy initiatives.

1 WHEREAS, Because of the COVID-19 pandemic, a public health emergency was declared by the Trump
2 Administration on March 13, 2020[1]; and
3
4 WHEREAS, During that time of emergency, numerous hospitals quickly became overcrowded and
5 oversubscribed, leading to an over-capacity inpatient census, which caused their health personnel and their systems of
6 care to become compromised regarding their ability to meet patient care needs; and
7
8 WHEREAS, Elsewhere, other area hospitals' capacities were simultaneously undersubscribed; and
9
10 WHEREAS, This uneven distribution of patients and the local over-crowding that subsequently occurred at
11 oversubscribed hospitals is widely believed to have led to avoidable morbidity and mortality, as a direct consequence
12 of this patient maldistribution; and
13
14 WHEREAS, In a scholarly article by Ioannides et al.[2], which appeared in the *Annals of Emergency Medicine*
15 in October of 2022, it was demonstrated that sufficient ambulance capacity existed throughout the early months of the
16 pandemic to have enabled extensive inter-hospital patient transfers to mitigate the effects of sporadic overcrowding, if
17 only local inter-hospital transfer protocols had been enacted and then followed by local health authorities; and
18
19 WHEREAS, In their manuscript, Ioannides et al. specifically advocated that regional Emergency Medical
20 Services (EMS) leaders should develop policies and procedures to facilitate a more even distribution of patients in
21 during future episodes of high hospital demand, toward employing EMS resources to facilitate inter-hospital transfers
22 of patients, and thus mitigate the sporadic over-subscribing of hospital capacities that demonstrably harmed patients;
23 and
24
25 WHEREAS, The existence of adequate EMS capacity to effect inter-hospital patients alone can be expected
26 to be insufficient to effect sufficiently numerous, voluntary patient transfers between hospitals (making this EMS
27 capacity be of questionable relevance), because offers for inter-hospital transfers would be likely to be resisted or
28 refused by many patients, if those patients were asked to transfer to a hospital that their health insurer considered to be
29 "out of network"; and
30
31 WHEREAS, The reason patients would be unlikely to agree to be transferred to an "out of network" facility
32 lies in the higher "out of pocket" "co-payments" that these patients would encounter when billed for care at "out of

33 network" locations; and
34
35 WHEREAS, This complicating factor of insurers "networks," which would blunt the salutatory effect of
36 updated inter-hospital transfer protocols, was spotlighted in a Letter to the Editor of the *Annals of Emergency*
37 *Medicine*[3] written by the author of this resolution (GM Gaddis), with that letter appearing in the May 2023 *Annals of*
38 *Emergency Medicine*; and
39
40 WHEREAS, The authors of the manuscript which precipitated that Letter to the Editor documented agreement
41 with the key points raised in Gaddis' Letter[3] in their reply[4]; and
42
43 WHEREAS, The senior author of the Ioannides manuscript, David Schriger, MD, FACEP, an Associate
44 Editor of the *Annals of Emergency Medicine*, has indicated that such advocacy for waiver of insurance networks was
45 exactly what the authorship team of Ioannides et al. hoped would happen in response to their manuscript[5] because
46 they did not believe it to be appropriate to engage in political advocacy within the text of a scientific article in a
47 scientific journal and thus, they did not take the opportunity to raise this point in their manuscript[2]; and
48
49 WHEREAS, These insurer "network" concerns are human-made barriers that could be eradicated by human
50 actions; and
51
52 WHEREAS, The logical and salutatory human action to eliminate these "network" considerations and barriers
53 during times of emergencies could be voluntarily undertaken by health care insurance companies; and
54
55 WHEREAS, Such health insurers may be unlikely to voluntarily waive "network" considerations for their
56 insureds, even during times of declared national emergencies, as can be judged from their failure to extend this
57 courtesy to their insured patients during the COVID-19 emergency; and
58
59 WHEREAS, In the absence of voluntary network suspensions, new governmental legislation or regulatory
60 mandates are likely to be needed to compel such actions on the part of health care insurance companies; and
61
62 WHEREAS, ACEP maintains a presence in our nation's capital to "lobby" for legislative and regulatory
63 changes desired by ACEP leaders, as does the American Medical Association (AMA); therefore be it
64
65 RESOLVED, That ACEP lobby at the federal level and provide assistance to chapters for state lobbying
66 efforts, for the enactment of legislation and/or regulations requiring health insurers to waive "network" rules and
67 considerations for their insured patients during times at which a Declaration of Emergency has been declared and
68 placed in force by a state governor or by the President of the United States, whether that state of emergency is the
69 result of a natural disaster, an act of war, a pandemic, or other causative forces; and be it further
70
71 RESOLVED, That ACEP submit a resolution to the American Medical Association for consideration by its
72 House of Delegates at its upcoming Interim Meeting, asking the AMA to join ACEP in the seeking of legislative or
73 regulatory change designed to compel health insurers to waive "network" considerations during times at which a
74 Declaration of Emergency has been declared and placed in force by a state governor or by the President of the United
75 States, whether that state of emergency is the result of a natural disaster, an act of war, a pandemic, or other causative
76 forces.

Resolution References

1. Centers for Disease Control. COVID-19 Timeline. https://www.cdc.gov/museum/timeline Accessed July 9, 2023
2. Ioannides KLH, Dekker A, Shin M, Schriger DL. Ambulances required to relieve overcapacity hospitals: A novel measure of hospital strain during the COVID-19 pandemic in the United States. *Ann Emerg Med.* 2022;80:301-13.
3. Gaddis GM. Response to "Ambulances Required to Relieve Overcapacity Hospitals: A Novel Measure of Hospital Strain during the COVID-19 Pandemic in the United States. *Ann Emerg Med.* 2023; 81:644-45.
4. Ioannides KLH et al. Reply to Response to "Ambulances Required to Relieve Overcapacity Hospitals: A Novel Measure of Hospital Strain during the COVID-19 Pandemic in the United States. Ann Emerg Med. 2023;81:645-6.
5. Schriger, D. Personal email communication; November, 2022.

Background

This resolution calls for the College to lobby at the federal level and provide assistance to chapters for state lobbying efforts, urging the enactment of legislation and/or regulations that require health insurers to waive "network" rules and considerations for their insured patients during times at which a Declaration of Emergency has been declared and placed in force. It further directs the College to submit a resolution to the American Medical Association asking them to join ACEP in the seeking of legislative or regulatory change designed to compel health insurers to waive “network” considerations during times at which a Declaration of Emergency has been declared and placed in force.

The resolution posits that insurer network considerations could serve as barriers to optimal patient care and out-of-network costs may deter inter-hospital patient transfers that could be beneficial in alleviating hospital capacity and crowding issues. The resolution suggests that waivers of insurer network requirements during emergencies could help eliminate these concerns by enabling overburdened/over-capacity facilities to transfer patients. During the COVID-19 pandemic, constraints on hospital resources became increasingly severe, leading to an increase in admitted patients remaining in the ED for prolonged periods of time. The resolution cites a study that suggests using only a modest portion of existing ambulance infrastructure would have significant impacts in load-balancing community resources and alleviating strain on over-capacity facilities.

The COVID-19 public health emergency provides some precedent for requiring health insurers to waive certain rules and considerations for their covered consumers. Group health plans and individual health insurance plans were obligated to cover COVID-19 tests and related services without requiring cost sharing, prior authorization, or other medical management requirements during the COVID-19 state of emergency. A coverage requirement was extended to over-the-counter (OTC) COVID-19 tests and health plans ensured coverage for up to 8 OTC at-home tests per covered individual each month. Alternatively, plans could establish a network to offer free OTC tests directly, thus eliminating the need for patients to pay upfront and submit reimbursement claims later.[1] Plans and issuers were obligated to cover COVID-19 vaccines without cost sharing, even if administered by out-of-network clinicians, and were required to reimburse for the administration of the vaccine at a reasonable amount, with federal regulations specifying the Medicare reimbursement rate as the rea.sonable amount. Many payers voluntarily waived or changed certain policies during the pandemic, such as certain cost-sharing requirements, prior authorization requirements, telehealth coverage, and others – some of which have even been implemented permanently. Plans also typically have processes for applying for waivers to receive out-of-network care with prior approval, though they are not obligated to approve such requests.

Many patient considerations in the context of out-of-network costs have essentially been obviated – at least in theory – by recent legislative and regulatory actions. State and federal laws have been enacted to remove patients from the middle of billing disputes between physicians/providers and insurers, banning the practice of “surprise medical billing” in cases where patients who receive care from physicians, providers, or hospitals that were not in their plan’s network. This includes the federal No Surprises Act (NSA; Public Law 116-260) that went into effect on January 1, 2022, which is in some respects a form of a network waiver for medically necessary care. Broadly, the NSA applies to emergency and non-emergency services, including air ambulance transportation but <u>not</u> ground ambulance transportation. The NSA bans physicians, hospitals, facilities, and other providers from billing of patients more than in-network cost sharing amounts for most emergency care, and requires insurers to cover out-of-network claims with patient cost-sharing at in-network amounts in these cases. However, the NSA protections for patients only exist when an insurer has not retrospectively declared the care and/or transportation “not medically necessary.”

The *No Surprises Act* extends its protections to additional services that emergency patients may receive in conjunction with an emergency visit even *after* they are stabilized—a new concept known as “post-stabilization services” in the law. Thus, a patient coming to the ED to be treated for a medical emergency cannot be balance billed for any of the out-of-network services they receive <u>up to the point of stabilization</u>, NOR for the care they receive once they are:

- admitted to the hospital; or,
- transferred to another facility via ambulance or other form of emergency medical transportation; or,
- placed into observation.

The protections end when the patient is discharged or when the insurer determines retrospectively that the care did not meet medical necessity criteria. They also can end when under the clinical judgment of the emergency physician, the out-of-network patient could have been transferred to a participating facility safely and without undue financial burden using a *non*-emergency form of transportation (like the patient's car, a bus, or a taxi), AND the patient signs a notice-and-consent given to them by the subsequent clinician.

There are still some gaps – the NSA does not cover non-emergency services provided in a variety of other settings, such as urgent care centers, clinics, nursing homes, substance use disorder treatment facilities, and others. In many of these non-emergency situations, providers may ask (but not require) patients to provide consent to waive their rights under the NSA and allow them to bill more as an out-of-network provider. So for patients who are forced to seek non-emergency care out-of-network during a declaration of emergency, the NSA's provisions will not address the situation as they could still find themselves needing to consent to costs of care higher than if they'd received the care in-network. In recognizing this potential gap in existing law, it is worth considering whether there will be any kind of significant numbers of patients seeking or needing non-emergency care during a declaration of emergency.

Background References

[1]https://www.kff.org/coronavirus-covid-19/issue-brief/what-happens-when-covid-19-emergency-declarations-end-implications-for-coverage-costs-and-access/#coverage-costs-and-payment
[2]https://www.jointcommission.org/-/media/tjc/documents/ standards/r3-reports/r3_report_issue_4.pdf
[3]https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217
[4]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8344999/
[5]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8276718/

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 professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Efforts pertaining to this issue would be prioritized with current committee and staff resources for federal and state advocacy initiatives.

Prior Council Action

None that is specific to waiving "network" rules and considerations for insured patients during a Declaration of Emergency.

Prior Board Action

None

Background Information Prepared by: Fred Essis
Congressional Lobbyist

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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 33(23)

SUBMITTED BY: Kathy Staats, MD, FACEP
Niki Thran, MD, FACEP
California Chapter

SUBJECT: Ban on Weapons Intended for Military or Law Enforcement Use

PURPOSE: 1) Support a ban on the sale, transfer, importation, and possession of weapons intended for military or law-enforcement use, including semi-automatic rifles and handguns, that are designed to fire multiple rounds; 2) Encourage state and federal policymakers to enact comprehensive legislation addressing the ban on such weapons while respecting the rights of responsible gun owners; 3) Advocate for evidence-based measures, including the ban on such weapons, to prevent and reduce gun-related injuries and fatalities through public education, research, and collaboration with relevant stakeholders; and 4) Urge members to engage in discussions with their patients, communities, and lawmakers to promote policies and initiatives aimed at reducing the availability and potential harm caused by such weapons, while recognizing the importance of mental health services and violence prevention programs in comprehensive strategies for reducing gun violence.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives related to firearms.

1 WHEREAS, ACEP is committed to the promotion of public health and safety; and
2
3 WHEREAS, Weapons intended for military or law enforcement use, including semi-automatic rifles and
4 handguns, designed to rapidly fire multiple rounds, pose a significant threat to public safety and contribute to mass
5 shootings and violence; and
6
7 WHEREAS, The proliferation of weapons intended for military or law enforcement use has resulted in an
8 alarming increase in the number and severity of injuries seen in emergency departments across the United States; and
9
10 WHEREAS, Studies have consistently demonstrated a correlation between the availability of weapons
11 intended for military or law enforcement use and increased rates of gun-related injuries and fatalities; and
12
13 WHEREAS, The possession of weapons intended for military or law enforcement use often serves no
14 legitimate purpose for self-defense or hunting, but rather enhances the potential for misuse and harm; and
15
16 WHEREAS, The banning of weapons intended for military or law enforcement use has proven effective in
17 reducing mass shootings and protecting the safety and well-being of individuals and communities in other countries;
18 and
19
20 WHEREAS, Responsible gun ownership and regulation should not infringe upon the rights of law-abiding
21 citizens to possess firearms for legitimate purposes, such as self-defense and recreational shooting; therefore be it
22
23 RESOLVED, That ACEP support a ban on the sale, transfer, importation, and possession of weapons
24 intended for military or law enforcement use, including semi-automatic rifles and handguns, that are designed to
25 rapidly fire multiple rounds; and be it further
26
27 RESOLVED, That ACEP encourage policymakers at the local, state, and federal levels to enact
28 comprehensive legislation that addresses the ban on weapons intended for military or law enforcement use while
29 respecting the rights of responsible gun owners; and be it further

30 RESOLVED, That ACEP advocate for evidence-based measures, including the ban on weapons intended for
31 military or law enforcement use, to prevent and reduce gun-related injuries and fatalities through public education,
32 research, and collaboration with relevant stakeholders; and be it further
33
34 RESOLVED, That ACEP urge members to engage in discussions with their patients, communities, and
35 lawmakers to promote policies and initiatives aimed at reducing the availability and potential harm caused by
36 weapons intended for military or law enforcement use, while recognizing the importance of mental health services
37 and violence prevention programs in comprehensive strategies for reducing gun violence.

References

https://www.acep.org/patient-care/policy-statements/firearm-safety-and-injury-prevention
https://www.rand.org/research/gun-policy/analysis/ban-assault-weapons.html
https://www.judiciary.senate.gov/press/dem/releases/studies-gun-massacre-deaths-dropped-during-assault-weapons-ban-increased-after-expiration

Background

The resolution calls for the College to: 1) support a ban on the sale, transfer, importation, and possession of weapons intended for military or law enforcement use, including semi-automatic rifles and handguns, that are designed to rapidly fire multiple rounds; 2) encourage policymakers at the local, state, and federal levels to enact comprehensive legislation that addresses the ban on weapons intended for military or law enforcement use while respecting the rights of responsible gun owners; 3) advocate for evidence-based measures, including the ban on weapons intended for military or law enforcement use, to prevent and reduce gun-related injuries and fatalities through public education, research, and collaboration with relevant stakeholders; and 4) urge members to engage in discussions with their patients, communities, and lawmakers to promote policies and initiatives aimed at reducing the availability and potential harm caused by weapons intended for military or law enforcement use, while recognizing the importance of mental health services and violence prevention programs in comprehensive strategies for reducing gun violence.

A fundamental challenge in the debate over firearms laws and policies revolves around language and semantics, particularly the lack of consensus on definitions and controversy over terminology. Defining objects by intended use is rarely definitive or restrictive. The term "intended for military or law enforcement use, including…" encompasses firearms of all types and historical periods, while also excluding most modern firearms, which are not marketed to the military or police. Conversely, all types of firearms are in current usage with the military and police for various purposes, e.g. basic marksmanship.

Defining firearms by mechanical function (kinetic energy, reloading mechanism, length, rapidity of fire) does not separate traditional and common sporting firearms from military and police firearms, except in the case of fully-automatic reloading mechanisms (firing multiple shots with a single trigger pull) and ammunition belt fed mechanisms.

The term "weapons intended for military or law enforcement use" is most generally used to refer to semi-automatic rifles and shotguns with certain cosmetic similarities, features, or accessories, e.g. pistol or vertical hand grips, removable ammunition magazines, integral mount rails, and bayonet lug. Accessories themselves, not integral to a firearm, have been treated separately under current state and federal laws, e.g. bump stocks (facilitating faster trigger actuation), ammunition magazines (capacity size), sound and flash suppressors, muzzle recoil breaks, folding stocks, forearm braces, and ammunition.

The U.S. Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), for example, states that "… certain features designed for military application are indicative of non-sporting rifles and shotguns.

Pistol functions, cosmetics, accessories, and ammunition have remained effectively indistinguishable between civilian, military, and police users for centuries. Certain accessories have been regulated at the state and federal levels, e.g. shoulder stocks, forearm braces, forward grips, magazine capacity, and ammunition.

The U.S. Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), for example, states that "… certain features designed for military application are indicative of non-sporting rifles and shotguns.."

Pro-firearm advocates oppose categorization of AR-15-style and other semi-automatic rifles as assault rifles, assault weapons, or even as weapons intended for military/LE use, and that these firearms are instead categorized as "modern sporting rifles," according to the Firearm Industry Trade Association's (NSSF) "Writer's Guide to Firearms and Ammunition."

To illustrate the difficulty in reconciling common definitions between the different camps of advocates, consider the following practical comparison: according to the manual for the Bushmaster XM15 E2S, a AR-15-style semi-automatic rifle available to the public, its rate of fire is 45 rounds per minute. The M4 carbine used by the U.S. military has a rate of fire of 700-950 rounds per minute. Again, while similar in form and basic function, on this example some would consider the XM15 E2S to be a weapon intended for military or law enforcement use while others would qualify it as a modern sporting rifle. Further complicating regulation is that AR-15-style rifles are offered in various ammunition choices, decreasing capacity of the same magazine by up to 66%.

As of 2023, ten U.S. states have banned or restricted the sale of AR- and AK-style and other similar firearms: California, Connecticut, Delaware, Hawaii, Maryland, Massachusetts, New Jersey, New York, Illinois, and most recently, Washington. These laws obviously vary by state, but generally prohibit manufacture, sale, and possession of such a firearm unless the owner lawfully possessed it prior to the ban. At the federal level, the Violent Crime Control and Law Enforcement Act of 1994 similarly banned the manufacture, transfer, or possession of these types of firearms and others ("pre-ban" firearms were grandfathered in), prohibited the manufacture of new large-capacity magazines except for government, military, or law enforcement sales, and banned possession and transfer of new large-capacity magazines, though pre-ban magazines were exempted and could be legally transferred and possessed as well. The 1994 law included a sunset clause and its provisions expired in 2004. Similar legislation to reinstate a ban has been introduced in Congress ever since, including the current 118th Congress, however none of these efforts have been successfully considered by Congress and enacted into law.

Evidence of the federal ban's effectiveness is mostly inconclusive with respect to impact on the overall U.S. homicide rate. Rifles of all types, regardless of features, were involved in 3% of firearm murders in 2020 according to the Pew Research Center. A 2020 RAND analysis of six studies found evidence to be inconclusive of the effect of state or federal bans on mass shootings (inconsistent evidence for the policy's effect on an outcome, or a single study only found uncertain or suggestive effects), while there is limited evidence that a ban on high-capacity magazines may decrease mass shootings. A 2019 study published in *The Journal of Trauma and Acute Care Surgery*, however, found that mass-shooting related homicides were reduced in the U.S. during the years of the 1994-2004 ban.

The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements, including the current policy statement, "Firearm Safety and Injury Prevention." Among the policy's provisions is the directive that ACEP support legislative and regulatory efforts that "[r]estrict the sale and ownership of weapons, munitions, and large-capacity magazines that are designed for military or law enforcement use, and prohibit the sale of after-market modifications that increase the lethality of otherwise legal firearms." ACEP's legislative and regulatory advocacy over the years includes working with members of Congress to promote efforts to prevent firearm-related injuries and deaths, reduce firearms-related violence, and support public and private initiatives to fund firearm safety and injury prevention research, and support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices. While not directly the same issue as the firearms identified in this resolution, ACEP has previously supported legislative efforts to ban the manufacture, possession, and sale of "bump stocks" that allow semi-automatic firearms to nearly replicate the firing rate of fully automatic firearms, such as those that were used to perpetrate the October 1, 2017 mass shooting in Las Vegas, NV that claimed the lives of 60 people. ACEP also supported the Trump Administration's 2019 ban on these and similar devices. This regulatory ban has come under scrutiny recently with two federal appeals courts ruling against the ban and its ultimate fate still uncertain.

The current "Firearm Safety and Injury Prevention" policy statement was originally developed by a task force of members with a diversity of positions on the firearms issue and opinions on where/whether ACEP could have a

meaningful impact. ACEP policies are reviewed on a 5-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The PHIPC developed a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board approved the revised policy statement in October 2019. The policy statement will be reviewed again by the PHIPC in the 2024-25 committee year as part of the policy sunset review process.

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 addition to the College's own specific efforts, ACEP staff and member representatives also continue to work with the American Medical Association (AMA), American College of Surgeons (ACS) and the ACS Committee on Trauma, the American Academy of Pediatrics (AAP), and other stakeholders to address firearm injury prevention and research. These include, but are not limited to:

- In September 2022, ACEP, ACS, AAP, the American College of Physicians (ACP) and the Council of Medical Specialty Societies (CMSS) cohosted the second Medical Summit on Firearm Injury Prevention, featuring representatives from more than 46 organizations ~~overall~~. This meeting served as a follow-up to the inaugural summit held in 2019, in which ACEP also participated. The proceedings, including the key takeaways from the summit, were published in the *Journal of the American College of Surgeons* in March 2023. As a continuation of the summit's efforts, the Healthcare Coalition for Firearm Injury Prevention (HCFIP) has been formed as a multidisciplinary coalition of professional organizations representing medicine and public health to collaborate on firearm injury prevention initiatives, with a focus on non-partisan and evidence-based/data driven solutions. The Steering Committee member organizations of HCFIP are AAP, ACEP, ACP, ACS, and CMSS. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.
- In February 2023, ACEP participated in a firearm injury prevention roundtable organized by the AMA. The meeting was joined by the ACS, AAP, the American College of Physicians (ACP), American Psychiatric Association (APA), and the American Academy of Family Physicians (AAFP). As a result of this initial meeting, the AMA has established a Firearm Injury Prevention Task Force on which an ACEP representative will also serve.
- Helped establish and currently serve as both a steering committee member and regular member of the Gun Violence Prevention Research Roundtable (GVPRR), an effort spearheaded by the AAP. The GVPRR is a nonpartisan and national coalition of leading medical, public health, and research organizations focused on advocating for the value for federal funding for firearm violence prevention research.

ACEP worked successfully with other physician specialties, health care providers, and other stakeholders to restore federal funding for firearm morbidity and mortality prevention research, with $25 million split between the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) in December 2019, after a more than 20-year hiatus of federal appropriations for this purpose. ACEP continues to advocate for increased funding for the NIH and CDC to continue and expand this research. For many consecutive years now, ACEP has joined an annual appropriations request letter urging Congress to provide continued funding for firearms injury prevention research. The most recent version of this letter for the 2024 fiscal year includes more than 400 signatories, and asks for a total of $61 million for the CDC, NIH, and the recently established National Institute of Justice (NIJ) to conduct public health research into firearm morbidity and mortality prevention. ACEP has also met with the National Collaborative on Gun Violence Research (NCGVR), a research collaborative with the mission to fund and disseminate nonpartisan scientific research to provide necessary data to establish fair and effective policies, in a discussion to share ACEP's policy priorities regarding firearms injury prevention.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP issuing public statements following a mass shooting event advocating for change consistent with the College' s policies, 62.5% were in support of making public statements while 28.1% did not support such action.

The PHIPC developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

ACEP has supported the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), including AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence. The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on research grants.

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 professional.

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives related to firearms.

Prior Council Action

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted. Directed ACEP to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted. Directed ACEP to work with stakeholders to raise awareness and advocate for research funding and legislation to address both firearm violence and intimate partner violence.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 ACEP Position Paper; and that ACEP support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted. Directed ACEP to revise the policy statement, "Firearm Safety and Injury Prevention" to reflect the current state of research and legislation.

Resolution 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for funding for research on firearm injury prevention and to work with the AMA and other medical societies to achieve this common cause.

Amended Resolution 31(12) Firearm Violence Prevention adopted. Condemned the recent massacres in Aurora, CO and WI and the daily violence throughout the U.S. and reaffirmed ACEP's commitment against gun violence including advocating for public and private funding to study the health effects of gun violence.

Amended Resolution 41(04) Assault Weapon Ban adopted. ACEP deplores the threat to public safety that is the result of widespread availability of assault weapons and high capacity ammunition devices and urges the Congress and the President to enact and sign into law a comprehensive ban on all sales of assault weapons and high capacity magazines.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted. Sought to collaborate with other medical specialty organizations on firearms issues.

Resolution 22(96) National Center for Injury Prevention and Control adopted. Directed ACEP to continue supporting funding for Injury Prevention and Control in the CDC in which firearms research was included.

Amended Resolution 69(95) Firearm Legislation adopted. Sought to limit access to Saturday night specials.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. Advocated for increased taxes on handguns and ammunition with proceeds going to fund the care of victims and/or programs to prevent gun violence and to fund firearm safety education.

Resolution 47(94) Firearm Classification referred to the Board of Directors. Directed ACEP to support legislation classifying firearms into three categories: 1) prohibited; 2) licensed; and 3) unlicensed.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted. Directed ACEP to support legislation requiring photo identification and specific qualifications for firearm possession.

Substitute Resolution 45(94) Firearm Possession adopted. Supported legislation (as was passed in the crime bill) to make it illegal for persons under 21 and persons convicted of violent crimes, spousal and/or child abuse or subject to a protective order to possess firearms; illegal to transfer firearms to juveniles; and support legislation making it illegal to leave a loaded handgun where it is accessible to a juvenile.

Substitute Resolution 44(94) Firearm Legislation adopted. Support comprehensive legislation to limit federal firearms licenses.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted. Supported national safety regulations for firearms.

Amended Resolution 18(93) Firearm Injury Reporting System adopted. Explore collaboration with existing governmental entities to develop a mandatory firearm injury reporting system.

Amended Resolution 17(93) Firearm Injury Prevention adopted. Consider developing and/or promoting public education materials regarding ownership of firearms and the concurrent risk of injury and death.

Amended Resolution 16(93) Possession of Handguns by Minors adopted. Support federal legislation to prohibit the possession of handguns by minors.

Amended Resolution 11(93) Violence Free Society adopted. Develop a policy statement supporting the concept of a violence free society and increase efforts to educate member about the preventable nature of violence and the important role physicians can play in violence prevention.

Resolution 15(90) Gun Control not adopted. Sought for ACEP to undertake a complete review of all medical, legal, technical, forensic, and other pertinent literature regarding firearm-related violence with emphasis on the effects of firearm availability to the incidence of such violence, and that ACEP withhold public comment on gun control until such study is completed and an informed, unemotional, and unpolarized position on weapons can be formulated.

Amended Resolution 14(89) Ban on Assault Weapons adopted. Support federal and state legislation to regulate as fully automatic weapons are regulated, the sale, possession, or transfer of semi-automatic assault weapons to private citizens and support legislation mandating jail sentences for individuals convicted of the use of a semi-automatic assault weapon in the commission of a crime.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted. Support federal and state legislation to require 15-day waiting period for the sale, purchase, or transfer of any firearm to allow time for a background check on the individual and also support legislation mandating significant penalties for possession of a firearm while committing a crime.

Substitute Resolution 16(84) Ban on Handguns adopted. Deplored the loss of life and limb secondary to the improper use of handguns; supported legislation mandating significant penalties for possession of a handgun while committing a crime; support legislation mandating significant penalties for the illegal sale of handguns; support a waiting period for all prospective handgun buyers; supported successful completion of an education program on handgun safe for all prospective handgun buyers; support development of educational programs on the proper use of handguns for existing owners; support requiring screening of prospective handgun buyers for previous criminal records and mental health problems that have led to violent behavior.

Resolution 15(83) Handgun Legislation not adopted. Urged legislative bodies to enact legislation restricting the availability of handguns to the general public and to monitor the results.

Prior Board Action

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted.

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted.

October 2019, approved the revised policy statement "Firearm Safety and Injury Prevention;" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

January 2019, approved $20,000 contribution to the American Federation for Firearm Injury Reduction in Medicine (AFFIRM).

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted.

June 2018, reviewed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention."

June 2014, approved the Research Committee's recommendations to convene a consensus conference of firearm researchers and other stakeholders to: 1) develop a research agenda and to consider the use of available research networks (including the proposed EM-PRN) to perform firearm research; 2) identify grant opportunities and promote them to emergency medicine researchers; 3) recommend EMF consider seeking funding for a research grant specifically supporting multi-center firearm research; and 4) advance the development of the EM-PRN so as to create a resource for representative ED-based research on this topic and others.

Resolution 27(13) Studying Firearm Injuries adopted.

Amended Resolution 31(12) Firearm Violence Prevention adopted.

Amended Resolution 41(04) Assault Weapon Ban adopted.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted.

Resolution 22(96) National Center for Injury Prevention and Control adopted.

Amended Resolution 69(95) Firearm Legislation adopted.

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

Resolution 47(94) Firearm Classification referred to the Board of Directors.

Amended Resolution 46(94) Photo Identification and Qualifications for Firearm Possession adopted.

Substitute Resolution 45(94) Firearm Possession adopted.

Substitute Resolution 44(94) Firearm Legislation adopted.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted.

Amended Resolution 18(93) Firearm Injury Reporting System adopted.

Amended Resolution 17(93) Firearm Injury Prevention adopted.

Amended Resolution 16(93) Possession of Handguns by Minors adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Amended Resolution 14(89) Ban on Assault Weapons adopted.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted.

Substitute Resolution 16(84) Ban on Handguns adopted.

Background Information Prepared by: Ryan McBride, MPP
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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 34(23)

SUBMITTED BY: Kathy Staats, MD, FACEP
Niki Thran, MD, FACEP
California Chapter

SUBJECT: White Paper on Weapons Intended for Military or Law Enforcement Use

PURPOSE: 1) Develop a white paper on the examination of weapons intended for military or law enforcement use to inform evidence-based policies, interventions, and public health strategies to address the risks and consequences associated with these firearms and seek collaboration among experts in emergency medicine, public health, and other stakeholders as appropriate to ensure a multidisciplinary approach in the development of the white paper; 2) include a range of components with a comprehensive review of existing literature; examination of specific characteristics and features of weapons intended for military or law enforcement; assessment of the societal impact and psychological consequences; evaluation of existing policies, legislative measures, and firearm regulations; consideration of potential interventions, strategies, and evidence-based approaches; 3) seek funding, partnerships, and collaboration with relevant stakeholders, organizations, and governmental bodies to support the development of the paper; 4) disseminate the paper to members, policymakers, public health officials, medical organizations, and other interested parties; and 5) actively engage in advocacy efforts to promote evidence-based policies aimed at reducing the risks and impact of weapons intended for military or law enforcement use on public health and safety.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. Development of a comprehensive white paper would require diverting current budgeted staff resources from other initiatives to support this effort. Unbudgeted costs of organizing/collaborating with relevant stakeholders for development of a comprehensive research paper, if the costs are not offset by funding opportunities, and unbudgeted funds of approximately $25,000 for an in-person stakeholder meeting for 20 people.

1 WHEREAS, ACEP is committed to the promotion of public health, safety, and the well-being of patients; and
2
3 WHEREAS, ACEP recognizes the alarming impact of firearms-related incidents on public health, including
4 the toll of mass shootings and assaults involving weapons intended for military or law enforcement use; and
5
6 WHEREAS, ACEP acknowledges the importance of evidence-based research and information in informing
7 policies and interventions aimed at reducing the risk and impact of firearm-related injuries and fatalities; and
8
9 WHEREAS, There is a need for a comprehensive understanding of the medical implications and public health
10 consequences associated with the use of weapons intended for military or law enforcement use; therefore be it
11
12 RESOLVED, That ACEP develop a white paper on the examination of weapons intended for military or law
13 enforcement use to inform evidence-based policies, interventions, and public health strategies to address the risks and
14 consequences associated with these firearms and seek collaboration among experts in emergency medicine, public
15 health, and other stakeholders as appropriate to ensure a multidisciplinary approach in the development of the white
16 paper; and be it further
17
18 RESOLVED, That the ACEP white paper on the examination of weapons intended for military or law
19 enforcement use include, but not be limited to, the following components:
20
21 1. A comprehensive review of existing literature, studies, and research on the medical and public health
22 impact of weapons intended for military or law enforcement use, including injury patterns, morbidity,
23 mortality, and the unique challenges they present to emergency medical response and care.

24 2. Examination of the specific characteristics and features of weapons intended for military or law
25 enforcement use that contribute to increased lethality and potential for mass casualties.
26 3. Assessment of the societal impact and psychological consequences associated with the use of weapons
27 intended for military or law enforcement use in mass shootings and other acts of violence.
28 4. Evaluation of existing policies, legislative measures, and firearm regulations pertaining to weapons
29 intended for military or law enforcement use at the federal and state levels and analysis of their
30 effectiveness in preventing and mitigating firearm-related injuries and fatalities.
31 5. Consideration of potential interventions, strategies, and evidence-based approaches to reduce the risks and
32 impact of weapons intended for military or law enforcement use on public health and safety, including but
33 not limited to, firearm safety education, mental health services, and law enforcement initiatives; and be it
34 further
35
36 RESOLVED, That ACEP seek funding, partnerships, and collaboration with relevant stakeholders,
37 organizations, and governmental bodies to support the development of the white paper on the examination of weapons
38 intended for military or law enforcement use; and be it further
39
40 RESOLVED, That upon completion of a white paper on the examination of weapons intended for military or
41 law enforcement use, ACEP will disseminate it to members, policymakers, public health officials, medical
42 organizations, and other interested parties to promote awareness, education, and evidence-based decision-making on
43 the topic of weapons intended for military or law enforcement use; and be it further
44
45 RESOLVED, That ACEP actively engage in advocacy efforts to promote evidence-based policies aimed at
46 reducing the risks and impact of weapons intended for military or law enforcement use on public health and safety.

References

https://www.acep.org/patient-care/policy-statements/firearm-safety-and-injury-prevention
https://www.rand.org/research/gun-policy/analysis/ban-assault-weapons.html
https://www.judiciary.senate.gov/press/dem/releases/studies-gun-massacre-deaths-dropped-during-assault-weapons-ban-increased-after-expiration

Background

The resolution directs the College to develop a white paper on the examination of weapons intended for military or law enforcement use to inform evidence-based policies, interventions, and public health strategies to address the risks and consequences associated with these firearms and seek collaboration among experts in emergency medicine, public health, and other stakeholders as appropriate to ensure a multidisciplinary approach in the development of the white paper; and include in the white paper, but not be limited to, the following components:

1. A comprehensive review of existing literature, studies, and research on the medical and public health impact of weapons intended for military or law enforcement use, including injury patterns, morbidity, mortality, and the unique challenges they present to emergency medical response and care.
2. Examination of the specific characteristics and features of weapons intended for military or law enforcement use that contribute to increased lethality and potential for mass casualties.
3. Assessment of the societal impact and psychological consequences associated with the use of weapons intended for military or law enforcement use in mass shootings and other acts of violence.
4. Evaluation of existing policies, legislative measures, and firearm regulations pertaining to weapons intended for military or law enforcement use at the federal and state levels and analysis of their effectiveness in preventing and mitigating firearm-related injuries and fatalities.
5. Consideration of potential interventions, strategies, and evidence-based approaches to reduce the risks and impact of weapons intended for military or law enforcement use on public health and safety, including but not limited to, firearm safety education, mental health services, and law enforcement initiatives.

It further directs the College to seek funding, partnerships, and collaboration with relevant stakeholders, organizations, and governmental bodies to support the development of the white paper on the examination of weapons intended for military or law enforcement use; upon completion of a white paper on the examination of weapons intended for military or law enforcement use, ACEP will disseminate to its members, policymakers, public health officials, medical organizations, and other interested parties to promote awareness, education, and evidence-based decision-making on the topic of weapons intended for military or law enforcement use; and, actively engage in advocacy efforts to promote evidence based policies aimed at reducing the risks and impact of weapons intended for military or law enforcement use on public health and safety.

A fundamental challenge in the debate over firearms laws and policies revolves around language and semantics, particularly the lack of consensus on definitions and controversy over terminology. Defining objects by intended use is rarely definitive or restrictive. The term "intended for military or law enforcement use, including…" encompasses firearms of all types and historical periods, while also excluding most modern firearms, which are not marketed to the military or police. Conversely, all types of firearms are in current usage with the military and police for various purposes, e.g., basic marksmanship.

Defining firearms by mechanical function (kinetic energy, reloading mechanism, length, rapidity of fire) does not separate traditional and common sporting firearms from military and police firearms, except in the case of fully-automatic reloading mechanisms (firing multiple shots with a single trigger pull) and ammunition belt fed mechanisms.

The term "weapons intended for military or law enforcement use" is most generally used to refer to semi-automatic rifles and shotguns with certain cosmetic similarities, features, or accessories, e.g. pistol or vertical hand grips, removable ammunition magazines, integral mount rails, and bayonet lug. Accessories themselves, not integral to a firearm, have been treated separately under current state and federal laws, e.g. bump stocks (facilitating faster trigger actuation), ammunition magazines (capacity size), sound and flash suppressors, muzzle recoil breaks, folding stocks, forearm braces, and ammunition.

Pistol functions, cosmetics, accessories, and ammunition have remained effectively indistinguishable between civilian, military, and police users for centuries. Certain accessories have been regulated at the state and federal levels, e.g., shoulder stocks, forearm braces, forward grips, magazine capacity, and ammunition.

The U.S. Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), for example, states that "… certain features designed for military application are indicative of non-sporting rifles and shotguns."

Pro-firearm advocates oppose categorization of AR-15-style and other semi-automatic rifles as assault rifles, assault weapons, or even as weapons intended for military/LE use, and that these firearms are instead categorized as "modern sporting rifles," according to the Firearm Industry Trade Association's (NSSF) "Writer's Guide to Firearms and Ammunition."

To illustrate the difficulty in reconciling common definitions between the different camps of advocates, consider the following practical comparison: according to the manual for the Bushmaster XM15 E2S, a AR-15-style semi-automatic rifle available to the public, its rate of fire is 45 rounds per minute. The M4 carbine used by the U.S. military has a rate of fire of 700-950 rounds per minute. Again, while similar in form and basic function, on this example some would consider the XM15 E2S to be a weapon intended for military or law enforcement use while others would qualify it as a modern sporting rifle. Further complicating regulation is that AR-15-style rifles are offered in various ammunition choices, decreasing capacity of the same magazine by up to 66%.

As of 2023, ten U.S. states have banned or restricted the sale of AR- and AK-style and other similar firearms: California, Connecticut, Delaware, Hawaii, Maryland, Massachusetts, New Jersey, New York, Illinois, and most recently, Washington. These laws obviously vary by state, but generally prohibit manufacture, sale, and possession of such a firearm unless the owner lawfully possessed it prior to the ban. At the federal level, the Violent Crime Control and Law Enforcement Act of 1994 similarly banned the manufacture, transfer, or possession of these types of firearms and others ("pre-ban" firearms were grandfathered in), prohibited the manufacture of new large-capacity magazines except for government, military, or law enforcement sales, and banned possession and transfer of new large-capacity

magazines, though pre-ban magazines were exempted and could be legally transferred and possessed as well. The 1994 law included a sunset clause and its provisions expired in 2004. Similar legislation to reinstate a ban has been introduced in Congress ever since, including the current 118th Congress, however none of these efforts have been successfully considered by Congress and enacted into law.

Evidence of the federal ban's effectiveness is mostly inconclusive with respect to impact on the overall U.S. homicide rate. Rifles of all types, regardless of features, were involved in 3% of firearm murders in 2020 according to the Pew Research Center. A 2020 RAND analysis of six studies found evidence to be inconclusive of the effect of state or federal bans on mass shootings (inconsistent evidence for the policy's effect on an outcome, or a single study only found uncertain or suggestive effects), while there is limited evidence that a ban on high-capacity magazines may decrease mass shootings. A 2019 study published in *The Journal of Trauma and Acute Care Surgery*, however, found that mass-shooting related homicides were reduced in the U.S. during the years of the 1994-2004 ban.

The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements, including the current policy statement, "Firearm Safety and Injury Prevention." Among the policy's provisions is the directive that ACEP support legislative and regulatory efforts that "[r]estrict the sale and ownership of weapons, munitions, and large-capacity magazines that are designed for military or law enforcement use, and prohibit the sale of after-market modifications that increase the lethality of otherwise legal firearms." ACEP's legislative and regulatory advocacy over the years includes working with members of Congress to promote efforts to prevent firearm-related injuries and deaths, reduce firearms-related violence, and support public and private initiatives to fund firearm safety and injury prevention research. While not directly the same issue as the firearms identified in this resolution, ACEP has previously supported legislative efforts to ban the manufacture, possession, and sale of "bump stocks" that allow semi-automatic firearms to nearly replicate the firing rate of fully automatic firearms, such as those that were used to perpetrate the October 1, 2017 mass shooting in Las Vegas, NV that claimed the lives of 60 people. ACEP also supported the Trump Administration's 2019 ban on these and similar devices. This regulatory ban has come under scrutiny recently, though, with two federal appeals courts ruling against the ban and its ultimate fate still uncertain.

The current "Firearm Safety and Injury Prevention" policy statement was originally developed by a task force of members with a diversity of positions on the firearms issue and opinions on where/whether ACEP could have a meaningful impact. ACEP policies are reviewed on a 5-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The PHIPC developed a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board approved the revised policy statement in October 2019. The policy statement will be reviewed again by the PHIPC in the 2024-25 committee year as part of the policy sunset review process.

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 addition to the College's own specific efforts, ACEP staff and member representatives also continue to work with the American Medical Association (AMA), American College of Surgeons (ACS) and the ACS Committee on Trauma, the American Academy of Pediatrics (AAP), and other stakeholders to address firearm injury prevention and research. These include, but are not limited to:

- In September 2022, ACEP, ACS, AAP, the American College of Physicians (ACP) and the Council of Medical Specialty Societies (CMSS) cohosted the second Medical Summit on Firearm Injury Prevention, featuring representatives from more than 46 organizations ~~overall~~. This meeting served as a follow-up to the

inaugural summit held in 2019, in which ACEP also participated. The proceedings, including the key takeaways from the summit, were published in the *Journal of the American College of Surgeons* in March 2023. As a continuation of the summit's efforts, the Healthcare Coalition for Firearm Injury Prevention (HCFIP) has been formed as a multidisciplinary coalition of professional organizations representing medicine and public health to collaborate on firearm injury prevention initiatives, with a focus on non-partisan and evidence-based/data driven solutions. The Steering Committee member organizations of HCFIP are AAP, ACEP, ACP, ACS, and CMSS. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.

- In February 2023, ACEP participated in a firearm injury prevention roundtable organized by the AMA. The meeting was joined by the ACS, AAP, the American College of Physicians (ACP), American Psychiatric Association (APA), and the American Academy of Family Physicians (AAFP). As a result of this initial meeting, the AMA has established a Firearm Injury Prevention Task Force on which an ACEP representative will also serve.
- Helped establish and currently serve as both a steering committee member and regular member of the Gun Violence Prevention Research Roundtable (GVPRR), an effort spearheaded by the AAP. The GVPRR is a nonpartisan and national coalition of leading medical, public health, and research organizations focused on advocating for the value for federal funding for firearm violence prevention research.

ACEP worked successfully with other physician specialties, health care providers, and other stakeholders to restore federal funding for firearm morbidity and mortality prevention research, with $25 million split between the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) in December 2019, after a more than 20-year hiatus of federal appropriations for this purpose. ACEP continues to advocate for increased funding for the NIH and CDC to continue and expand this research. For many consecutive years now, ACEP has joined an annual appropriations request letter urging Congress to provide continued funding for firearms injury prevention research. The most recent version of this letter for the 2024 fiscal year includes more than 400 signatories, and asks for a total of $61 million for the CDC, NIH, and the recently established National Institute of Justice (NIJ) to conduct public health research into firearm morbidity and mortality prevention. ACEP has also met with the National Collaborative on Gun Violence Research (NCGVR), a research collaborative with the mission to fund and disseminate nonpartisan scientific research to provide necessary data to establish fair and effective policies, in a discussion to share ACEP's policy priorities regarding firearms injury prevention.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP Resolution 36(19) Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence Page 3 issuing public statements following a mass shooting event advocating for change consistent with the College' s policies, 62.5% were in support of making public statements while 28.1% did not support such action.

The PHIPC developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered

with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

ACEP has supported the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), including AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence. The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on research grants.

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 professional.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. Development of a comprehensive white paper would require diverting current budgeted staff resources from other initiatives to support this effort. Unbudgeted costs of organizing/collaborating with relevant stakeholders for development of a comprehensive research paper, if the costs are not offset by funding opportunities, and unbudgeted funds of approximately $25,000 for an in-person stakeholder meeting for 20 people.

Prior Council Action

The Council has discussed and adopted many resolutions about firearms, although none have focused solely on developing a comprehensive white paper on weapons intended for military or law enforcement use.

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted. Directed ACEP to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted. Directed ACEP to work with stakeholders to raise awareness and advocate for research funding and legislation to address both firearm violence and intimate partner violence.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 ACEP Position Paper; and that ACEP support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted. Directed ACEP to revise the policy statement, "Firearm Safety and Injury Prevention" to reflect the current state of research and legislation.

Resolution 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for funding for research on firearm injury prevention and to work with the AMA and other medical societies to achieve this common cause.

Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs referred to the Board of Directors. Called for a task force to develop a research network of EDs to study the impact of firearm violence and invite interested stakeholders to participate in the network.

Amended Resolution 31(12) Firearm Violence Prevention adopted. Condemned the recent massacres in Aurora, CO and WI and the daily violence throughout the U.S. and reaffirmed ACEP's commitment against gun violence including advocating for public and private funding to study the health effects of gun violence.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted. Sought to collaborate with other medical specialty organizations on firearms issues.

Resolution 22(96) National Center for Injury Prevention and Control adopted. Directed ACEP to continue supporting funding for Injury Prevention and Control in the CDC in which firearms research was included.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted. Supported national safety regulations for firearms.

Amended Resolution 18(93) Firearm Injury Reporting System adopted. Explore collaboration with existing governmental entities to develop a mandatory firearm injury reporting system.

Amended Resolution 17(93) Firearm Injury Prevention adopted. Consider developing and/or promoting public education materials regarding ownership of firearms and the concurrent risk of injury and death.

Amended Resolution 11(93) Violence Free Society adopted. Develop a policy statement supporting the concept of a violence free society and increase efforts to educate member about the preventable nature of violence and the important role physicians can play in violence prevention.

Resolution 15(90) Gun Control not adopted. Sought for ACEP to undertake a complete review of all medical, legal, technical, forensic, and other pertinent literature regarding firearm-related violence with emphasis on the effects of firearm availability to the incidence of such violence, and that ACEP withhold public comment on gun control until such study is completed and an informed, unemotional, and unpolarized position on weapons can be formulated.

Prior Board Action

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted. Directed ACEP to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

Amended Resolution 36(19) Research Funding and Legislation to Address Both Firearm Violence and Intimate Partner Violence adopted.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted.

October 2019, approved the revised policy statement "Firearm Safety and Injury Prevention;" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted.

June 2018, reviewed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention."

Resolution 27(13) Studying Firearm Injuries adopted.

December 2013, assigned Referred Resolution 19(13) Developing a Research Network to Study Firearm Violence in EDs to the Research Committee to provide a recommendation to the Board of Directors regarding further action on the resolution.

Amended Resolution 31(12) Firearm Violence Prevention adopted.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted.

Resolution 22(96) National Center for Injury Prevention and Control adopted.

Resolution 47(94) Firearm Classification referred to the Board of Directors.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted.

Amended Resolution 18(93) Firearm Injury Reporting System adopted.

Amended Resolution 17(93) Firearm Injury Prevention adopted.

Amended Resolution 11(93) Violence Free Society 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 35(23)

SUBMITTED BY: District of Columbia Chapter

SUBJECT: Declaring Firearm Violence a Public Health Crisis

PURPOSE: Declare firearm violence a public health crisis in the United States.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives related to firearms and communications to members and the public. Potential unbudgeted costs depending on other ways ACEP might address the issue, possibly as much as $100,000 depending on the scope of the campaign.

1 WHEREAS, Emergency physicians have the privilege of working on the front lines of health crises; and
2
3 WHEREAS, Emergency physicians have the responsibility to care for victims of firearms violence in our
4 communities; and
5
6 WHEREAS, Firearm violence is an increasing threat to our public health; and
7
8 WHEREAS, Each day, 327 people are shot in the United States; and
9
10 WHEREAS, Firearm violence is the number one cause of death for children and teens in the United States;
11 and
12
13 WHEREAS, ACEP previously stated that emergency physicians have a public health responsibility to address
14 the effects of firearm violence in our communities; and
15
16 WHEREAS, The "Firearm Safety and Injury Prevention" policy statement, last revised in 2019, upholds
17 ongoing support for research, new legislation and regulatory actions, community engagement, addressing social
18 determinants of health in reducing firearm violence, increased mental health resources, and more; and
19
20 WHEREAS, ACEP believes that engaging in firearm violence discussions from the purview of public health
21 and safety is our professional and ethical obligation for our communities; and
22
23 WHEREAS, Other national medical groups (including the, American Academy of Family Physicians,
24 American Academy of Pediatrics, American College of Surgeons, American Medical Association, American
25 Psychological Association, Association of American Medical Colleges, American Public Health Association) have
26 declared firearm violence to be a public health crisis; therefore be it
27
28 RESOLVED, That ACEP declare firearm violence to be a public health crisis in the United States.

Background

The resolution calls for the College to declare firearm violence a public health crisis in the United States. While the resolution does not specify how ACEP might approach the issue, the authors cite similar examples where other physician and medical associations have declared firearm violence a public health crisis using methods such as a white paper, policy statement, letter to Congress or media campaign.

The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements, including the policy statement "Firearm Safety and Injury Prevention" (as also cited in the resolution).

The first paragraph of the policy states:

> "The American College of Emergency Physicians condemns the current rates of injury and death from firearms in the United States. Firearm injury is a leading cause of death among young Americans, is the most common means of suicide death among all Americans, and has psychological and financial ramifications for victims, their families, and the healthcare system. As emergency physicians, we witness the toll firearm injuries take on our patients each day across the United States. We support the need for funding, research, and protocols *to help address this public health issue* [emphasis added]."

While the policy does not emphatically state firearm violence is a public health crisis, it does call attention to firearm violence as a public health issue and also identifies comprehensive legislative, regulatory, public health, and health care efforts that ACEP supports. The policy statement was originally developed by a task force of members with a diversity of positions on the firearms issue and opinions on where/whether ACEP could have a meaningful impact. ACEP policies are reviewed on a 5-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The resolution was assigned to the PHIPC. The committee drafted a revised policy statement. that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board approved the revised policy statement in October 2019. The policy statement will be reviewed again by the PHIPC in the 2024-25 committee year as part of the policy sunset review process.

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."

Recently, ACEP federal advocacy staff recently worked closely with Representative Robin Kelly (D-IL), Vice Chair of the House Gun Violence Prevention Task Force, to help develop and substantially inform the "Gun Violence as a Public Health Emergency Act" (H.R. 5010). Essentially all the information and suggestions provided by ACEP staff and ACEP member experts on the topic were included in the product ultimately introduced in the House of Representatives on July 27, 2023. The legislation calls for the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention to publish data on national firearm deaths and injuries, disaggregated by age, sex, gender, location, type of violence, and type of firearm; information on the types of programs used to respond to and reduce gun violence and their effectiveness; and, data on federal funding and the frequency of research relating to gun violence. ACEP's legislative and regulatory priorities over the years have also included working with members of Congress to promote efforts that may prevent firearm-related injuries and deaths, reduce firearms-related violence, and support public and private initiatives to fund firearm safety and injury prevention research and support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

In addition to the College's own specific efforts, ACEP staff and member representatives also continue to work with the American Medical Association (AMA), American College of Surgeons (ACS) and the ACS Committee on Trauma, the American Academy of Pediatrics (AAP), and other stakeholders to address firearm injury prevention and research. These include, but are not limited to:

- In September 2022, ACEP, ACS, AAP, the American College of Physicians (ACP) and the Council of Medical Specialty Societies (CMSS) cohosted the second Medical Summit on Firearm Injury Prevention,

featuring representatives from more than 46 organizations ~~overall~~. This meeting served as a follow-up to the inaugural summit held in 2019, in which ACEP also participated. The proceedings, including the key takeaways from the summit, were published in the *Journal of the American College of Surgeons* in March 2023. As a continuation of the summit's efforts, the Healthcare Coalition for Firearm Injury Prevention (HCFIP) has been formed as a multidisciplinary coalition of professional organizations representing medicine and public health to collaborate on firearm injury prevention initiatives, with a focus on non-partisan and evidence-based/data driven solutions. The Steering Committee member organizations of HCFIP are AAP, ACEP, ACP, ACS, and CMSS. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.

- In February 2023, ACEP participated in a firearm injury prevention roundtable organized by the AMA. The meeting was joined by the ACS, AAP, the American College of Physicians (ACP), American Psychiatric Association (APA), and the American Academy of Family Physicians (AAFP). As a result of this initial meeting, the AMA has established a Firearm Injury Prevention Task Force on which an ACEP representative will also serve.
- Helped establish and currently serve as both a steering committee member and regular member of the Gun Violence Prevention Research Roundtable (GVPRR), an effort spearheaded by the AAP. The GVPRR is a nonpartisan and national coalition of leading medical, public health, and research organizations focused on advocating for the value for federal funding for firearm violence prevention research.

ACEP worked successfully with other physician specialties, health care providers, and other stakeholders to restore federal funding for firearm morbidity and mortality prevention research, with $25 million split between the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) in December 2019, after a more than 20-year hiatus of federal appropriations for this purpose. ACEP continues to advocate for increased funding for the NIH and CDC to continue and expand this research. For many consecutive years now, ACEP has joined an annual appropriations request letter urging Congress to provide continued funding for firearms injury prevention research. The most recent version of this letter for the 2024 fiscal year includes more than 400 signatories, and asks for a total of $61 million for the CDC, NIH, and the recently established National Institute of Justice (NIJ) to conduct public health research into firearm morbidity and mortality prevention. ACEP has also met with the National Collaborative on Gun Violence Research (NCGVR), a research collaborative with the mission to fund and disseminate nonpartisan scientific research to provide necessary data to establish fair and effective policies, in a discussion to share ACEP's policy priorities regarding firearms injury prevention.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP Resolution 36(19) Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence Page 3 issuing public statements following a mass shooting event advocating for change consistent with the College' s policies, 62.5% were in support of making public statements while 28.1% did not support such action.

The PHIPC developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention

programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

ACEP has supported the mission and vision of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), including AFFIRM's efforts to fund medical and public health research of firearm-related violence, injury and death and development of evidence-based, best practice recommendations for health care providers to prevent and reduce the incidence and health consequences of firearm-related violence. The Emergency Medicine Foundation (EMF) has partnered with AFFIRM on research grants.

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 professional.

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives related to firearms and communications to members and the public. Potential unbudgeted costs depending on other ways ACEP might address the issue, possibly as much as $100,000 depending on the scope of the campaign.

Prior Council Action

The Council has discussed and adopted many resolutions about firearms, although none have focused solely on declaring firearms a public health crisis.

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted. Directed ACEP to support a public health approach to firearms-related violence and the prevention of firearm injuries and deaths as enumerated in the 2018 ACEP Position Paper; and that ACEP support the mission and vision of AFFIRM to advocate for the allocation of federal and private research dollars to further this agenda.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted. Directed ACEP to revise the policy statement, "Firearm Safety and Injury Prevention" to reflect the current state of research and legislation.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted. Sought to collaborate with other medical specialty organizations on firearms issues.

Amended Resolution 11(93) Violence Free Society adopted. Develop a policy statement supporting the concept of a violence free society and increase efforts to educate member about the preventable nature of violence and the important role physicians can play in violence prevention.

Prior Board Action

Resolution 19(19) Support of the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) adopted.

October 2019, approved the revised policy statement "Firearm Safety and Injury Prevention;" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved

October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

January 2019, approved $20,000 contribution to the American Federation for Firearm Injury Reduction in Medicine (AFFIRM).

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted.

June 2018, reviewed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention."

Amended Resolution 11(93) Violence Free Society 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 36(23)

SUBMITTED BY: California Chapter
Leslie Mukau, MD, FACEP
Valerie Norton, MD, FACEP
Bing Pao, MD, FACEP
Scott Pasichow, MD, MPH, FACEP
Katherine Staats, MD, FACEP
Niki Thran, MD, FACEP
Randall Young, MD, FACEP

SUBJECT: Mandatory Waiting Period for Firearm Purchases

PURPOSE: Advocate for a mandatory federal waiting period prior to firearm purchases; assist state chapters in promoting legislation on mandatory waiting periods at the state level; and, add language to the "Firearm Safety and Injury Prevention" policy statement supporting mandatory waiting periods prior to firearm purchases.

FISCAL IMPACT: Budgeted staff resources for ongoing federal advocacy initiatives related to firearms and budgeted committee and staff resources for revising policy statements. Unbudgeted resources would be needed to assist chapters in promoting legislation on mandatory waiting periods and would require diverting current budgeted staff resources from other state advocacy work to support this effort.

1 WHEREAS, More than 48,000 people died in firearm-related incidents in 2021 in the United States, a 23%
2 increase compared to 2019; and
3
4 WHEREAS, Studies show that a mandatory waiting period prior to firearm purchases diminishes the
5 incidence of firearm-related injuries and deaths; and
6
7 WHEREAS, The American Medical Association supports a waiting period of at least one week before
8 purchasing any form of firearm in the United States; and
9
10 WHEREAS, ACEP has an interest in reducing firearm-related injuries and deaths; therefore be it
11
12 RESOLVED, That ACEP advocate for a mandatory federal waiting period prior to firearm purchases; and
13 be it further
14
15 RESOLVED, That ACEP assist state chapters in promoting legislation on mandatory waiting periods at
16 the state level; and be it further
17
18 RESOLVED, That ACEP add language to its "Firearm Safety and Injury Prevention" policy statement
19 supporting mandatory waiting periods prior to firearm purchases.

References

1. Luca M, Malhotra D, Poliquin C., "Handgun waiting periods reduce gun deaths." Proc Natl Acad Sci U S A. 2017;114(46):12162-12165.
2. AMA Policy: Waiting Period Before Gun Purchase H-145.992: https://policysearch.ama-assn.org/policyfinder/detail/waiting%20period?uri=%2FAMADoc%2FHOD.xml-0-549.xml
3. https://www.pewresearch.org/short-reads/2023/04/26/what-the-data-says-about-gun-deaths-in-the-u-s/

Background

The resolution calls for ACEP to advocate for a mandatory federal waiting period prior to firearm purchases; assist state chapters in promoting legislation on mandatory waiting periods at the state level; and, add language to its "Firearm Safety and Injury Prevention" policy statement supporting mandatory waiting periods prior to firearm purchases.

Advocates of mandatory waiting periods for firearms purchases cite evidence that mandatory waiting periods reduce firearms-related injuries and deaths, including suicides, by allowing a prospective buyer to "cool off" and prevent acting upon impulsive behaviors or emotions that may otherwise lead to harm of others or oneself. Several studies have found evidence that waiting periods reduce gun homicides, such as the Luca, Malhotra, and Poliquin study that found a 17 percent reduction in gun homicides based on changes in state-level policy since 1970. Another study of four handgun laws – waiting periods, universal background checks, gun locks, and open carrying regulations – found significantly lower firearm suicide rates. Analyses of multiple studies conducted by RAND's Gun Policy in America initiative have found moderate evidence that mandatory waiting periods reduce total homicides, limited evidence that waiting periods may reduce firearm homicides, and limited evidence that waiting periods may reduce total suicides and moderate evidence that waiting periods may reduce firearms suicides.

Those opposed to mandatory waiting periods suggest that waiting periods are an "unnecessary time tax" on both purchasers and licensed firearms dealers after a federal background check has been carried out under the National Instant Criminal Background Check System (NICS). Additionally, advocates of more permissive firearms policies suggest that these waiting periods are unnecessary burdens that could put an individual who needs a firearm for protection at risk, and that an individual intent on committing a criminal act with a firearm is unlikely to purchase a firearm through legal means so waiting periods disproportionately affect law-abiding citizens.

There is currently no waiting period for firearms purchases at the federal level. Currently, 10 states and the District of Columbia have laws establishing waiting periods applicable to some types of firearms. The specifics of these laws vary by state, but below is a brief overview:

Waiting periods for all firearms purchases:

- California – 10 days
- Colorado – 3 days
- D.C. – 10 days
- Florida – 3 days or time required to complete background check, whichever is later
- Hawaii – 14 days
- Illinois – 72 hours
- Rhode Island – 7 days

Waiting periods for certain types of firearms purchases:

- Minnesota – 30 days. Applies to handguns and "semiautomatic military-style assault weapons" according to statute. All or a portion of the waiting period may be waived by chief of police or sheriff under certain conditions.
- Washington – 10 days. Applies to semi-automatic rifles.

Waiting periods for handgun purchases only:

- Maryland – 7 days
- New Jersey – 7 days

From 1994 through 1998, the Brady Handgun Violence Prevention Act (P.L. 103-159) imposed a federal 5-day waiting period for handgun purchases until superseded by the implementation of NICS in 1998. NICS applies to all types of firearms, not just handguns, and requires all firearms manufacturers, dealers, and importers who hold a

Federal Firearms License (FFL) to submit a background check on all buyers before transferring a firearm (sales/transfers between private parties do not require background checks). The vast majority of NICS background checks are returned immediately (85.30 percent in 2020, 87.98 percent in 2021), with the remainder requiring additional information or investigation which the Federal Bureau of Investigation (FBI) has three days to complete. The FBI NICS Section targets an immediate determination rate of 90 percent. If a NICS request is not completed within three days, the FFL holder may proceed to complete the sale and transfer the firearm to an individual, though they are not required to – Walmart, for example, voluntarily chooses to not complete so-called "default proceed" sales.

The "default proceed" sale process is now referred to by some as the "Charleston loophole" as this is how the perpetrator of the 2015 mass shooting at the Emanuel AME Church in Charleston, SC, was able to acquire a firearm though he should have been prevented from purchasing one. Federal legislation to address this issue, the Enhanced Background Checks Act, has been introduced several times in Congress. This proposal would provide the FBI with additional time to complete a background check before a firearm sale is completed, and if a background check has not been completed within 10 days, the purchaser may request an escalated FBI review. This escalated review triggers a more intensive FBI investigation intended to resolve the case within an additional 10-business day period. If that additional 10-day period lapses, the FFL may proceed with the sale or transfer to the purchaser. This legislation passed the House of Representatives in both the 116th Congress and 117th Congress, but was not considered in the Senate. ACEP has and continues to support this legislation, in line with the current "Firearm Safety and Injury Prevention policy statement."

The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements, including the current policy statement, "Firearm Safety and Injury Prevention." Among the policy's provisions is the directive that ACEP "support universal background checks for all firearm transactions, including private sales and transfers," as well as "support adequate enforcement of existing laws and support new legislation that prevents high-risk and prohibited individuals from obtaining firearms." The policy statement also states that ACEP supports public health and health care efforts that "promote access to effective, affordable, and sustainable mental health services for emergency department patients with acute mental illness for whom access to a firearm poses a real risk to life for themselves or others" and "support research into public policies that may reduce the risk of all types of firearm-related injuries, including risk characteristics that might make a person more likely to engage in violent and/or suicidal behavior."

The current "Firearm Safety and Injury Prevention" policy statement was originally developed by a task force of members with a diversity of positions on the firearms issue and opinions on where/whether ACEP could have a meaningful impact. ACEP policies are reviewed on a 5-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of research and legislation. The PHIPC developed a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board approved the revised policy statement in October 2019. The policy statement will be reviewed again by the PHIPC in the 2024-25 committee year as part of the policy sunset review process. If adopted, this resolution would be assigned to the PHIPC to review the policy statement during the 2023-24 committee year.

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 addition to the College's own specific efforts, ACEP staff and member representatives also continue to work with the American Medical Association (AMA), American College of Surgeons (ACS) and the ACS Committee on Trauma, the American Academy of Pediatrics (AAP), and other stakeholders to address firearm injury prevention and

research. These include, but are not limited to:

- In September 2022, ACEP, ACS, AAP, the American College of Physicians (ACP) and the Council of Medical Specialty Societies (CMSS) cohosted the second Medical Summit on Firearm Injury Prevention, featuring representatives from more than 46 organizations ~~overall~~. This meeting served as a follow-up to the inaugural summit held in 2019, in which ACEP also participated. The proceedings, including the key takeaways from the summit, were published in the *Journal of the American College of Surgeons* in March 2023. As a continuation of the summit's efforts, the Healthcare Coalition for Firearm Injury Prevention (HCFIP) has been formed as a multidisciplinary coalition of professional organizations representing medicine and public health to collaborate on firearm injury prevention initiatives, with a focus on non-partisan and evidence-based/data driven solutions. The Steering Committee member organizations of HCFIP are AAP, ACEP, ACP, ACS, and CMSS. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.
- In February 2023, ACEP participated in a firearm injury prevention roundtable organized by the AMA. The meeting was joined by the ACS, AAP, the American College of Physicians (ACP), American Psychiatric Association (APA), and the American Academy of Family Physicians (AAFP). As a result of this initial meeting, the AMA has established a Firearm Injury Prevention Task Force on which an ACEP representative will also serve.
- Helped establish and currently serve as both a steering committee member and regular member of the Gun Violence Prevention Research Roundtable (GVPRR), an effort spearheaded by the AAP. The GVPRR is a nonpartisan and national coalition of leading medical, public health, and research organizations focused on advocating for the value for federal funding for firearm violence prevention research.

ACEP worked successfully with other physician specialties, health care providers, and other stakeholders to restore federal funding for firearm morbidity and mortality prevention research, with $25 million split between the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) in December 2019, after a more than 20-year hiatus of federal appropriations for this purpose. ACEP continues to advocate for increased funding for the NIH and CDC to continue and expand this research. For many consecutive years now, ACEP has joined an annual appropriations request letter urging Congress to provide continued funding for firearms injury prevention research. The most recent version of this letter for the 2024 fiscal year includes more than 400 signatories, and asks for a total of $61 million for the CDC, NIH, and the recently established National Institute of Justice (NIJ) to conduct public health research into firearm morbidity and mortality prevention. ACEP has also met with the National Collaborative on Gun Violence Research (NCGVR), a research collaborative with the mission to fund and disseminate nonpartisan scientific research to provide necessary data to establish fair and effective policies, in a discussion to share ACEP's policy priorities regarding firearms injury prevention.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP Resolution 36(19) Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence Page 3 issuing public statements following a mass shooting event advocating for change consistent with the College' s policies, 62.5% were in support of making public statements while 28.1% did not support such action.

The PHIPC developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

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 professional.

Fiscal Impact

Budgeted staff resources for ongoing federal advocacy initiatives related to firearms and budgeted committee and staff resources for revising policy statements. Unbudgeted resources would be needed to assist chapters in promoting legislation on mandatory waiting periods and would require diverting current budgeted staff resources from other state advocacy work to support this effort.

Prior Council Action

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted. Directed ACEP to revise the policy statement, "Firearm Safety and Injury Prevention" to reflect the current state of research and legislation.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted. Sought to collaborate with other medical specialty organizations on firearms issues.

Amended Resolution 11(93) Violence Free Society adopted. Develop a policy statement supporting the concept of a violence free society and increase efforts to educate member about the preventable nature of violence and the important role physicians can play in violence prevention.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted. Support federal and state legislation to require 15-day waiting period for the sale, purchase, or transfer of any firearm to allow time for a background check on the individual and also support legislation mandating significant penalties for possession of a firearm while committing a crime.

Substitute Resolution 16(84) Ban on Handguns adopted. Deplored the loss of life and limb secondary to the improper use of handguns; supported legislation mandating significant penalties for possession of a handgun while committing a crime; support legislation mandating significant penalties for the illegal sale of handguns; support a waiting period for all prospective handgun buyers; supported successful completion of an education program on handgun safe for all prospective handgun buyers; support development of educational programs on the proper use of handguns for existing owners; support requiring screening of prospective handgun buyers for previous criminal records and mental health problems that have led to violent behavior.

Prior Board Action

October 2019, approved the revised policy statement "Firearm Safety and Injury Prevention;" approved April 2013 with current title, replacing rescinded policy statement titled "Firearm Injury Prevention;" revised and approved October 2012, January 2011; reaffirmed October 2007; originally approved February 2001 replacing 10 separate policy statements on firearms.

June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.
.
Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted.

June 2018, reviewed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention."

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted.

Amended Resolution 11(93) Violence Free Society adopted.

Amended Resolution 13(89) Waiting Period to Purchase Firearms adopted.

Substitute Resolution 16(84) Ban on Handguns adopted.

Background Information Prepared by: Ryan McBride, MPP
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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 37(23)

SUBMITTED BY: Leslie Mukau, MD, FACEP
Valerie Norton, MD, FACEP
Bing Pao, MD, FACEP
Katherine Staats, MD, FACEP
Niki Thran, MD, FACEP
Randall Young, MD, FACEP
California Chapter

SUBJECT: Support for Child-Protective Safety Firearm Safety and Storage Systems

PURPOSE: Support efforts to improve firearm safety in the United States, including smart gun technology, while respecting responsible firearm ownership, and promote child-protective firearm safety and storage systems.

FISCAL IMPACT: Budgeted staff resources for ongoing advocacy initiatives related to firearms. Unbudgeted funds may be required if further action beyond advocacy is needed.

1 WHEREAS, Firearm-related fatalities are now the number one cause of death in the United States in children
2 and adolescents since 2020[2,3,4,] with a disproportionate effect on children from communities of color[5]; and
3
4 WHEREAS, Firearm safety laws, including those that address child-protective firearm safety and storage
5 systems, have been associated with reduced firearm-related mortality[1]; and
6
7 WHEREAS, Smart gun technology has the potential to reduce accidental firearm injuries and teenage suicide;
8 therefore be it
9
10 RESOLVED, That ACEP support efforts to improve firearm safety in the United States, including smart gun
11 technology, while respecting responsible firearm ownership; and be it further
12
13 RESOLVED, That ACEP promote child-protective firearm safety and storage systems.

References

1. https://www.pewresearch.org/short-reads/2023/04/26/what-the-data-says-about-gun-deaths-in-the-u-s/, accessed June 17, 2023.
2. Stevens J, Pickett K, Reppucci ML, Nolan M, Moulton SL. National trends in pediatric firearm and automobile fatalities. J Pediatr Surg. 2023 Jan;58(1):130-135.
3. Kaufman EJ, Richmond TS, Hoskins K. Youth Firearm Injury: A Review for Pediatric Critical Care Clinicians. Crit Care Clin. 2023 Apr;39(2):357-371.
4. Goldstick JE, Cunningham RM, Carter PM. Current causes of death in children and adolescents in the United States. NEJM. 2022;386(20):1955–6.
5. Lanfear CC, Bucci R, Kirk DS, Sampson RJ. Inequalities in Exposure to Firearm Violence by Race, Sex, and Birth Cohort From Childhood to Age 40 Years, 1995-2021. JAMA Netw Open. 2023 May 1;6(5):e2312465.

Background

The resolution directs the College to support efforts to improve firearm safety in the United States, including smart gun technology, while respecting responsible firearm ownership, and to promote child-protective firearm safety and storage systems.

Smart gun technology only allows a firearm to be operated by an authorized user. These systems may include fingerprint or other biometric recognition, radiofrequency identification (RFID) tags and readers, other proximity sensors or detectors, magnetic rings, or mechanical locks. While such technology has been developed, tested, and theoretically feasible for commercial firearms sales in the U.S. for decades, only recently (July 2023) has a manufacturer released a smart gun to the market. Reliability testing failures have thus far prevented military or police acceptance. Such technology has been promoted by advocates of greater firearms safety and injury prevention as a safety feature that could help prevent unauthorized use, reducing both unintentional and intentional injuries (especially for children and teenagers), preventing accidental discharges, discouraging firearms theft and illicit sales. Others, while not necessarily opposed to the technology itself, have expressed concerns that smart gun technology may lead to legal mandates for all firearms to be equipped with these systems. Advocates for more permissive firearms laws and regulations also state concerns that smart gun technology may fail or be unreliable in critical moments, such as when an individual is under duress; that systems may be defeated or manipulated by bad actors; or, that smart gun systems using wireless/RFID technology could be monitored by criminals or law enforcement to detect who is carrying a firearm in a given area (thus hindering the purpose of concealed carry).Additionally, smart guns are typically significantly more expensive than their more traditional counterparts, limiting potential uptake, and retrofitting the technology to existing firearms is not feasible.

Child-protective firearm safety and safe storage systems encompass a variety of measures – safes or lockboxes for handguns, locked gun safes for rifles and shotguns, trigger locks that prevent the trigger from being pulled, cable locks, and separate lockboxes for ammunition, among others. According to the American Academy of Pediatrics (AAP), 16 states and the District of Columbia have laws requiring firearms to be stored locked, two states have laws requiring trigger locks to accompany firearm purchases, and nine states requiring firearms to be stored locked and trigger locks to accompany purchases. Some safe storage laws do not require all firearms to be stored locked, but are limited to child access prevention. Virginia law, for example, prohibits any individual from "recklessly" leaving a loaded, unsecured firearm in such a manner as to endanger the life or limb of any child under the age of fourteen, and also prohibits any individual from knowingly authorizing a child under the age of twelve to use a firearm unless under the direct supervision of an adult. Supporters of child-protective or safe storage policies note growing evidence-based research that such policies are associated with reductions in suicide, unintentional injuries and death, and homicides, including for young adults. The AAP, for example, "…supports a number of measures to reduce the destructive effects of guns in the lives of children and adolescents, including safe storage and CAP laws." Those opposed to safe storage mandates, note concerns that restrictive laws prevent quick, timely access to firearms for self-defense, and further that the U.S. Supreme Court already ruled in *District of Columbia v. Heller* (2008) that D.C.'s requirement that rifles must be unloaded or disassembled or bound by a trigger lock violated the Second Amendment.

The College has addressed the issue of firearms many times over the years through Council resolutions and policy statements, including the current policy statement, "Firearm Safety and Injury Prevention." Among the policy's provisions is the directive that ACEP "support research into public policies that may reduce the risk of all types of firearm-related injuries, including risk characteristics that might make a person more likely to engage in violent and/or suicidal behavior."

Various studies have shown a strong correlation between firearm safety instruction to children and a reduction in dangerous interactions with firearms. A study published July 2023 in JAMA Pediatrics found that children ages 8-12 were three times more likely to avoid touching a discovered firearm when they had been shown a single one-minute firearm safety video a week prior. They were also three times more likely to tell an adult.

The current "Firearm Safety and Injury Prevention" policy statement was originally developed by a task force of members with a diversity of positions on the firearms issue and opinions on where/whether ACEP could have a meaningful impact. ACEP policies are reviewed on a 5-year cycle as part of the policy sunset review process. Committees and section are assigned specific policies for review and recommendations are then made to the Board to reaffirm, revise, rescind or sunset the policy statement. The policy statement was assigned to the Public Health & Injury Prevention Committee (PHIPC) for review during the 2018-19 committee year. Subsequently, a resolution was submitted to the 2018 Council that called for the revision of the policy, requesting an emphasis on the importance of research in firearm injury and on the relationship of firearm use in suicide attempts; and included additional language restricting the sale of after-market modifications to firearms that increase the lethality of otherwise legal weapons. The Council adopted a substitute resolution that directed the policy statement be revised to reflect the current state of

research and legislation. The PHIPC developed a revised policy statement that reflected many of the revisions as recommended in the original resolution submitted to the 2018 Council. The Board approved the revised policy statement in October 2019. The policy statement will be reviewed again by the PHIPC in the 2024-25 committee year as part of the policy sunset review process.

The policy statement "Violence-Free Society" also notes that "ACEP believes emergency physicians have a public health responsibility to reduce the prevalence and impact of violence through advocacy, education, legislation, and research initiatives."

In 2018, the Public Health and Injury Prevention Committee developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" that provides information on prevention of firearm injuries, including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs, and listings of community-based firearm violence prevention programs by state.

In addition to the College's own specific efforts, ACEP staff and member representatives also continue to work with the American Medical Association (AMA), American College of Surgeons (ACS) and the ACS Committee on Trauma, the American Academy of Pediatrics (AAP), and other stakeholders to address firearm injury prevention and research. These include, but are not limited to:

- In September 2022, ACEP, ACS, AAP, the American College of Physicians (ACP) and the Council of Medical Specialty Societies (CMSS) cohosted the second Medical Summit on Firearm Injury Prevention, featuring representatives from more than 46 organizations ~~overall~~. This meeting served as a follow-up to the inaugural summit held in 2019, in which ACEP also participated. The proceedings, including the key takeaways from the summit, were published in the *Journal of the American College of Surgeons* in March 2023. As a continuation of the summit's efforts, the Healthcare Coalition for Firearm Injury Prevention (HCFIP) has been formed as a multidisciplinary coalition of professional organizations representing medicine and public health to collaborate on firearm injury prevention initiatives, with a focus on non-partisan and evidence-based/data driven solutions. The Steering Committee member organizations of HCFIP are AAP, ACEP, ACP, ACS, and CMSS. Additional invitations to join the coalition will be disseminated to a preliminary list of nearly 70 organizations and work should formally start in late 2023 or early 2024.
- In February 2023, ACEP participated in a firearm injury prevention roundtable organized by the AMA. The meeting was joined by the ACS, AAP, the American College of Physicians (ACP), American Psychiatric Association (APA), and the American Academy of Family Physicians (AAFP). As a result of this initial meeting, the AMA has established a Firearm Injury Prevention Task Force on which an ACEP representative will also serve.
- Helped establish and currently serve as both a steering committee member and regular member of the Gun Violence Prevention Research Roundtable (GVPRR), an effort spearheaded by the AAP. The GVPRR is a nonpartisan and national coalition of leading medical, public health, and research organizations focused on advocating for the value for federal funding for firearm violence prevention research.

ACEP worked successfully with other physician specialties, health care providers, and other stakeholders to restore federal funding for firearm morbidity and mortality prevention research, with $25 million split between the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) in December 2019, after a more than 20-year hiatus of federal appropriations for this purpose. ACEP continues to advocate for increased funding for the NIH and CDC to continue and expand this research. For many consecutive years now, ACEP has joined an annual appropriations request letter urging Congress to provide continued funding for firearms injury prevention research. The most recent version of this letter for the 2024 fiscal year includes more than 400 signatories, and asks for a total of $61 million for the CDC, NIH, and the recently established National Institute of Justice (NIJ) to conduct public health research into firearm morbidity and mortality prevention. ACEP has also met with the National Collaborative on Gun Violence Research (NCGVR), a research collaborative with the mission to fund and disseminate nonpartisan scientific research to provide necessary data to establish fair and effective policies, in a discussion to share ACEP's policy priorities regarding firearms injury prevention.

ACEP conducted an all member survey in the fall of 2018. Three of the survey questions were about firearms. The following questions were asked:

- Do you support ACEP's policies on firearms safety and injury prevention (increased access to mental health services, expanded background checks, adequate support and training for the disaster response system, increased funding for research, and restrictions on the sale and ownership of weapons, munitions, and large-capacity magazines designed for military or law enforcement use)?
- Do you support limiting firearms purchases to individuals 21 years or older?
- When mass shootings occur, should ACEP issue public statements advocating for change consistent with the College's policies (referred to above)?

The survey was sent to 32,400 members including medical students and residents with 3,465 responses. Sixty-nine percent of the respondents support the current ACEP policy statement in its entirety with 21.3 % in support of part of the policy. Limiting firearm purchases to individuals 21 years or older was supported by 68.7% of the respondents and not supported by 25.3%. Almost 6% did not know if they supported the age limit or not. When asked about ACEP Resolution 36(19) Research Funding and Legislation to Curb Gun Violence and Intimate Partner Violence Page 3 issuing public statements following a mass shooting event advocating for change consistent with the College' s policies, 62.5% were in support of making public statements while 28.1% did not support such action.

The PHIPC developed the information paper "Resources for Emergency Physicians: Reducing Firearm Violence and Improving Firearm Injury Prevention" on prevention of firearm injuries including relevant emergency medicine firearm violence and injury prevention programs, prevention practice recommendations, firearm suicide prevention programs as well as listings of community-based firearm violence prevention programs by state. ACEP also partnered with the American Medical Association and the American College of Surgeons to work on issues of common concern to address gun violence through public health research and evidence-based practice.

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 professional.

Fiscal Impact

Budgeted staff resources for ongoing advocacy initiatives related to firearms. Unbudgeted funds may be required if further action beyond advocacy is needed.

Prior Council Action

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted. Directed ACEP to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

Substitute Resolution 44(18) Firearm Safety and Injury Prevention Policy Statement adopted. Directed ACEP to revise the policy statement, "Firearm Safety and Injury Prevention" to reflect the current state of research and legislation.

Resolution 27(13) Studying Firearm Injuries adopted. Directed ACEP to advocate for funding for research on firearm injury prevention and to work with the AMA and other medical societies to achieve this common cause.

Resolution 14(00) Childhood Firearm Injuries referred to the Board of Directors. Directed ACEP to support legislation that requires safety locks on all new guns sold in the USA and support legislation that holds the adult gun owner legally responsible if a child is accidentally injured with the gun.

Resolution 18(97) ACEP Collaboration with Other Medical Specialty Organizations on Firearms Issues adopted. Sought to collaborate with other medical specialty organizations on firearms issues.

Amended Resolution 43(94) Support of National Safety Regulations for Firearms adopted. Supported national safety regulations for firearms.

Amended Resolution 17(93) Firearm Injury Prevention adopted. Consider developing and/or promoting public education materials regarding ownership of firearms and the concurrent risk of injury and death.

Amended Resolution 11(93) Violence Free Society adopted. Develop a policy statement supporting the concept of a violence free society and increase efforts to educate member about the preventable nature of violence and the important role physicians can play in violence prevention.

Prior Board Action

Resolution 33(21) Formation of a National Bureau for Firearm Injury Prevention adopted. Directed ACEP to support the creation of a National Bureau for Firearm Injury Prevention that would lead and coordinate a long-term, multidisciplinary campaign to reduce firearm injury and deaths based on proven public health research and practices.

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June 2019, approved sending a survey on firearms research, safety, and policy to the ACEP Council.

April 2019, approved the revised policy statement "Violence-Free Society;" reaffirmed June 2013, revised and approved January 2007; reaffirmed October 200; originally approved January 1996.

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Amended Resolution 11(93) Violence Free Society 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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RESOLUTION: 38(23)

SUBMITTED BY: Pennsylvania College of Emergency Physicians

SUBJECT: Advocating for Sufficient Reimbursement for Emergency Physicians in Critical Access Hospitals and Rural Emergency Hospitals

PURPOSE: Advocate for sufficient reimbursement for emergency physician services in critical access hospitals and rural emergency hospitals to ensure the availability of board certified emergency physicians who possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient safety, and supporting the sustainability of health care services in rural communities.

FISCAL IMPACT: Budgeted staff resources for continuing current advocacy initiatives.

1 WHEREAS, Critical access hospitals and rural emergency hospitals play a crucial role in providing
2 emergency care in geographically underserved areas, often operating with limited resources and facing unique
3 challenges; and
4
5 WHEREAS, These rural healthcare facilities require staffing by board certified emergency physicians who
6 possess the necessary skills and expertise to treat a wide range of injuries, illnesses, and perform interventions,
7 including resuscitative procedures and trauma stabilization across all age groups; and
8
9 WHEREAS, Insufficient reimbursement for professional services in rural emergency departments has led to
10 financial constraints, forcing these departments to rely on inadequately trained personnel, such as nurse practitioners
11 and physicians assistants, without the presence of a board certified emergency physician on site; and
12
13 WHEREAS, Section 125 of the Consolidated Appropriations Act of 2021 established the Rural Emergency
14 Hospital (REH) as a new Medicare provider type, allowing struggling rural hospitals to continue operating with
15 outpatient and emergency services to preserve access to essential healthcare services in underserved areas; and
16
17 WHEREAS, Under the act, REHs have the opportunity to receive enhanced payment upon meeting certain
18 requirements, recognizing the additional challenges and resource limitations faced by these health care facilities;
19 therefore be it
20
21 RESOLVED, That ACEP advocate for sufficient reimbursement for emergency physician services in critical
22 access hospitals and rural emergency hospitals to ensure the availability of board certified emergency physicians who
23 possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing
24 the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient
25 safety, and supporting the sustainability of health care services in rural communities.

Background

The resolution calls for ACEP to advocate for sufficient reimbursement for emergency physician services in critical access hospitals and rural emergency hospitals to ensure the availability of board certified emergency physicians who possess the necessary skills and expertise to provide high-quality care in these underserved areas, thereby recognizing the critical role of board certified emergency physicians in delivering high-quality emergency care, promoting patient safety, and supporting the sustainability of health care services in rural communities.

With rural EDs representing 53% of all hospitals in the U.S. and 24% of total ED patient volume the care provided at these sites significantly affects the overall health of the U.S. population and, as such, demands the attention of our organization.

To increase access to emergency services in rural areas, the implementation of the REH designation under Medicare was included in the Consolidated Appropriations Act 2021 (Public Law 116-260) passed by Congress in late December 2020 and would allow critical access hospitals and small rural hospitals (with fewer than 50 beds) to convert to an REH beginning January 1, 2023. Once established, an REH will not provide any inpatient services, but must be able to provide 24/7 coverage for emergency services. They must also meet other requirements, including, but not limited to, having transfer agreements in place with a level I or II trauma center; adhering to quality measurement reporting requirements to be set by CMS; and following new emergency department conditions of participation (COPs). REHs will receive a five percent reimbursement bump for facility payments that hospitals traditionally receive for outpatient services under the Medicare OPPS and will receive an additional facility payment on top of that. However, while this new provider designation provides higher facility payments for REHs, emergency physicians will not receive higher payments under the Medicare Physician Fee Schedule (PFS) for providing services in an REH. CMS is currently in the process of writing the regulations and processing comments on the new designation that will be included in the CY20223 OPPS rule.

ACEP worked with Congress on the legislative language that was included in the initial Consolidated Appropriations Act and was proactive in reaching out to CMS to help construct various REH requirements. In June 2021, ACEP specifically requested that although REHs can legally be staffed by non-physician practitioners, we strongly believe that all care provided in REHs should be supervised by a board-certified emergency physician, even remotely via telehealth. ACEP also had a Congressional meeting on this before any regulations were released. ACEP submitted comprehensive response on proposed regulations establishing conditions of participation for REHs that were released in July 2022. ACEP also submitted a joint response to the regulation with the American Academy of Family Physicians focusing on the issue of scope of practice and the importance of having physician-led teams provide the care that is delivered in REHs. We strongly recommended that physicians should supervise all care delivered by non-physician practitioners in REHs. When possible, board-certified emergency physicians should conduct that supervision, but we understand that, due to workforce issues, that is not always possible. When a board-certified emergency physician is not available, it is still critical that physicians experienced and/or trained in emergency medicine (such as family physicians) oversee care being delivered by non-physician practitioners in REHs.

ACEP has also advocated for increased reimbursement for clinicians, including emergency physicians, that may work in rural emergency hospitals (REHs) once they have been established. To incentivize physicians and other clinicians to work in rural areas and appropriately staff REHs, ACEP requested in our official response to the Calendar Year (CY) 2023 OPPS proposed rule that the Centers for Medicare & Medicaid Services (CMS) consider creating an add-on code or modifier under the Medicare Physician Fee Schedule (PFS) that clinicians could append to claims for services delivered in REHs. CMS could consider setting the value of this add-on code or modifier at five percent of the PFS rate for each code that is billed – consistent with the additional OPPS payment that the statute provides. In other words, although the statute provides an additional payment for facilities, ACEP argued that there must also be a commensurate payment for clinicians under the PFS in order for REHs to have the resources and staff necessary to be a viable option for patients who need emergency treatment or other services in rural areas.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas called for ACEP to engage appropriate stakeholders, including at the federal and state levels, to find innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians. Whereas global budgeting models have focused on the hospital/facility side of reimbursement, not on professional physician fee reimbursement that is still largely dependent on patient volumes or subsidies, this resolution proposed a global budgeting model specifically for professional physician fee reimbursement could address this gap, decoupling emergency care from more traditional volume-dependent payment, helping incentivize and maintaining financial viability of coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians. Some in favor of this

approach propose that in such a system, emergency physicians would be paid at a market-determined fixed rate, whether employed directly by a hospital under a global physician budget or employed by a practice management organization that contracts directly with the facility. Proponents of this model suggest that this would help eliminate the challenges of balancing high vs. low reimbursed visits relative to the resources expended, would help guarantee 24/7/365 coverage of rural EDs, and would also help provide a financial cushion to provide for surge capacity. Some of the key considerations noted by proponents and observers alike are the need for a well-defined catchment area or the ability to identify an appropriate reference population needed to determine a global budget, as well as if the service area can provide enough patient volume to sustain the model. Some have also noted that given the growth of new value-based payment pathways, rural hospitals may be able to adopt other payment mechanisms (e.g., managed care programs, accountable care organizations, etc.) that are easier to implement while achieving the same ultimate results in care delivery transformation. Another potential challenge may be the willingness for payers to participate in an all-payer global budgeting model and other issues posed by longstanding conflict between hospitals/systems and payers.

ACEP has had three separate task forces in the past ten years to address the issue of attracting emergency physicians to practice in rural areas. 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, even though 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.

In May 2018, ACEP met with the Centers for Medicare & Medicaid Services (CMS) to discuss innovative payment approaches that would improve access to care in rural areas. ACEP staff provided an overview of a data analysis ACEP prepared on Medicare ED utilization in rural areas, and discussed how ACEP's alternative payment model, the Acute Unscheduled Care Model (AUCM), could be implemented in these areas. Since that meeting, ACEP's federal affairs staff have continued to follow up with CMS and provide additional information to help inform the ongoing work in this area. CMS has not yet approved the AUCM model for use.

ACEP's current legislative and regulatory priorities for the First Session of the 118th Congress include:

- Promote legislative options and solutions to ensure rural patients maintain access to emergency care, including supporting the use of government funding for rural elective rotations for EM residents at rural CAHs.
- Support innovative models of care that enable or promote access to emergency care, such as Rural Emergency Hospitals, digital health, Free Standing Emergency Departments, telehealth, etc.
- Monitor the willingness of critical access hospitals and rural hospitals to convert to Rural Emergency Hospitals, and develop policy suggestions that would make this a more attractive option.
- Develop and propose federal legislation to address unique challenges for the current and future EM workforce, with special consideration for solutions to promote access to board-certified EPs in rural and underserved communities.
- Support student loan forgiveness for physicians choosing to practice EM in rural areas.

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 professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted staff resources for continuing current advocacy initiatives.

Prior Council Action

The Council has discussed and adopted many resolutions regarding rural emergency care. The following resolutions are specific to advocating for sufficient reimbursement for emergency physician services in critical access hospitals and rural emergency hospitals and to ensure the availability of board certified emergency physicians in these underserved areas.

Amended Resolution 50(22) Supporting Emergency Physicians to Work in Rural Settings adopted. The resolution directed ACEP to support and encourage emergency medicine trained and board certified emergency physicians to work in rural EDs; help establish, with the Council of Residency Directors in Emergency Medicine, a standardized training program for emergency medicine residents with aspirations to work in rural settings; and support working with the Accreditation Council for Graduate Medical Education and Centers for Medicare and Medicaid Services to increase resident exposure and remove regulatory barriers to rural emergency medicine.

Resolution 49(22) Enhancing Rural Emergency Medicine Patient Care not adopted. The resolution called for ACEP to 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; support initiatives that promote rural EDs to seek coverage by emergency medicine trained and board certified physicians; and 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.

Resolution 35(21) Preserving Care in Rural Critical Access Hospitals and Rural Emergency Hospitals first two resolveds adopted and last three resolveds referred to the Board of Directors. The resolution directed ACEP to: 1) Support the rural critical access hospital program, including conversion of certain rural hospitals into rural emergency hospitals; 2) support rural health services research to better understand the optimal funding mechanism for rural hospitals; 3) support cost-based reimbursement for rural critical access hospitals and rural emergency hospitals at a minimum of 101% of patient care; 4) support changes in CMS regulation to allow rural off-campus EDs and rural emergency hospitals to collect the facility fee as well as the professional fee; and 5) advocate for insurance plans to aggregate all institutional and professional billing related to an episode of care and send one unified bill to the patient.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas adopted. The resolution directed that ACEP engage appropriate stakeholders, including at the federal and state levels, to find innovative staffing, payment, and reimbursement models, including but not limited to potential global budgeting for emergency physician professional services that incentivize and maintain financial viability of the coverage of emergency departments in rural and underserved areas by board eligible/certified emergency physicians.

Prior Board Action

February 2023, approved the legislative and regulatory priorities for the First Session of the 118th Congress that include several initiatives related to rural emergency care.

Amended Resolution 50(22) Supporting Emergency Physicians to Work in Rural Settings adopted.

June 2022, approved the revise policy statement "Rural Emergency Medical Care" with the current title; originally approved June 2017 titled "Definition of Rural Emergency Medicine."

January 2022, approved the legislative and regulatory priorities for the Second Session of the 117th Congress that included several initiatives related to rural emergency care.

Resolution 35(21) Preserving Care in Rural Critical Access Hospitals and Rural Emergency Hospitals first two resolveds adopted.

Resolution 34(21) Global Budgeting for Emergency Physician Reimbursement in Rural and Underserved Areas adopted.

January 2021, approved the legislative and regulatory priorities for the First Session of the 117th Congress that include several initiatives related to rural emergency care.

October 2020, filed the report of the Rural Emergency Care Task Force. ACEP's Strategic Plan was updated to include tactics to address recommendations in the report.

Background Information Prepared by: David McKenzie
Reimbursement 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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RESOLUTION: 39(23)

SUBMITTED BY: Bing Pao, MD. FACEP
Thomas Sugarman, MD, FACEP
California Chapter

SUBJECT: Medicaid Reimbursement for Emergency Services

PURPOSE: Advocate at the federal and state level for Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates and submit a resolution to the AMA to advocate for reimbursing emergency physicians at rates equivalent to or above Medicare rates.

FISCAL IMPACT: Budgeted staff resources for ongoing federal and state advocacy initiatives.

1 WHEREAS, EMTALA requires emergency departments to provide care to any patient that seeks emergency
2 service; and
3
4 WHEREAS, Emergency departments must provide care even if a patient is uninsured and can't afford to pay
5 for emergency medical care; and
6
7 WHEREAS, Emergency physicians must accept Medicare and Medicaid payments even if the reimbursement
8 is below the cost of care[1]; and
9
10 WHEREAS, Emergency departments are not reimbursed for providing standby capacity; and
11
12 WHEREAS; More than 150 rural hospitals nationwide closed between 2005 and 2019 mainly because of
13 financial difficulties[2]; and
14
15 WHEREAS, The federal government reimbursed emergency providers at Medicare rates for uninsured covid
16 related care[3]; and
17
18 WHEREAS, Many states reimburse emergency providers at or above Medicare rates for Medicaid enrollees[4];
19 and
20
21 WHEREAS, The No Surprises Act has allowed commercial plans to reduce payment for emergency
22 professional care and increase the financial burden for emergency providers to care for the uninsured and under-
23 insured; and
24
25 WHEREAS, Access to emergency care is being threatened because of the financial strain of adequately
26 staffing emergency departments; therefore be it
27
28 RESOLVED, That ACEP advocate at the federal level and support chapters in advocating at the state level for
29 Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates; and be it
30 further
31
32 RESOLVED, That ACEP submit a resolution to the American Medical Association to advocate for
33 reimbursing emergency physicians at rates equivalent to or above Medicare rates.

References
1. Pines JM, Zocchi MS, Black BS, Carr BG, Celedon P, Janke AT, Moghtaderi A, Oskvarek JJ, Venkatesh AK, Venkat A; US Acute Care Solutions Research Group. The Cost Shifting Economics of United States Emergency Department Professional Services (2016-2019). Ann Emerg Med. 2023 Jun 15:S0196-0644(23)00353-0. doi: 10.1016/j.annemergmed.2023.04.026. Epub ahead of print. PMID: 37330720.
2. Center for Healthcare Quality and Payment Reform. (n.d.). Rural Hospitals at risk of closing - CHQPR. https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
3. Coronavirus Aid, Relief, and Economic Security Act" or the ``CARES Act, Pub. L. No. 116-136 (2020), https://www.govinfo.gov/app/details/PLAW-116publ136.
4. KFF. (n.d.). Medicaid-to-Medicare Fee Index. https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Background

The resolution requests that ACEP advocate at the federal and state level for Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates and submit a resolution to the AMA to advocate for reimbursing emergency physicians at rates equivalent to or above Medicare rates.

Medicaid patients currently count for around 40% of the payer mix in many emergency departments. This is a significant increase from close to 20% 15 years ago before the original Patient Protection and Affordable Care Act (PPACA, also known as the Affordable Care Act or ACA) required all states to expand Medicaid eligibility and shifted much of the previously uninsured population to Medicaid coverage. The current percentage may start to decline with the unwinding of Medicaid expansion following the end of the public health emergency, although with a likely increase in the percentage of uninsured patients.

Historically, Medicaid payments are set by individual states based on statutory and budget constraints and make up the majority of state general fund spending. Each state is responsible for paying a percentage of their claims with the federal government picking up the other half or more of the cost of Medicaid. If a state runs out of the budget for Medicaid payments before the year is over, it may suspend payment in arrears until the next budget cycle, thereby starting the next year's budget already underfunded for new claims.

When Medicaid rates are very low in a state for primary care office visits, it tends to drive this vulnerable population to seek care in the emergency department where EMTALA mandates they receive appropriate care. All these factors place a heavy burden on the emergency department to provide quality care, usually at a payment rate lower than the cost it entails. The federal budget has little room for increased spending, so achieving Medicaid payment parity rates with Medicare will be a heavy lift.

ACEP has advocated at the state and federal level for parity between Medicaid and Medicare going back to at least the ACA in 2010. Individual state chapters have also advanced legislation to put Medicaid reimbursement on par with Medicare rates, with mixed success. Advocacy efforts have been geared toward Medicaid expansion in states that failed to expand Medicaid eligibility and funding for the most vulnerable populations following the implementation of the ACA.

The AMA has been a proponent of parity between Medicaid and Medicare rates since 2013 when they supported the *Ensuring Access to Primary Care for Women and Children Act* that would continue the current requirement that Medicaid pay at rates no lower than Medicare for services provided by family physicians, general internists, and pediatricians, as well for as ob-gyns who provide a significant volume of certain primary care services. More recently, the AMA House of Delegates has supported parity for additional services beyond primary care, however this has yet to become part of the AMA's policy objectives.

Over the years, ACEP has developed Medicaid resources for members and chapters in advocating for adequate and fair reimbursement policies at the state level. Resolution 40(22) Support for Medicaid Expansion directed ACEP 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. This resolution was assigned to the State Legislative/Regulatory Committee and is in progress.

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 professional.

Fiscal Impact

Budgeted staff resources for ongoing federal and state advocacy initiatives.

Prior Council Action

The Council has discussed and adopted many resolutions regarding Medicaid, Medicare, and reimbursement, although, none that are specific to advocating at the federal and state level for Medicaid programs to reimburse emergency physicians at rates equivalent to or above Medicare rates. The following resolutions are related to advocacy for Medicaid reimbursement rates.

Resolution 40(22) Support for Medicaid Expansion adopted. Directed ACEP 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.

Resolution 30(21) Unfair Health Plan Payment Policies adopted. Directed the College to develop model legislation and advocate for enactment at both the state and federal levels, prohibiting health plans from implementing new payment policies during the term of a provider's contracts, unless the new policy is required by new laws or regulations, as well as to advocate at the American Medical Association to pass legislation prohibiting health plan contracts from requiring adherence to new health plan payment policies unless the new policy is required by new laws or regulations.

Amended Resolution 29(21) Downcoding adopted. Directed ACEP to develop strategies to assist chapters in identifying if downcoding is occurring in their state; work with the Centers for Medicare & Medicaid Services and private insurers to prevent the practice of downcoding in state Medicaid programs and by private insurers; and work with chapters to develop specific model legislative language to require transparency when insurance companies make changes to or require additional information for a claim.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted. The resolution directed ACEP to commission an independent study on the financial influence exerted by health insurers to leverage EMTALA mandates and withhold appropriate reimbursement and work with other allied organizations to better understand their impact on physician delivery of emergency care.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted. Directed ACEP to develop and enact strategies (including state and federal legislative solutions) to prevent payors from arbitrarily downcoding charts and work to develop and enact policy at the state and federal level that prevents payors from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in states that have the definition in law.

Prior Board Action

June 2023, approved the revised policy statement "Fair Payment for Emergency Department Services;" revised and approved June 2022 and April 2016; originally approved April 2009.

June 2023, approved the revised policy statement "Fair Reimbursement When Services are Mandated" with the current title; revised and approved April 2017 titled "Fair Coverage when Services are Mandated;" reaffirmed April 2011 and September 2005; originally approved June 1999 titled "Compensation when Services are Mandated."

Resolution 40(22) Support for Medicaid Expansion adopted.

Resolution 30(21) Unfair Health Plan Payment Policies adopted.

Amended Resolution 29(21) Downcoding adopted.

June 2021, approved an RFP to commission an independent study on the financial influence of health insurers on emergency physicians, with a focus on Emergency Medical Treatment and Labor Act (EMTALA)-related mandates and associated reimbursement issues affecting emergency physicians.

June 2021, approved filing the report of the EDPMA/ACEP Unfair Health Plan Payment Policy Task Force and utilizing the recommendations contained in the report as options for future implementation to address unfair health plan payment policies.

April 2021, approved the revised policy statement "Compensation Arrangements for Emergency Physicians;" revised and approved April 2015, April 2002 and June 1997; reaffirmed October 2008 and April 1982; originally approved June 1988.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted.

October 2020, approved the revised policy statement "Third-Party Payers and Emergency Medical Care;" revised and approved April 2014, June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

February 2020, approved prudent layperson model state legislation stipulating that "the health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway."

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

July 2019, reviewed the information paper "Medicaid Cost savings Measures for Emergency Care."

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

Resolution 43(97) Prudent Layperson Legislation adopted.

Background Information Prepared by: David McKenzie
Reimbursement 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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RESOLUTION: 40(23)

SUBMITTED BY: Dual Training Section
Geriatric Emergency Medicine Section
Observation Medicine Section
Maryland Chapter

SUBJECT: Support for Reimbursement of Geriatric ED Care Processes

PURPOSE: Directs the College to advocate for development of policies that will reimburse geriatric emergency care.

FISCAL IMPACT: Budgeted resources as part of ACEP's ongoing efforts to increase emergency physician and ED reimbursement.

1 WHEREAS, Older adults visit the emergency department (ED) at disproportionally higher rates compared to
2 younger adults, a trend anticipated to continue in the coming decades.[1] These older adults patients have increased
3 length of stays[2], use more resources[3] and are more likely to be hospitalized compared to younger adults[3]; and
4
5 WHEREAS, The American College of Emergency Physicians (ACEP), has been instrumental in encouraging
6 the implementation of care processes in geriatric emergency medicine by initiating the Geriatric Emergency
7 Department Accreditation Program in 2018; and
8
9 WHEREAS, Over 420 EDs have received recognition from ACEP as an accredited geriatric ED; and
10
11 WHEREAS, Many of these care processes in place among accredited geriatric emergency departments have
12 been shown to decrease ED length of stay[7], ED revisits[4,5], hospital admissions and re-admissions[6] as well as improve
13 the patient experience[5,7]; and
14
15 WHEREAS, These care processes include but are not limited to functional and cognitive screening, falls
16 evaluations, delirium management interventions, caregiver burden assessment, post-discharge follow up programs,
17 medication reconciliation procedures; and
18
19 WHEREAS, Implementation of such care processes requires additional education and training for staff as
20 well as incremental increases in resources to help ensure appropriate delivery; and
21
22 WHEREAS, Similar care processes in other health care settings such as transitional care management after an
23 inpatient stay is reimbursable; and
24
25 WHEREAS, Such geriatric specific ED care process and interventions are often not reimbursed through
26 traditional evaluation and management codes, thereby limiting more widespread adoption of such practices; therefore
27 be it
28
29 RESOLVED, That ACEP advocate for and support the development of policies that will allow for appropriate
30 reimbursement for high value geriatric emergency department care processes that have been shown to improve both
31 health system focused and patient centered outcomes.

References

1. Cairns C, Kang K. National Hospital Ambulatory Medical Care Survey: 2019 emergency department summary tables. DOI: https://dx.doi.org/10.15620/cdc:115748. Retrieved on 11/18/22.

2. Samaras N, Chevalley T, Samaras D, et al. Older patients in the emergency department: a review. *Ann Emerg Med.* 2010;56(3):261–9.
3. Singal BM, Hedges JR, Rousseau EW, et al. Geriatric patient emergency visits part I: comparison of visits by geriatric and younger patients. *Ann Emerg Med.* 1992;21(7):802–7.
4. Lesser A, Israni J, Kent T, et al. Association between physical therapy in the emergency department and emergency department revisits for older adult fallers: a nationally representative analysis. *J Am Geriatr Soc*. 2018;66(11):2205-2212.
5. Guttman A, Afilalo M, Guttman R, et al. An emergency department-based nurse discharge coordinator for elder patients: does it make a difference. *Acad Emerg Med*. 2004;11(12):1318-27.
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Background

This resolution directs the College to advocate for and support the development of policies that will allow for appropriate reimbursement for high value geriatric emergency department care processes that have been shown to improve both health system focused and patient centered outcomes.

ACEP has a longstanding interest in improving geriatric emergency care. The Geriatric Emergency Medicine Section works to:

- continuously improve ED training and cultural attitudes towards aging,
- advance better policies, protocols and guidelines for geriatric-centered care,
- improve evidence-basedrisk stratification
- inform members about geriatric-specific risk management issues, and
- advocate for availability of specialized equipment and adaptations to the ED environment of care to prevent further illness and injury.

ACEP has also developed the Geriatric Emergency Department Accreditation (GEDA) program. GEDA represents a major ongoing investment of time, energy and ACEP resources to promote the goals of quality of care for older people; enhanced staffing and education; geriatric-focused policies and protocols including transitions of care; quality improvement and metrics; and optimal preparation of the physical environment in the form of tiered accreditation levels and surveys of facilities. GEDA is informed by the "Geriatric Emergency Department Guidelines", a joint policy statement between ACEP, American Geriatrics Society, Emergency Nurses Association, and Society for Academic Emergency Medicine.

Geriatric care processes for emergency departments (EDs) include but are not limited to functional and cognitive screening, falls evaluations, delirium management interventions, caregiver burden assessment, post-discharge follow up programs, and medication reconciliation procedures, all of which require education and training for staff and specific resources to incorporate into ED care. However, geriatric focused, ED-based care does not have a specific reimbursement payment mechanism for emergency departments that have implemented some or all of the recommended care processes.

For example, accurate medication reconciliation is a critical part of safe geriatric care. While there is a CPT code for medication reconciliation for outpatients (CPT 1111F, medication reconciliation after discharge), it does not apply to the ED and is therefore not a separately billable charge. There are also care transition codes (Transitional Care Management, CPT 99495 and 99496) that currently apply to transitioning from an inpatient to a community setting that could be adjusted to support care transition efforts and care-coordination from the ED to avoid inpatient hospitalization. Advocating for expansion of these CPT codes to apply to the ED setting could allow for reimbursement of geriatric care.

The Fiscal Year 2024 Inpatient Prospective Payment System proposed rule from the Centers for Medicare and Medicaid Services (CMS) included a request for comment on future inclusion of an attestation-based Geriatric Hospital structural measure in the Hospital Inpatient Quality Reporting Program (Hospital IQR). Data for selected

measures are used for paying a portion of hospitals based on the quality and efficiency of care. Further, CMS sought comment on the consideration of a geriatric care hospital designation that would recognize hospitals that have implemented best practices for geriatric care. ACEP's response to this comment solicitation supported the Geriatric Hospital measure and requested to work with CMS going forward in the process of designing a geriatric care hospital designation and advocacy work in support of this response is ongoing.

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.

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 resources as part of ACEP's ongoing efforts to increase emergency physician and ED reimbursement.

Prior Council Action

Substitute Resolution 38(14) Geriatric Emergency Department Accreditation referred to the Board of Directors. The resolution directed ACEP to work with regulatory agencies that are or may become involved in the development of accreditation requirements for geriatric emergency departments.

Prior Board Action

June 2023, approved including the "GEDA ED Boarding Care Processes and Outcomes" to the Geriatric Emergency Department Accreditation Program Criteria for Level 1 and Level 2 accreditation or re-accreditation.

September 2022, approved the revised Geriatric Emergency Department Accreditation Program Governance Charter; revised and approved June 2021, April 2020, September 2019, April 2019; initial governance charter approved April 2017.

September 2022, rescinded the policy statement "Quality Improvement Initiatives for the Care of Geriatric Patients in the Emergency Department;" originally approved April 2016. The creation of the Geriatric Emergency Department Accreditation Program eliminated the need for the policy statement.

June 2019, approved the revised Geriatric ED Accreditation Program Criteria.

January 2019, reaffirmed the "Geriatric Emergency Department Guidelines;" originally approved October 2013.

January 2017, approved proceeding with the Geriatric Emergency Department Accreditation Program and the program criteria.

September 2016, Board authorized staff to proceed in developing a formal business plan and framework of a Geriatric ED Accreditation Program.

April 2015, approved the Emergency Medicine Practice Committee's recommendation to collaborate with regulatory agencies if they pursue development of accreditation requirements for geriatric EDs. The committee was assigned an objective for the 2015-16 committee year to develop a policy statement in support of quality improvement initiatives for the care of geriatric patients in the ED.

Background Information Prepared by: Erin Grossmann
Regulatory & External Affairs 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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RESOLUTION: 41(23)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Use of Medical Coders in Payment Arbitration

PURPOSE: Advocate with CMS to require under the No Surprises Act that Independent Dispute Resolution Entities (IDREs) be required to use experienced medical coders in arbitration cases in which the code level assigned is in dispute.

FISCAL IMPACT: Budgeted staff resources for ongoing efforts related to the IDR process.

1 WHEREAS, The No Surprises Act permits Independent Dispute Resolution Entities (IDREs) to arbitrate
2 disputes between emergency physicians and patients' health insurance plans when there is a conflict between the
3 charges billed to the patient and the Qualifying Payment Amount (QPA) offered by the health plan; and
4
5 WHEREAS, Such disputes often result from downcoding by the health plan based on the plan's judgement
6 that the medical record provides insufficient documentation to justify a higher code; and
7
8 WHEREAS, Downcoding results in a QPA that is substantially less than the reimbursement requested; and
9
10 WHEREAS, To maintain their status as neutral third parties, IDREs should utilize a professional medical
11 billing coder to determine the correct billing code, based on the actual documentation submitted in the medical record;
12 and
13
14 WHEREAS, Centers for Medicare and Medicaid Services (CMS) has not committed to requiring IDREs to
15 use medical coders to adjudicate the correct billing code as part of the arbitration process; therefore be it
16
17 RESOLVED, That ACEP advocate for Centers for Medicare and Medicaid Services (CMS) to require that
18 Independent Dispute Resolution Entities use experienced medical billing coders to determine the appropriate billing
19 code in arbitration cases under the No Surprises Act involving disagreements between the code submitted by the
20 physician and the code allowed by the patient's health plan.

Background

This resolution requests ACEP to advocate for CMS to require that Independent Dispute Resolution Entities use experienced medical billing coders to determine the appropriate billing code in arbitration cases under the No Surprises Act involving disagreements between the code submitted by the physician and the code allowed by the patient's health plan.

As part of the No Suprises Act an Independent Dispute Resolution (IDR) process was developed as a mechanism to settle disputes between payers and providers on individual claims about the appropriateness and fairness of the resulting payment allowed. Independent Dispute Resolution Entities (IDREs) are the entities that arbitrate these disputes. This resolution calls for ACEP to advocate that the IDREs must hire independent experienced coders as a neutral party to determine the appropriateness of codes assigned to the disputed claims.

Arbiters are not experts at coding and coders are not experts at arbitration. The current regulations do not disallow use of coders, but also do not mandate them in cases involving coding disputes, which creates ambiguity.

While considering allowing, or even encouraging an IDR to use an independent certified coding expert to assist in the analysis, one should be cognizant of the following considerations.

The IDR process does not authorize the IDR to consider the appropriateness of the coding level assigned to the claim(s) in question. The sole task of the IDR is to determine the appropriate payment to be made to the claim(s) in question. A determination that the claim(s) should have been adjudicated at a different level is outside of the IDR's scope of authority. The dispute is typically over the Qualified Payment Amount (QPA) rather than the code level assigned by the original coder who were hopefully trained experts in ED coding and billing rules.

The No Surprises Act final rule was issued in August 2022 and due to ACEP's advocacy, it implements the specific protections from downcoding ACEP asked for in its response to the IFRs. While there are some concerning provisions in the rule, it establishes for the first time a federally-recognized official definition of downcoding as well as a requirement that if a QPA is based on a downcoded service code or modifier, the plan must provide an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and which modifiers were altered, added, or removed, if any; and the amount that would have been the QPA had the service code or modifier not been downcoded. The rule also notes that without information on what the QPA would have been had the claim not been downcoded, the provider may be at a disadvantage during open negotiation compared to the plan or issuer.

ACEP was instrumental in getting the Departments to require insurers who downcode to justify their reasoning and what the QPA would have been in the absence of downcoding. A Joint ACEP/EDPMA No Suprises Act Task Force has been meeting with CMS for years to advocate on our IDR concerns.

If an independent coding expert were somehow to be used in the IDR process, the fees charged by the independent coding expert would need to be paid by the IDR, which in turn would likely need to pass on those fees to the parties involved in the IDR potentially with the losing party having to pay the expense. These additional fees would further increase the burden of the high cost of the IDR process currently.

ACEP Advocacy & Practice Affairs staff were successful in strengthening existing prudent layperson protections with inclusion of new language in the first interim final rule (IFR) to implement the No Surprises Act. While this language focused predominantly on retroactive denials, it could help strengthen our opposition to downcoding broadly. ACEP Advocacy & Practice Affairs staff continued efforts to gain further protections from downcoding via regulatory channels by providing strong recommendations in comment letters on the first IFR, and in advance of the second IFR's release. The second IFR mainly focused on the federal independent dispute resolution process. ACEP, and most all physician organizations, expressed extreme concern regarding the qualified payment amount in the independent resolution process. ACEP issued a statement on October 1, 2021, opposing the IFR, and another statement on November 9, 2021, standing firmly with more than 150 bipartisan members of Congress calling on the Biden Administration to change the IFR. ACEP, the American Society of Anesthesiologists (ASA), and the American College of Radiology (ACR), filed a lawsuit against the federal government on December 22, 2021, charging that the IFR goes against the language of the No Surprises Act and will ultimately harm patients and access to care. Lawsuits were also filed by the American Medical Association and American Hospital Association, the Texas Medical Association, an individual in New York, an air ambulance association, and the Georgia College of Emergency Physicians. ACEP/ASA/ACR filed a motion for summary judgement in the lawsuit on February 9, 2022. A federal judge in Texas ruled on February 23, 2022, in the lawsuit filed by the Texas Medical Association, that the No Surprises Act implementation fails to follow the letter of the law, and that giving unequal weight to the Qualified Payment Amount (QPA) tilts the process unreasonably in favor of insurance companies. The court also determined that by skipping a customary notice and comment period while the law was being finalized, the government failed to follow its own well-established and transparent regulatory process. The federal government has appealed to the Texas court ruling and TMA lawsuits I through IV continue to work their way through the legal process.

ACEP and the Medical Association of Georgia were involved in litigation with Anthem/Blue Cross Blue Shield regarding retroactive denial of emergency department claims starting in July 2018. On October 22, 2020, the 11th Circuit Court ruled in favor of the appeal filed by ACEP and the Medical Association of Georgia. The case was remanded back to the Northern District Court in Georgia. The wording of the opinion was strongly supportive of ACEP's position It was announced on March 9, 2022, that ACEP and the Medical Association of Georgia agreed to

withdraw the lawsuit in response to the discontinuation of Blue Cross Blue Shield Healthcare Plan (BCBSHP) of Georgia, Inc.'s "avoidable ER" program. The change was effective March 28, 2022.

ACEP continues to work in conjunction with EDPMA to analyze claims data, as well as developing a contract with an outside vendor to collect additional information about claims denials to get a better understanding of the scope of this problem. In addition to supplementing ACEP's advocacy actions with federal regulators, the results of these data collection efforts would also be helpful in ACEP's legislative efforts to persuade federal lawmakers to address this issue. The Federal Government Affairs Committee, the Reimbursement Committee, and the State Legislative/ Regulatory Committee continue to track actions by insurers to deny and downgrade claims. ACEP has sent letters protesting actions by United Health Care and various Medicaid plans. ACEP met with several members of Congress in the Maryland delegation to highlight inappropriate denials by United's Optum for mental health care provided by emergency physicians in the ED in the state. ACEP has also been working with the VA chapter to resolve downcoding issues in the state with Medicaid managed care plans. In July 2022, ACEP sent a joint letter with the California Chapter to CCIIO and the entire California Congressional delegation to bring attention to payment denials by Anthem to small groups in the state. The letters have already prompted follow-up investigatory actions by several members of the delegation and the federal agencies.

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 professional.

Fiscal Impact

Budgeted staff resources for ongoing efforts related to the IDR process.

Prior Council Action

Amended Resolution 29(21) Downcoding adopted. Directed ACEP develop strategies to assist chapters in identifying if downcoding is occurring in their state; work with the Centers for Medicare & Medicaid Services and private insurers to prevent the practice of downcoding in state Medicaid programs and by private insurers; and work with chapters to develop specific model legislative language to require transparency when insurance companies make changes to or require additional information for a claim.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted. The resolution directed ACEP to commission an independent study on the financial influence exerted by health insurers to leverage EMTALA mandates and withhold appropriate reimbursement and work with other allied organizations to better understand their impact on physician delivery of emergency care.

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted. Directed ACEP to develop and enact strategies (including state and federal legislative solutions) to prevent payors from arbitrarily downcoding charts and work to develop and enact policy at the state and federal level that prevents payors from downcoding based on a final diagnosis and provides meaningful disincentives for doing so.

Amended Resolution 40(17) Reimbursement for Emergency Services adopted. Directed ACEP to continue to uphold federal PLP laws by advocating for patients to prevent negative clinical or financial impact caused by lack of reimbursement, and to partner with the AMA and work with third-party payers to ensure access to and reimbursement for emergency care.

Resolution 28(15) Standards for Fair Payment of Emergency Physicians referred to the Board. Directed ACEP to increase resources related to establishing and defending fair payment standards for emergency physician services by monitoring state-by-state changes, developing model legislation, providing resources to chapters, and encouraging research into the detrimental effects of legislation that limits the rights of emergency physicians to fair payment.

Resolution 43(97) Prudent Layperson Legislation adopted. Directed ACEP to study the problem of retroactive denial of payment and the impact of passage of the prudent layperson definition in states that have the definition in law.

Prior Board Action

June 2023, approved the revised policy statement "Fair Payment for Emergency Department Services;" revised and approved June 2022 and April 2016; originally approved April 2009.

June 2023, approved the revised policy statement "Fair Reimbursement When Services are Mandated" with the current title; revised and approved April 2017 titled "Fair Coverage When Services Are Mandated;" reaffirmed April 2011 and September 2005; revised and approved June 1999 titled "Compensation When Services Are Mandated;" originally approved September 1992.

June 2023, approved the revised policy statement "Prior Authorization;" revised and approved April 2017, April 2010, February 2003; originally approved October 1998.

Amended Resolution 29(21) Downcoding adopted.

June 2021, approved and RFP to commission an independent study on the financial influence of health insurers on emergency physicians, with a focus on Emergency Medical Treatment and Labor Act (EMTALA)-related mandates and associated reimbursement issues affecting emergency physicians.

Resolution 25(20) Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement and Optimal Coverage adopted.

October 2020, approved the revised policy statement **"**Third-Party Payers and Emergency Medical Care**;"** revised and approved April 2014, June 2007, July 2000, and January 1999; approved March 1993 with title "Managed Health Care Plans and Emergency Care;" originally approved September 1987.

February 2020, approved prudent layperson model state legislation stipulating that "the health plan shall, in accordance with payment timeliness regulations, reimburse any undisputed amount while review of disputed portions of the claim is underway."

Amended Resolution 35(19) Prudent Layperson Visit Downcoding adopted.

February 2018, reaffirmed the policy statement "Assignment of Benefits;" reaffirmed April 2012; originally approved April 2006.

July 2018, ACEP and the Medical Association of Georgia filed suit against Anthem's Blue Cross Blue Shield of Georgia in federal court to compel the insurance giant to rescind its controversial and dangerous emergency care policy that retroactively denies coverage for emergency patients.

January 2018, ACEP and 11 other medical societies, sent a letter to Anthem stating concerns with several of their reimbursement policies (outpatient radiology, emergency denials, modifier-25).

Amended Resolution 40(17) Reimbursement for Emergency Services adopted.

Resolution 43(97) Prudent Layperson Legislation adopted.

Background Information Prepared by: David McKenzie
Reimbursement 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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RESOLUTION: 42(23)

SUBMITTED BY: Indiana Chapter

SUBJECT: On-site Physician Staffing in Emergency Departments

PURPOSE: Work with chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments, and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

FISCAL IMPACT: Budgeted committee and staff resources for ongoing federal and state advocacy initiatives.

1 WHEREAS, ACEP believes that all patients who present to emergency departments (EDs) deserve to have
2 access to high quality, patient-centric, care delivered by emergency physician-led care teams; and
3
4 WHEREAS, ACEP defines an emergency physician as a physician who is certified (or eligible to be certified)
5 by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency
6 Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM in emergency
7 medicine or pediatric emergency medicine, or who is eligible for active membership in the American College of
8 Emergency Physicians; and
9
10 WHEREAS, ACEP has a policy statement "Guidelines Regarding the Role of Physician Assistants and
11 Advanced Practice Registered Nurses in the Emergency Department" most recently approved March 2022; and
12
13 WHEREAS, Indiana ACEP has successfully passed legislation requiring on-site and on-duty physician
14 coverage at all emergency departments in the state; therefore be it
15
16 RESOLVED, That ACEP work with state chapters to encourage and support legislation promoting the
17 minimum requirement of on-site and on-duty physicians in all emergency departments; and be it further
18
19 RESOLVED, That ACEP continue to promote that the gold standard for those physicians working in an
20 emergency department is a board-certified/board-eligible emergency physician.

Background

This resolution directs ACEP to work with state chapters to encourage and support legislation promoting the minimum requirement of on-site and on-duty physicians in all emergency departments, and to continue to promote that the gold standard for those physicians working in an emergency department is a board-certified/board-eligible emergency physician.

The State Legislative/Regulatory Committee (SLRC) was assigned an objective for the 2022-23 committee year to "Monitor legislative and regulatory efforts by nurse practitioners and physician assistants to expand their scope of practice in emergency medicine in a way that is inconsistent with ACEP policy and develop resources to assist state chapter advocacy on this issue." The committee developed a toolkit after the successful passage of the Indiana legislation and used the language from that legislation (HOUSE BILL No. 1199) along with other model provisions, drafting notes and definitions, as well as current regulatory language to consider. The toolkit will be distributed to chapters in time for the 2023-24 state legislative season.

ACEP's policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department" was most recently updated in June 2023 and states:

> "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."

The policy further states:

> "The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician. 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."

ACEP's policy statement "Emergency Physician Rights and Responsibilities" states:

> "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."

ACEP's policy statement "Emergency Department Planning and Resource Guidelines" states:

> "The emergency physician should serve as the leader of the ED team."

ACEP has continually promoted the gold standard that physicians working in an emergency department should be board-certified/board-eligible emergency physicians. ACEP has also advocated for this standard to the Centers for Medicare and Medicaid Services, the Department of Health and Human Services, and the U.S. Congress.

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 professional.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted staff resources for ongoing federal and state advocacy initiatives.

Prior Council Action

Amended Resolution 46(22) Safe Staffing for Non-Physician Providers Supervision adopted. Directed ACEP to investigate and make recommendations regarding appropriate and safe staffing roles, ratios, responsibilities, and models of emergency physician-led teams, taking into account appropriate variables to allow for safe, high-quality care and appropriate supervision in the setting of a physician-led emergency medicine team.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to 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.

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 referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

Amended Resolution 23(04) Specialized Emergency Medicine Training for Midlevel Providers Who Work in Emergency Departments adopted. 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 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022 and 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."

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

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."

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: Adam Krushinskie
Director, State Government Relations

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

2023 Council Meeting
Reference Committee Members

Reference Committee C – Emergency Medicine Practice

Resolutions 43-55

Dan Freess, MD, FACEP (CT) – Chair
Angela P. Cornelius, MD, FACEP (TX)
Joshua R. Frank, MD, FACEP (WA)
Kenneth L. Holbert, MD, FACEP (TN)
Jeffrey F. Linzer, Sr., MD, FACEP (GA)
Jennifer L. Savino, DO, FACEP (PA)

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

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 43(23)

SUBMITTED BY: Emergency Medicine Workforce Section

SUBJECT: Adopt Terminology "Unsupervised Practice of Medicine"

PURPOSE: Adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

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

1 WHEREAS, The American Association of Nurse Practitioners (AANP) is advocating for "Full practice
2 authority" to have independent practice without physician supervision or collaboration; and
3
4 WHEREAS, "Full practice authority" is a term created by nurse practitioner groups and has no legal or
5 regulatory definition; and
6
7 WHEREAS, ACEP's NP/PA supervision policy statement recommends direct on-site supervision of non-
8 physician practitioners as the gold standard; and
9
10 WHEREAS, Having a standard terminology would help define our goal of supervised practice in the
11 emergency department; therefore be it
12
13 RESOLVED, That ACEP adopt terminology to refer to the independent practice of medicine by non-
14 physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site
15 supervision of non-physician practitioners.

Background

This resolution calls for adopt terminology to refer to the independent practice of medicine by non-physicians as "Unsupervised Practice of Medicine" and continue promotion of the gold standard ideals to have on site supervision of non-physician practitioners.

Currently, Nurse Practitioners (NP) can practice independently in 27 states and in Washington, DC as well in the Veterans Affairs System.[1] 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[2]:

> **"Emergency Physician Supervision of PAs and NPs**
> ACEP believes:
> - PAs and NPs should not perform independent, unsupervised care in the ED.
> - The gold standard for emergency department care is that provided by an emergency physician. If PAs and NPs are utilized for providing emergency department care, the standard is onsite supervision by an emergency physician."

A March 2022 public opinion survey from ACEP and Morning Consult shows that the vast majority of adults most trust a physician to lead their medical care, and many patients would be concerned if a physician was unavailable during their medical emergency.

- Eight-in-ten adults (79%) prefer a doctor/physician to lead their medical care while in the emergency department.
- Nine-in-ten adults 65 and over (91%) prefer a doctor/physician to lead their medical care in the emergency department
- After learning more about the training requirements for each of the medical professionals, adults still preferred a doctor/physician to lead their medical care in the emergency department.

A study from Stanford in October 2022 found that relying on unsupervised NPs led to unnecessary tests and procedures, and hospital admissions. Overall, the study shows that NPs increase the cost of care in the emergency department by 7%, about $66 per patient. NPs were more likely than physicians to order x-rays, CT scans, and seek formal consults. These choices also impact patient outcomes. NPs practicing without physician supervision increased length of stay in the emergency department by 11% and raised 30-day preventable hospitalizations by 20%.[4,5]

Adoption of the resolution would codify the terminology used to describe independent practice as unsupervised care and further support the need for supervision of NPs and PAs.

ACEP has developed resources that are available on the website to assist members in fighting for physician-led care.

Background References

1. https://www.aanp.org/advocacy/state/state-practice-environment
2. https://www.acep.org/patient-care/policy-statements/guidelines-regarding-the-role-of-physician-assistants-and-nurse-practitioners-in-the-emergency-department
3. https://www.emergencyphysicians.org/article/access/poll-adults-view-247-access-to-the-er-essential--prefer-care-led-by-physicians-in-a-crisis
4. https://www.acep.org/who-we-are/leadership/board-blog/board-blog-articles/november-4-2022-new-data-underscores-cost-and-health-outcome-concerns-with-independent-practice
5. https://www.nber.org/papers/w30608

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 professional.

Fiscal Impact

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

Prior Council Action

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted. Directed ACEP to 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.

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.

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. 4) Develop strategies, including legislative solutions, to require on-site supervision of non-physicians by an emergency physician.

Resolution 27(10) Emergency Department (ED) Staffing by Nurse Practitioners referred to the Board of Directors. Called for ACEP to study the training and independent practice of NPs in emergency care, survey states and hospitals on where independent practice by NPs is permitted and provide a report to the Council in 2011.

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 2023, approved the revised policy statement "Guidelines Regarding the Role of Physician Assistants and Nurse Practitioners in the Emergency Department;" revised and approved March 2022 and 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."

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.

Resolution 45(22) Onsite Supervision of Nurse Practitioners and Physician Assistants adopted.

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.

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: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce & 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 44(23)

SUBMITTED BY: Emily Ager, MD
Kimberly Chernoby, MD
Kelly Quinley, MD
Rachel Solnick, MD
Katherine Wegman, MD
American Association of Women Emergency Physicians Section

SUBJECT: Clinical Policy – Emergency Physicians' Role in the Medication & Procedural Management of Early Pregnancy Loss

PURPOSE: Develop a new clinical policy with two critical questions related to the medication management and procedural management of early pregnancy loss.

FISCAL IMPACT: Budgeted committee and staff resources for the development of each new single-question clinical policy. The development of each new single-question clinical policy takes approximately one year and requires staff (0.8 FTE) and volunteer time, as well as the use of outside methodologists. Each new clinical policy would need to be added to the currently budgeted and prioritized list of new and existing policies.

1 WHEREAS, Approximately 900,000 emergency department visits per year in the U.S. are related to vaginal
2 bleeding and miscarriage in the first trimester[1], and as such, constitute a significant portion of emergency medicine
3 time and resources; and
4
5 WHEREAS, Up to 20% of pregnancies end in early pregnancy loss (miscarriage in the first trimester), and
6 compared with other ED patients, these patients are more likely to be younger, be Black or Hispanic, or be publicly
7 insured[1]; and
8
9 WHEREAS, Pregnancy complications are the fifth most common reason women between ages 15-64 visit
10 Emergency Departments in the U.S.[2]; and
11
12 WHEREAS, As many as 84% of pregnant people visit an Emergency Department during pregnancy[3]; and
13
14 WHEREAS, Legal changes in the US resulting in reduced access to family planning and abortion services
15 will likely lead to increasing numbers of patients experiencing early pregnancy loss to seek care in an Emergency
16 Department[4]; and
17
18 WHEREAS, A February 2023 report found that 217 labor and delivery units have closed across the US since
19 2011[5], meaning that more Emergency Physicians will provide care for patients experiencing early pregnancy loss
20 without the benefit of in-house Obstetricians and Gynecologists, and/or with the nearest obstetrical specialist located
21 outside of their facility and farther away; and
22
23 WHEREAS, Research shows patients experiencing early pregnancy loss who are given options for medical
24 management or procedural management versus expectant management alone are more satisfied than those not given
25 the option[6]; and
26
27 WHEREAS, Research shows that medication management of early pregnancy loss using mifepristone and
28 misoprostol compared to expectant management leads to higher rates of completed miscarriage and lower rates of
29 complications such as hemorrhage requiring blood transfusion[7]; and
30

31 WHEREAS, Research indicates that adopting procedural management with uterine aspiration in the
32 Emergency Department in lieu of admission and operating room-based uterine aspiration can reduce patient wait
33 times and hospital costs in an era when our healthcare system is financially strained[8]; and
34
35 WHEREAS, Research shows that procedural management of early pregnancy loss reduces the risk of
36 bleeding, re-admission, and need for subsequent procedure for failed therapy[9]; and
37
38 WHEREAS, The American College of Obstetricians & Gynecologists' (ACOG) Practice Bulletin on Early
39 Pregnancy Loss states mifepristone and misoprostol should be used to medically manage miscarriage where
40 available[10]; and
41
42 WHEREAS, A recent change in FDA policy means that mifepristone can now be dispensed from retail
43 pharmacies like other medications prescribed from the Emergency Department[11]; and
44
45 WHEREAS, Mifepristone and misoprostol are routinely prescribed in outpatient settings and via telemedicine
46 making them safe for prescription from the Emergency Department[12, 13]; and
47
48 WHEREAS, Offering medication management to patients with first-trimester miscarriage can reduce
49 emergency bounceback visits for patients when compared to discharging patients with no treatments (expectant
50 management)[14]; and
51
52 WHEREAS, Pregnant people who present with hemorrhage or hemodynamic instability from early pregnancy
53 loss should be treated urgently, often with procedural uterine evacuation[10]; and
54
55 WHEREAS, As a primary approach, procedural uterine evacuation results in faster and more predictable
56 complete evacuation. The success of procedural uterine evacuation of early pregnancy loss approaches 99%[16],
57 meaning these patients do not need more medications or another procedure; and are less likely to require unscheduled
58 medical care; and
59
60 WHEREAS, Procedural management (also known as uterine aspiration or suction curettage) is most
61 commonly performed in an office setting with a manual vacuum aspirator, under local anesthesia without the addition
62 of sedation[17, 18]; and
63
64 WHEREAS, Training programs exist that teach miscarriage management to emergency physicians including
65 medication and procedural management, such as the Training, Education and Advocacy in Miscarriage Management
66 (TEAMM) project, a University of Washington-affiliated program that has assisted over 100 clinical and academic
67 sites, including emergency medicine clinicians, develop tailored interventions to integrate early pregnancy loss
68 management into their services[19]; and
69
70 WHEREAS, ACOG also hosts a training program where OBGYN specialists travel to Emergency
71 Departments and hospitals to help clinicians train in uterine aspiration and medical management of early pregnancy
72 loss[20]; and
73
74 WHEREAS, Research shows that emergency medicine clinicians can incorporate manual uterine aspiration
75 for the management of early pregnancy loss into their clinical practice[21]; and
76
77 WHEREAS, In 2022, the ACEP Council adopted a resolution to encourage hospitals and emergency medicine
78 residency training programs to provide education, training, and resources outlining best clinical practices on early
79 pregnancy loss care[22]; however, what educational expectations this entails in terms of medical versus procedural
80 management as of yet is unclear; and
81
82 WHEREAS, In 2022, the ACEP Council adopted a resolution that ACEP supports an individual's ability to
83 access the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental
84 health care[23]; and
85

86 WHEREAS, ACEP clinical policies provide guidance on the clinical management of emergency department
87 patients and are not intended to represent a legal standard of care nor the only diagnostic and management options that
88 the emergency physician should consider and ACEP recognizes the importance of the individual physician's judgment
89 and patient preferences; and
90
91 WHEREAS, Past ACEP clinical policies regarding early pregnancy have incorporated data from studies
92 conducted in care settings outside the emergency department[24]; therefore be it
93
94 RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation
95 on the following clinical question: For patients experiencing early pregnancy loss, is medication management safe,
96 effective, and patient-centered compared to expectant management?; and be it further
97
98 RESOLVED, That the Board of Directors direct the Clinical Policies Committee to issue a recommendation
99 on the following clinical question: For patients experiencing early pregnancy loss, is procedural management safe,
100 effective, and patient-centered compared to expectant management.

References

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Background

This resolution calls for ACEP to develop a new clinical policy with two critical questions related to the medication management and procedural management of early pregnancy loss.

An estimated quarter of all women will experience the early loss of a pregnancy (EPL) in their lifetime (Ghosh 2021). Twenty percent of these losses will require some form of intervention to completely clear the uterus of retained tissue (Manning, 2023). Methods for managing a miscarriage include expectant management, medication management, and procedural management. Over 70% of obstetricians provide either procedural or medication interventions for miscarriage management (KFF, 2023). However, an August 2023 report from the March of Dimes demonstrates that almost one in ten counties in the United States do not have an obstetrics unit in their hospitals, leaving 5.6 million women in counties with limited maternity care, including EPL management. Each year, over 900,000 patients present to the emergency department with early pregnancy loss (EPL) (Benson, 2021), accounting for 2.7% of all ED visits for women ages 15-44 years.

ACEP's Emergency Medicine Reproductive Health & Patient Safety Task Force developed the policy statement "Access to Reproductive Health Care in the Emergency Department." This policy states, in part, "ACEP encourages hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications including miscarriage, post-abortion care, and self-managed abortions."

The Clinical Policies Committee (CPC) 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 CPC can include studies that have not been conducted in the emergency department. Clinical policies are comprised of one or more critical questions. Critical questions addressed are drafted as PICO (Problem/Population, Intervention, Comparison, Outcome) questions. A review of the clinical policy development process was initiated in 2019. During the review, workgroups of the CPC assessed the development, methodology, and value of the policies to stakeholders. One of the obstacles identified to the timely updating of clinical policies was

the multiple question format. A multi-question clinical policy takes, on average, 18-24 months from initiation to completion. Each clinical policy is currently updated, on average, every 8.6 years. In April 2021, the CPC proposed trialing single-question clinical policies with the goal of reducing the time from initiation to completion to approximately 12 months. When fully implemented, the single-question format will enable the CPC to revise up to 10 clinical policies per year in addition to assigned policy statements and will allow the CPC to consider issues that are of the greatest importance to members while allowing faster turnaround time for clinical policy updates.

ACEP's current "Clinical Policy: Critical Issues in the Initial Evaluation and Management of Patients Presenting to the Emergency Department in Early Pregnancy" is based on two critical questions:

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?

This clinical policy was approved in 2016 and is currently in the process of being updated. The writing group has decided to proceed with updating the clinical policy to include a single critical question regarding the safety of imaging modalities in suspected pulmonary embolism. In accordance with CPC procedures , the critical questions called for in this resolution would require development of two new single-question clinical policies.

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 committee and staff resources for the development of each new single-question clinical policy. The development of each new single-question clinical policy takes approximately one year and requires staff (0.8 FTE) and volunteer time, as well as the use of outside methodologists. Each new clinical policy would need to be added to the currently budgeted and prioritized list of new and existing policies.

Prior Council Action

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted. Directed ACEP to develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide and advocate for universal access to emergency contraception in the emergency department.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP 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. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving 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. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the 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. Directed ACEP to support 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.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Prior Board Action

June 2023, approved the policy statement "Access to Reproductive Health Care in the Emergency Department."

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

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.

Background Information Prepared by: Kaeli Vandertulip, MSLS, MBA, AHIP
Clinical Practice Manager

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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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 45(23)

SUBMITTED BY: American Association of Women Emergency Physicians Section
Social Emergency Medicine Section

SUBJECT: Emergency Physicians' Role in the Medication and Procedural Management of Early Pregnancy Loss

PURPOSE: 1) Create a task force with ABEM, CORD, and other relevant stakeholders to determine best approaches for preparing emergency medicine trainees for the management of early pregnancy loss, particularly in care settings where immediate obstetrical services may not be available; 2) Recognize the role of emergency physicians in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where no obstetrical services are available; and 3) Develop a policy statement acknowledging the emergency physician's role in the management of patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

FISCAL IMPACT: Unbudgeted staff resources for establishing and supporting a task force and unbudgeted funds of approximately a minimum of $10,000 for an in-person meeting for 10 people.

1 WHEREAS, Approximately 900,000 emergency visits per year in the U.S. are related to vaginal bleeding and
2 miscarriage in the first trimester,[i] and as such, constitute a significant portion of emergency medicine time and
3 resources; and
4
5 WHEREAS, Up to 20% of pregnancies end in early pregnancy loss (aka miscarriage in the first trimester),
6 and compared with other ED patients, these patients are more likely to be younger, be Black or Hispanic, or be
7 publicly insured[ii]; and
8
9 WHEREAS, Legal changes in the US resulting in reduced access to family planning and abortion services
10 will likely lead to increasing numbers of patients experiencing early pregnancy loss to seek care in an emergency
11 department;[iii]; and
12
13 WHEREAS, A February 2023 report found that 217 labor and delivery units have closed across the US since
14 2011[iv] with a disproportionate impact on rural areas. This reduction in accessibility to prenatal care forces pregnant
15 individuals to travel further for the care of emergent pregnancy complications, and it implies that in many areas of the
16 US emergency physicians may be the most well-equipped and most proximal physicians to care for a pregnancy-
17 related emergency; and
18
19 WHEREAS, Research shows patients given options for medical management or procedural management
20 versus expectant management alone are more satisfied than those not given the option;[v]; and
21
22 WHEREAS, Research indicates that adopting uterine aspiration in the emergency department in lieu of
23 admission and operating room-based uterine aspiration can reduce patient wait times and hospital costs in an era when
24 our healthcare system is financially strained[vi]; and
25
26 WHEREAS, The American College of Obstetricians & Gynecologists' Practice Bulletin on Early Pregnancy
27 Loss states mifepristone should be used to medically manage miscarriage where available,[vii] and emergency
28 physicians with education and training would be capable of prescribing these medications; and

29 WHEREAS, Offering medication management to patients with first-trimester miscarriage can reduce
30 emergency bounceback visits for patients when compared to discharging patients with no treatments[viii]; and
31
32 WHEREAS, Pregnant people who present with hemorrhage or hemodynamic instability from early pregnancy
33 loss should be treated urgently, often with procedural uterine evacuation[ix]; and
34
35 WHEREAS, As a primary approach, procedural uterine evacuation results in faster and more predictable
36 complete evacuation[x]. The success of procedural uterine evacuation of early pregnancy loss approaches 99%[xi],
37 meaning these patients do not need more medications or another procedure; and are less likely to require unscheduled
38 medical care; and.
39
40 WHEREAS, Suction curettage is most commonly performed in an office setting with a manual vacuum
41 aspirator, under local anesthesia without the addition of sedation [xii, xiii]; and
42
43 WHEREAS, Training programs exist that teach miscarriage management, such as the Training, Education and
44 Advocacy in Miscarriage Management (TEAMM) project, a University of Washington-affiliated program that has
45 assisted over 100 clinical and academic sites, including emergency medicine clinicians, develop tailored interventions
46 to integrate early pregnancy loss management into their services[xiv]; and
47
48 WHEREAS, ACOG also hosts a training program where OBGYN specialists travel to emergency
49 departments and hospitals to help clinicians train in uterine aspiration and medical management of miscarriage[xv]; and
50
51 WHEREAS, Research shows that emergency medicine physicians can incorporate manual uterine aspiration
52 for the management of miscarriages into their clinical practice;[xvi]; and
53
54 WHEREAS, Some EM residency programs are currently planning to start or have recently started training
55 their residents in providing manual uterine aspirations for patients with first-trimester miscarriage; and
56
57 WHEREAS, In 2022, ACEP Council passed a resolution to encourage hospitals and emergency medicine
58 residency training programs to provide education, training, and resources outlining best clinical practices on
59 miscarriage care.[xvii] However, what educational expectations this entails in terms of medical versus procedural
60 management as of yet is unclear; and
61
62 WHEREAS, In 2022, ACEP Council passed a resolution that ACEP supports an individual's ability to access
63 the full spectrum of evidence-based pre-pregnancy, prenatal, peripartum, and postpartum physical and mental health
64 care; therefore be it
65
66 RESOLVED, That ACEP, ABEM, CORD and other relevant stakeholders, form a task force to determine the
67 best approaches for preparing emergency medicine trainees for the management of early pregnancy loss, including
68 prescribing medication management (utilizing ACOG best practice approaches), and to provide or support provision
69 of manual uterine aspiration procedural management, such that future emergency physicians will be able respond to
70 early pregnancy loss emergencies in care settings where immediate obstetrical services may not be available; and be it
71 further
72
73 RESOLVED, That ACEP recognize the importance of the emergency physician's role in stabilizing and
74 treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural
75 management, especially in low-resource settings, hospitals without Labor and Delivery, or where there are no
76 obstetrical services available; and be it further
77
78 RESOLVED, That ACEP develop a policy statement acknowledging the emergency physician's role in the
79 management of emergency medicine patients presenting with early pregnancy loss and encourage and support
80 physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient
81 obstetrical services available to further their education on first-trimester miscarriage management.

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[i] https://onlinelibrary.wiley.com/doi/full/10.1002/emp2.12549
[ii] https://onlinelibrary.wiley.com/doi/full/10.1002/emp2.12549
[iii] https://www.acepnow.com/article/the-emergency-department-after-the-fall-of-roe-are-you-prepared/
[iv] https://www.statnews.com/2023/04/18/neonatal-care-closure-rural-labor-delivery-services/
[v] https://pubmed.ncbi.nlm.nih.gov/36920395/_
[vi] https://pubmed.ncbi.nlm.nih.gov/7926246/
[vii] https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss
[viii] https://pubmed.ncbi.nlm.nih.gov/22381604/
[ix]https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss
[x] Sotiriadis A , Makrydimas G , Papatheodorou S , Ioannidis JP . Expectant, medical, or surgical management of first-trimester miscarriage: a meta-analysis . Obstet Gynecol 2005 ; 105 : 1104 – 13 .
[xi] Zhang J , Gilles JM , Barnhart K , Creinin MD , Westhoff C , Frederick MM . A comparison of medical management with misoprostol and surgical management for early pregnancy failure. National Institute of Child Health Human Development (NICHD) Management of Early Pregnancy Failure Trial . N Engl J Med 2005 ; 353 : 761 – 9 .
[xii] Goldberg AB , Dean G , Kang MS , Youssof S , Darney PD . Manual versus electric vacuum aspiration for early first-trimester abortion: a controlled study of complication rates . Obstet Gynecol 2004 ; 103 : 101 – 7 .
[xiii] Dalton VK , Harris L , Weisman CS , Guire K , Castleman L , Lebovic D . Patient preferences, satisfaction, and resource use in office evacuation of early pregnancy failure . Obstet Gynecol 2006 ; 108 : 103 – 10
[xiv] https://www.miscarriagemanagement.org/impact
[xv] https://www.acog.org/programs/optimizing-care-for-pregnancy-loss/about-the-program
[xvi] https://pubmed.ncbi.nlm.nih.gov/29248332/
[xvii]https://www.acep.org/what-we-believe/actions-on-council-resolutions/council/action-on-2022-resolutions

Background

This resolution calls for ACEP to: 1) Create a task force with ABEM, CORD, and other relevant stakeholders to determine best approaches for preparing emergency medicine trainees for the management of early pregnancy loss, particularly in care settings where immediate obstetrical services may not be available; 2) Recognize the role of emergency physicians in stabilizing and treating patients experiencing early pregnancy loss, inclusive of the potential for medication and procedural management, especially in low-resource settings, hospitals without Labor and Delivery, or where no obstetrical services are available; and 3) Develop a policy statement acknowledging the emergency physician's role in the management of patients presenting with early pregnancy loss and encourage and support physicians working in low-resource settings, hospitals without Labor and Delivery, or where there are insufficient obstetrical services available to further their education on first-trimester miscarriage management.

The issue of access to and provision of prophylaxis, contraception, abortion, and other reproductive health measures continues to be in a state of significant uncertainty as a result of the 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. Given wide variation in state regulation of abortion and reproductive health procedures 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 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 physicians for assisting individuals in accessing emergency care for pregnancy loss, or aggressive enforcement of mandatory reporting laws that may put physicians in legal peril.

An estimated quarter of all women will experience the early loss of a pregnancy in their lifetime (Ghosh 2021) and 20% of these losses will require some form of intervention to completely clear the uterus of retained tissue (Manning, 2023). Up to 20% of pregnancies end in early pregnancy loss and early pregnancy loss or bleeding in early pregnancy accounts for a combined 2.7% of all emergency department (ED) visits among reproductive-aged women, or approximately 900,000 ED visits annually. Although some patients go to their primary obstetric providers for evaluation of early pregnancy loss, many seek care in the emergency department. Additionally, patients who come to

the ED with early pregnancy loss are younger and more likely to be Black or Hispanic compared with other patients in the ED. Studies have also shown that the patients were also less likely to be the primary insurance policy holder or to have established prenatal care as compared to patients presenting to the outpatient setting; these characteristics were also all associated with decreased odds of active early pregnancy loss management.

A February 2023 report found that 217 labor and delivery units have closed across the nation since 2011 and additionally, the 2021 National Vital Statistics System reported a 38% increase in maternal mortality rates. Given the closures of obstetric units and reproductive health clinics around the United States, limiting access to women's health services for the most disadvantaged, EDs will increasingly need to fill gaps in care. Therefore, provision of comprehensive and high-quality early pregnancy loss care in the ED setting will be one critical component to ensuring healthy outcomes and equitable care for women in the United States.

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).

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.

ACEP also appointed a cross-disciplinary Emergency Medicine Reproductive & Patient Safety Health Task Force to help identify and develop recommendations to address gaps in existing regulation or statute that could create clinical and legal barriers to how emergency physicians practice emergency medicine. The work of the task force has informed the creation of ACEP Emergency Reproductive Health resource center that includes updated federal and state regulations. The task force also developed the policy statement "Access to Reproductive Health Care in the Emergency Department" that was approved by the Board of Directors in June 2023.

The Model of the Clinical Practice of Emergency Medicine (EM Model) is designed for use as the core document for the specialty of emergency medicine and provides the foundation for developing medical school and residency curricula, certification examination specifications, continuing education objectives, research agendas, residency program review requirements, and other documents necessary for the definition, skills acquisition, assessment, and practice of the specialty. The 2022 EM Model includes topics in obstetrics and gynecology, including first trimester bleeding and abortion. However, the Dobbs decision will exacerbate existing disparities in maternal health access and delivery and will likely drive related pregnancy and miscarriage care to the ED. Emergency medicine education will necessarily expand to include contraception screening and provision, manual uterine evacuation, and the provision of medication abortions in the ED. There is precedent for emergency physicians performing these functions, but they need to be further developed and more widely incorporated into residency training. Additionally, it is increasingly important for emergency physicians to be well-versed in pregnancy, abortion, and miscarriage management and to collaborate with obstetrics and gynecology colleagues to provide compassionate, patient-centered care, minimize trauma, and prevent criminalization of patients beyond residency programs. This could include incorporation of online resources such as Innovating Education in Reproductive Health, Training in Early Abortion for Comprehensive Healthcare, and Training, Education, & Advocacy in Miscarriage Management, as well as utilization of teaching and education for multi-modal formats such as simulations. The COVID-19 pandemic showed the utility of using virtual learning and programs could leverage the virtual environment and organize shared grand rounds or other conferences, where lecturers from different practice environments could interact.

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

Unbudgeted staff resources for establishing and supporting a task force and unbudgeted funds of approximately $10,000 for an in-person meeting for 10 people.

Prior Council Action

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted. Directed ACEP to develop a policy statement endorsing the accessibility of emergency contraception in emergency departments nationwide and advocate for universal access to emergency contraception in the emergency department.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP 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. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving 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. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the 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. Directed ACEP to support 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.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Prior Board Action

June 2023, approved the policy statement "Access to Reproductive Health Care in the Emergency Department."

Resolution 27(22) Equitable Access to Emergency Contraception in the ED adopted.

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

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.

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

Background Information Prepared by: Sam Shahid, MBBS, MPH
Senior Manager, Practice Management

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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 46(23)

SUBMITTED BY: Emily Ager, MD
Kimberly Chernoby, MD
James Feldman, MD, FACEP
Kelly Quinley, MD
Rachel Solnick, MD
Katherine Wegman, MD
Social Emergency Medicine Section

SUBJECT: Consensus with ACOG on the Care of Pregnant Individuals with Substance Use Disorder

PURPOSE: 1) Endorse ACOG's Committee Opinion No. 473: "Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist;" and 2) adopt a policy statement discouraging drug enforcement policies that deter women from seeking prenatal care, and advocates for the retraction of drug enforcement policies in states with legislation that punishes women for substance abuse during pregnancy.

FISCAL IMPACT: Budgeted committee and staff resources to review the ACOG policy statement and develop a new policy statement. Unbudgeted staff resources for advocacy specific to the new policy statement.

1 WHEREAS, Substance use disorder is a medical condition with evidence-based treatment modalities[1]; and
2
3 WHEREAS, 25 states and the District of Columbia consider substance use during pregnancy to be child abuse
4 under civil child-welfare statutes, and 3 consider it grounds for civil commitment[2]; and
5
6 WHEREAS, Punitive drug enforcement policies that deter women from seeking prenatal care are contrary to
7 the welfare of both the mother and the fetus[3]; and
8
9 WHEREAS, Research has shown that incarceration or the threat of incarceration are ineffective in reducing
10 the incidence of alcohol or drug abuse during pregnancy[4,5,6]; therefore be it
11
12 RESOLVED, That ACEP endorse the American College of Obstetricians & Gynecologists Committee
13 Opinion on the Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist; and be it
14 further
15
16 RESOLVED, That ACEP issue a publicly available policy statement: "Drug enforcement policies that deter
17 women from seeking prenatal care are contrary to the welfare of the mother and the fetus. In states with legislation
18 that punishes women for substance abuse during pregnancy, ACEP advocates for the retraction of such policies."

Resolution References

[1]https://www.samhsa.gov/medications-substance-use-disorders
[2]https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy
[3]https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2011/01/substance-abuse-reporting-and-pregnancy.pdf
[4]Poland ML, Dombrowski MP, Ager JW, Sokol RJ. Punishing pregnant drug users: enhancing the flight from care. Drug Alcohol Depend 1993;31:199–203
[5]Chavkin W. Drug addiction and pregnancy: policy crossroads. Am J Public Health 1990;80:483–7
[6]Schempf AH, Strobino DM. Drug use and limited prenatal care: an examination of responsible barriers. Am J Obstet Gynecol 2009;200:412.e1–412.e10

Background

This resolution requests ACEP to endorse the American College of Obstetricians & Gynecologists Committee Opinion No. 473: "Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist" and adopt a policy statement that discourages drug enforcement policies that deter women from seeking prenatal care, and advocates for the retraction of drug enforcement policies in states with legislation that punishes women for substance abuse during pregnancy.

The first resolved asks that ACEP "endorse the American College of Obstetricians & Gynecologists Committee Opinion No. 473: "Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist." The AGOG Committee Opinion No. 473: "Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist" was originally approved by the ACOG in 2011 and reaffirmed in 2022. All requests for endorsement must be reviewed and approved in accordance with ACEP's established processes for endorsement of policy statements or documents from other organizations. ACOG has not requested endorsement from ACEP.

AGOG, as an organization produces seven types of documents from their board and committee work. These are defined on their website (https://www.acog.org/-/media/project/acog/acogorg/clinical/list-of-titles/combined-list-of-titles.pdf) as follows:

- **Clinical Consensus:** documents provide recommendations on focused clinical issues based on a careful examination of available scientific data, supplemented with expert opinion when the evidence is limited.
- **Committee Opinions**: provide ACOG committee assessments of emerging issues in obstetric and gynecologic practice.
- **Committee Statements:** address issues related to the practice of obstetrics and gynecology, such as ethics and access to care for underserved populations.
- **Clinical Practice Guidelines:** provide clinical management recommendations that are developed through assessment of the benefits and harms of care options based on a systematic review of the evidence.
- **Practice Bulletins:** are evidence-based documents that summarize current information on techniques and clinical management issues for the practice of obstetrics and gynecology.
- **Obstetric Care Consensus:** documents are developed jointly with the Society for Maternal-Fetal Medicine and include high-quality, consistent, and concise clinical recommendations for practicing obstetricians and maternal-fetal medicine subspecialists.
- **Technology Assessments:** provide an overview of technology in obstetrics and gynecology.

In addition to being highly specific to the role and responsibilities of the obstetrician-gynecologist, this particular document (Opinion # 473) has not met apparent higher levels of evidentiary and ACOG Board guidance present in Clinical Consensus documents, Committee Statements, Practice Bulletins, and Clinical Practice guidelines. Additionally, opinion #473 was issued out of a single ACOG committee (Committee on Health Care for Underserved Women) and does not align fully with a similar opinions from other ACOG committees.

The second resolved asks that ACEP "adopt a policy statement that discourages drug enforcement policies that deter women from seeking prenatal care, and advocates for the retraction of drug enforcement policies in states with legislation that punishes women for substance abuse during pregnancy".

Since 1991, ACEP has supported the emergency physicians' ability to protect the confidentiality of their patients' personal health information during emergency medical treatment. The policy statements "Code of Ethics for Emergency Physicians" and "Confidentiality of Patient Information" are general in scope and not explicitly specific to drug enforcement policies that target or deter women seeking prenatal care contrary to the mother and fetus. However, the two policy statements do already address the difficult decisions emergency physicians may face in sharing patient information in response to requests by law enforcement, parents or guardians of minor children, public health officers, and the media. Current policy has been carefully crafted so that no particular patient population or condition is specifically included or excluded. It is therefore able to be applied to all patients presenting for emergency care regardless of variation in local, state, or federal laws as a guiding principle for the emergency physician.

The policy statement "Law Enforcement Information Gathering in the Emergency Department" is also general in scope and, while not explicitly specific to prenatal care, adds to ACEP's position on physician-patient confidentiality by stating the following with regard to sharing personal health information with law enforcement:

> "ACEP recognizes that law enforcement officials perform valuable functions in the emergency department (ED), and that one of these functions is investigation of criminal acts. As part of these investigations, law enforcement officials may request personal health information (PHI) gathered in the ED. Emergency physicians may honor these requests only under the following circumstances:
>
> 1. The patient consents to release of the requested PHI to law enforcement officers, or
> 2. Applicable laws or regulations mandate the reporting of the requested PHI to law enforcement officers, or
> 3. Law enforcement officers produce a subpoena or other court order requiring release of the requested PHI to them."

This policy statement further states:

> "Emergency physicians may conscientiously refuse to carry out or comply with legal orders that they deem violate emergency patient and privacy-related rights or jeopardize the welfare of their patients, recognizing that there may be legal or professional repercussions for these decisions."

ACEP's 2023 policy statement "Access to Reproductive Care in the Emergency Department" states:

> "ACEP also opposes mandatory reporting with the intent (explicit or implicit) to prosecute patients or their healthcare providers, which includes, but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss." The policy statement further states that "ACEP opposes the statuary provision of criminal penalties for any medically appropriate care provided in the emergency department."

Mandatory notification and reporting policies for pregnant and postpartum women with substance use disorder vary by state and the state's definition of child abuse and neglect.[1] Depending on the state's policies and definition of child abuse and neglect, mandatory reporting can be either a facilitator or a barrier to the provision of substance use disorder treatment for pregnant and postpartum women. In states that consider substance use during pregnancy to be child abuse and possible grounds for civil commitment, pregnant women may not trust health care personnel to protect them from the social and legal consequences of their substance abuse and therefore be less forthcoming about their substance use.

Finally, ACEP's policy statement "Interference in the Physician-Patient Relationship" states:

> "The American College of Emergency Physicians (ACEP) believes 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."

Background Reference

1. Bureau of Justice Assistant U.S. Department of Justice. *Substance Use and Pregnancy—Part 1 Current State Policies on Mandatory Reporting of Substance Use During Pregnancy, and Their Implications (March 2023)*. Available at https://bja.ojp.gov/library/publications/substance-use-and-pregnancy-part-1-current-state-policies-mandatory-0. Accessed August 10, 2023.

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 committee and staff resources to review the ACOG policy statement and develop a new policy statement. Unbudgeted staff costs for advocacy specific to the new policy statement.

Prior Council Action

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted. Directed ACEP to encourage hospitals and emergency medicine residency training programs to provide education, training, and resources outlining evidence-based clinical practices on acute presentations of pregnancy-related complications, including miscarriage, post-abortion care, and self-managed abortions; continue to develop clinical practices and policies that protect the integrity of the physician-patient relationship, the legality of clinical decision-making, and possible referral to additional medical care services – even across state lines – for pregnancy-related concerns (including abortions); and support clear legal protections for emergency physicians providing federally-mandated emergency care, particularly in cases of conflict between federal law and state reproductive health laws.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted. Directed ACEP 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. Additionally, directed that ACEP support the position that the early termination of pregnancy a medical procedure involving 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. Also directed ACEP to oppose statutory provision of criminal penalties for any medically appropriate care provided in the ED and additionally oppose mandatory reporting with the intent (explicit or implicit) to prosecute patients or their health care professionals, including but is not limited to, care for any pregnancy, pregnancy-related complications, or pregnancy loss. Also directed ACEP to specifically oppose the 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. Directed ACEP to support 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.

Amended Resolution 24(22) Access to Reproductive Right adopted. Directed that ACEP support equitable, nationwide access to reproductive health care procedures, medications, and other interventions.

Amended Resolution 46(18) Law Enforcement Information Gathering in the ED Policy Statement. Called for the revision of the policy statement "Law Enforcement Information Gathering in the Emergency Department" to provide clarification and guidance on the ethical and legal obligations for searches, with or without a warrant, in investigations involving DUI.

Prior Board Action

June 2023, approved the policy statement "Access to Reproductive Health Care in the Emergency Department."
June 2023, approved the revised policy statement "Law Enforcement Information Gathering in the Emergency Department;" revised and approved June 2017 and April 2003, originally approved September 2003. originally approved September 2003.

February 2023, approved the revised policy statement "Confidentiality of Patient Information;" revised and approved January 2017 with the current title; reaffirmed October 2008, October 2002, and October 1998; originally approved January 1994 titled "Patient Confidentiality."

Amended Resolution 26(22) Promoting Safe Reproductive Health Care for Patients adopted.

Amended Resolution 25(22) Advocacy for Safe Access to Full Spectrum Pregnancy Related Health Care adopted.

Amended Resolution 24(22) Access to Reproductive Right adopted.

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

Amended Resolution 46(18) "Law Enforcement Information Gathering in the ED Policy Statement" adopted.

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

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice Manager

Kaeli Vandertulip, MSLS, MBA, AHIP
Clinical Practice 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 47(23)

SUBMITTED BY: Kevin Durgun MD
Adam Kruse, MD
Brooks Walsh MD
District of Columbia Chapter
Social Emergency Medicine Section
EMS-Prehospital Care Section

SUBJECT: Clarification of and Taking a Position Against Use of Excited Delirium Syndrome

PURPOSE: 1) Rescind approval of the 2009 White Paper Report on Excited Delirium Syndrome; 2) remove or update content and/or literature on website that relies on the outdated information regarding "excited delirium" or conditions with a similar definition as described in the 2009 paper; 3) disseminate the position that ACEP no longer endorses or approves the 2009 White Paper on Excited Delirium among the wider medical and public health community, law enforcement organizations, and ACEP members acting as expert witnesses testifying in relevant civil or criminal litigation; and 4) future ACEP work on the evaluation and management of in-hospital and out-of-hospital behavioral emergencies should utilize experts in EMS, neurology, emergency psychiatry, and health equity, and also consider the perspectives of community and advocacy leaders.

FISCAL IMPACT: Budgeted committee and staff resources.

1 WHEREAS, ACEP approved, published, and circulated a 2009 White Paper Report with the consensus that
2 Excited Delirium Syndrome is a unique syndrome[1, 2]; and
3
4 WHEREAS, The trade press[3] and law enforcement organizations[4-6] have cited the 2009 White Paper with the
5 characterization that ACEP recognized excited delirium syndrome as a medical condition without contest from ACEP
6 and that such citations persist today in first responder training and policy, and emergency physician expert court
7 testimony[5-6]; and
8
9 WHEREAS, Multiple medical organizations have rescinded support of, or explicitly stated positions against
10 the "condition or diagnosis of excited delirium" or excited delirium syndrome including the American Academy of
11 Emergency Medicine[7], the National Association of Medical Examiners[8], and the American College of Medical
12 Toxicology[9]; and
13
14 WHEREAS, ACEPs 2021 Task Force Report on Hyperactive Delirium Syndrome was "not to be construed as
15 an update or refutation of the 2009 paper" and does not formally disavow ACEP support of the 2009 White Paper on
16 Excited Delirium[10]; and
17
18 WHEREAS, The ACEP Board of Directors released a statement April 14, 2023 that states ACEP "does not
19 recognize the use of the term "excited delirium" and its use in clinical settings"[11], despite use of the term elsewhere on
20 the ACEP website, and with multiple references within the 2021 ACEP Task Force Report on Hyperactive
21 Delirium[12,13]; therefore be it
22
23 RESOLVED, That ACEP clarify its position in writing, that the 2009 white paper is inaccurate and outdated,
24 and that while the ACEP Board of Directors had previously approved the 2009 White Paper Report on Excited
25 Delirium, it has withdrawn such approval; and be it further
26
27 RESOLVED, That ACEP and its sections either remove or update content and/or literature on its website that
28 relies on the outdated information regarding "excited delirium" or conditions with a similar definition as that

29 described in the 2009 White Paper Report on Excited Delirium; and be it further
30
31 RESOLVED, That ACEP disseminate their position that they no longer endorse or approve the 2009 White
32 Paper on Excited Delirium among the wider medical and public health community, law enforcement organizations,
33 and ACEP members acting as expert witnesses testifying in relevant civil or criminal litigation; and be it further
34
35 RESOLVED, That future ACEP work on the evaluation and management of in-hospital and out-of-hospital
36 behavioral emergencies should utilize not only experts in emergency medical services, neurology, emergency
37 psychiatry, and health equity, but must also consider the perspectives of community and advocacy leaders.

Resolution References

1. 2008 Council Resolution 21: Excited Delirium https://www.acep.org/what-we-believe/actions-on-council-resolutions/councilresolution/?rid=CF76C941-5383-EB11-A9C2-995F1D3A2B04
2. DeBard ML, Adler J, Bozeman W, et al. American College of Emergency Physicians; 2009. Accessed June 2, 2023. https://www.prisonlegalnews.org/media/publications/acep_report_on_excited_delirium_syndrome_sept_2009.pdf
3. ACEP Recognizes Excited Delirium Syndrome: Emergency Medicine News 10/2009 https://journals.lww.com/em-news/Documents/ExDS-pdf-final.pdf
4. IACP. Excited delirium syndrome. International Association of Chiefs of Police. November 1, 2015. Accessed June 2, 2023. https://www.theiacp.org/resources/resolution/excited-delirium-syndrome.
5. Budhu J, O'Hare M, Saadi A. Brookings Institute; 2020. Accessed June 2, 2023. https://www.brookings.edu/blog/how-we-rise/2020/08/10/how-excited-delirium-is-misused-to-justify-police-brutality/.
6. Bhatia B de S, Naples-Mitchell J, Saadi A, Sherwin J. Physicians for Human Rights; 2022. Accessed June 2, 2023. https://phr.org/our-work/resources/excited-delirium/.
7. AAEM. AAEM revised excited delirium statement. AAEM. June 1, 2023. Accessed June 2, 2023. https://www.aaem.org/statements/excited-delirium/.
8. NAME. Excited Delirium Statement. National Association of Medical Examiners. March 2023. Accessed June 2, 2023. https://name.memberclicks.net/assets/docs/Excited%20Delirium%20Statement%203%20-%202023.pdf.
9. ACMT. ACMT position statement on end the use of excited delirium. American College of Medical Toxicology. May 1, 2023. Accessed June 2, 2023. https://www.acmt.net/news/acmt-position-statement-on-end-the-use-of-excited-delirium/.
10. Hatten BW, Bonney C, Dunne RB, et al. American College of Emergency Physicians; 2021. Accessed June 2, 2023. https://www.acep.org/siteassets/new-pdfs/education/acep-task-force-report-on-hyperactive-delirium-final.pdf.
11. ACEP. ACEP's position on hyperactive delirium. ACEP. April 14, 2023. Accessed May 3, 2023. https://www.acep.org/news/acep-newsroom-articles/aceps-position-on-hyperactive-delirium.
12. Wong D. Excited Delirium for the TEMS provider. American College of Emergency Physicians Tactical And Law Enforcement Medicine Section. June 16, 2021. Accessed May 3, 2023. https://web.archive.org/web/20230306183449/https://www.acep.org/talem/newsroom/jun2021/excited-delirium-for-the-tems-provider/.
13. Bradley K. Perspectives on excited delirium and ketamine. ACEP Tactical and law Enforcement Medicine Section. May 4, 2022. Accessed May 3, 2023. https://www.acep.org/talem/newsroom/april-2022/perspectives-on-excited-delirium-and-ketamine.

Background

This resolution requests that ACEP rescind approval of the 2009 White Paper Report on Excited Delirium Syndrome; remove or update content and/or literature on website that relies on the outdated information regarding "excited delirium" or conditions with a similar definition as described in the 2009 paper; disseminate the position that ACEP no longer endorses or approves the 2009 White Paper on Excited Delirium among the wider medical and public health community, law enforcement organizations, and ACEP members acting as expert witnesses testifying in relevant civil or criminal litigation; and future ACEP work on the evaluation and management of in-hospital and out-of-hospital behavioral emergencies should utilize experts in EMS, neurology, emergency psychiatry, and health equity, and also consider the perspectives of community and advocacy leaders.

ACEP first addressed a form of altered mental status distinguished by disordered thinking and psychomotor agitation, often accompanied by a hyperadrenergic state, with the 2009 task force report titled "Excited Delirium Task Force White Paper Report on Excited Delirium Syndrome."[1] The 20-member task force, consisted primarily of emergency physicians, provided a review of the history, epidemiology, clinical perspectives, potential pathophysiology,

diagnostic characteristics, differential diagnoses, and clinical treatment of what at the time was commonly referred to in the medical community as "excited delirium syndrome."

Since 2009, ACEP has made efforts to study the existence of excited delirium syndrome as a disease entity and has worked to synthesize the most current information available regarding the recognition, evaluation, and management of patients presenting with the constellation of signs and symptoms associated with a syndrome not fitting a previously established medical condition. In 2020, in response to urgent questions surrounding the initial management of excited delirium raised by ACEP membership, the scientific community, community leaders, media, and governmental agencies, a 10-member task force of emergency physicians was appointed. This task force was complimented by a 17-member multi-specialty review panel with representatives from the American Academy of Clinical Toxicology, American College of Medical Toxicology, American Society of Anesthesiologists, American Society of Health-System Pharmacists, Emergency Nurses Association, National Association of EMS Physicians, National Association of Medical Examiners, and the Washington Advocates for Patient Safety.[2]

In June 2021, the ACEP Board of Directors approved the "ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings." Since the completion of the report, ACEP has used the term "hyperactive delirium with severe agitation" when referring to patients exhibiting agitated or combative behavior associated with a delirious state where the individual is not capable of interacting with other individuals or the environment.[2] The term "hyperactive delirium with severe agitation" is the term commonly used in recent research for delirium associated with increased neuromuscular activity, often accompanied by agitation and is more descriptive of the identified mental status and level of activity exhibited by patients of interest, and expands upon the term "hyperactive delirium."[2]

ACEP's website includes "ACEP's Position on Hyperactive Delirium." The webpage states that "ACEP does not recognize the use of the term 'excited delirium' and its use in clinical settings."[3] The statement further states that any multidisciplinary work on hyperactive delirium should include emergency physicians as well as stakeholders with diverse backgrounds and expertise in EMS, toxicology, neurology, emergency psychiatry, law enforcement, and health equity.[3] **The 2009 report no longer exists on the ACEP website and references to the term "excited delirium" only appear in reference to past resolutions, in citations appearing in external publications, or in the context of the 2021 report.**

Work is currently underway to summarize the 2021 "ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings" for submission to *JACEP Open* for publication consideration when finalized. A first draft of this summary is expected in early October 2023.

ACEP's Frontline podcast, hosted by Ryan Stanton, MD, FACEP, featured a discussion with ACEP Board member Jeff Goodloe, MD, FACEP, on July 11, 2022, about hyperactive delirium, the risk, management, and the evidence. ACEP also developed the online course "Recognition and Management of Hyperactive Delirium in Emergency Settings" that is available in the online learning center.

Background References

1. Debard ML, Adler J, Bozeman W, et al. Excited Delirium Task Force White Paper Report on Excited Delirium Syndrome. September 2009.
2. Hatten BW, Bonney C, Dunne RB, et al. ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings. 23 June 2021. Available at: www.acep.org/siteassets/new-pdfs/education/acep-task-force-report-on-hyperactive-delirium-final.pdf
3. American College of Emergency Physicians. ACEP's Position on Hyperactive Delirium. 14 April 2023. Available at: https://www.acep.org/news/acep-newsroom-articles/aceps-position-on-hyperactive-delirium.

ACEP Strategic Plan Reference

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

Budgeted committee and staff resources.

Prior Council Action

Amended Resolution 38(21) Prehospital Oversight and Management of Patients Experiencing Hyperactive Delirium with Severe Agitation adopted. Directed the College to advocate at the state and national levels to have ABEM/AOBEM-certified providers serve as the only and highest-level medical experts on the management of hyperactive delirium with severe agitation and partner with the NAEMSP on all issues pertaining to out-of-hospital management of hyperactive delirium with severe agitation.

Amended Resolution 21(08) Excited Delirium. Directed the College to establish a multidisciplinary group to study "excited delirium" and to make clinical recommendations.

Prior Board Action

Amended Resolution 38(21) Prehospital Oversight and Management of Patients Experiencing Hyperactive Delirium with Severe Agitation adopted.

June 2021, approved the "ACEP Task Force Report on Hyperactive Delirium with Severe Agitation in Emergency Settings."

October 2009, approved the "White Paper Report on Excited Delirium Syndrome" and authorized its distribution to appropriate entities.

Amended Resolution 21(08) Excited Delirium adopted.

Background Information Prepared by: Travis Schulz, MLS, AHIP
Clinical Practice 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 48(23)

SUBMITTED BY: New York Chapter

SUBJECT: Medical Malpractice Certificate of Merit

PURPOSE: Requests ACEP to recommend an affidavit of merit must be from a doctor who is board certified and licensed in the same specialty.

FISCAL IMPACT: Budgeted committee and staff resources to develop a new a policy statement or revise existing policy statements.

1 WHEREAS, In most states medical malpractice actions must be accompanied by a certificate from the plaintiff's
2 attorney, declaring that he or she consulted with a licensed physician who has determined there are adequate grounds for
3 pursuing such action; and
4
5 WHEREAS, The affidavit of merit mandate is intended to filter out frivolous claims before they are brought to
6 court[a]; and
7
8 WHEREAS, Several states (New York, Ohio, and Minnesota, as examples) allow for certificates of merit to be
9 produced by any physician, regardless of his or her specialty or expertise; and
10
11 WHEREAS, Several states (New Jersey, Michigan, and Pennsylvania, as examples) currently require that a
12 certificate of merit be produced by a physician of the same specialty as the potential defendant; therefore be it
13
14 RESOLVED, That ACEP recommend an affidavit of merit must be from a doctor who is board certified and
15 licensed in the same specialty.

[a] *So currently a retired dermatologist could review a case against an emergency physician.*

Background

This resolution requests ACEP to recommend an affidavit of merit must be from a doctor who is board certified and licensed in the same specialty.

ACEP has three current policy statements that address the medical background of expert witnesses:

"Expert Witness Cross-Specialty Testimony for Standard of Care"
Expert witness cross-specialty testimony occurs when a physician in one medical specialty provides an expert witness opinion regarding the standard of care in a different medical specialty. Since medical expert witness testimony has the potential to establish standards of care, the American College of Emergency Physicians believes that the standard of care for emergency medicine should only be established and attested to by emergency physicians.

"Expert Witness Guidelines for the Specialty of Emergency Medicine" (excerpted)
To qualify as an expert witness in the specialty of emergency medicine, a physician shall:

- Be currently licensed in a state, territory, or area constituting legal jurisdiction of the United States as a doctor of medicine or osteopathic medicine;
- Be certified by a recognized certifying body in emergency medicine;

"Medical Practice Review and the Practice of Medicine" (excerpted)

- Opinions regarding the appropriateness and quality of medical care, including but not limited to expert witness testimony, peer review, utilization review and decisions regarding insurance coverage involving care authorization or care denial, should constitute the practice of medicine as defined in state Medical Practice Acts and should be limited to currently licensed physicians whose practice is governed by the respective state's Board of Medicine.
- Opinions, not related to internal group operations, regarding the appropriateness of medical care should be made by physicians who practice or have practiced in the same specialty, who possess an active, unrestricted license (preferably in the same state), and with at least comparable certification and expertise as the physician whose medical care is under review.

ACEP also has a current policy statement opposing affidavits of merit by an anonymous party.

> "Anonymous Affidavits of Merit" (excerpted)
> Anonymous testimony, in any form, prevents confirmation of the expert's qualifications, authoritative expertise, and potential bias, all of which are crucial to fair and proper evaluation of claims.

As described in the resolution, an affidavit of merit is a sworn statement that a medical expert has reviewed a medical malpractice claim and determined that there are sufficient grounds for pursuit of the action. According to the National Conference of State Legislatures, 28 states have requirements for filing an affidavit or certificate of merit for a medical liability and malpractice claim to move forward. Qualifications to provide an affidavit of merit in some states, such as Michigan, require the health professional to meet the same qualifications as an expert witness to testify in court in such a case. Other states, such as Nevada, that require an affidavit of merit do not require the health professional providing the affidavit to meet the same criteria as an expert witness.

ACEP's existing policy on expert witness qualifications will, in some states, leave unaddressed the qualifications of the health professional providing an affidavit of merit in a medical malpractice claim.

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 professional.

Fiscal Impact

Budgeted committee and staff resources developing a new a policy statement or revising existing policy statements.

Prior Council Action

Amended Substitute Resolution 46(85) Ethics of Expert Witness Testimony adopted. The resolution directed ACEP to develop expert witness criteria requiring only clinically active emergency physicians provide expert witness testimony in cases related to care rendered by an emergency physician; investigate the feasibility of developing model state legislation that includes the criteria; and investigate the ramifications of establishing a malpractice review panel to which expert testimony can be submitted for review.

Prior Board Action

April 2022, approved the revised policy statement "Anonymous Affidavits of Merit;" originally approved June 2016.

June 2021, reaffirmed the policy statement "Expert Witness Guidelines for the Specialty of Emergency Medicine;" revised and approved June 2015, June 2010, August 2000, and September 1995; originally approved September 1990.

June 2020, approved the policy statement "Expert Witness Cross-Specialty Testimony for Standard of Care."

May 2018, approved the policy statement "Medical Practice Review and the Practice of Medicine."

Amended Substitute Resolution 46(85) Ethics of Expert Witness Testimony adopted.

Background Information Prepared by: 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 49(23)

SUBMITTED BY: Jennifer Conn, MD, FACEP
Olga Gokova, MD, FACEP
Rachel Levitan, MD
Anne Richter, MD, FACEP
Arizona College of Emergency Physicians

SUBJECT: Patients Leaving the ED Prior to Completion of Care Against Medical Advice

PURPOSE: Affirm that patients leaving the ED against medical advice prior to completion of care may 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.

1 WHEREAS, Patients initiate an episode of care by presenting to the emergency department for evaluation of a
2 medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a
3 prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence
4 of immediate medical attention to result in: a) placing the patient's health in serious jeopardy; b) serious impairment
5 to bodily functions; or c) serious dysfunction of any bodily organ or part; and
6
7 WHEREAS, Patients without intent to harm themselves or others have the right to choose to leave the
8 emergency department and sign out against medical advice at any point during their evaluation, workup, and
9 management ending their episode of care; and
10
11 WHEREAS, Emergency physicians manage multiple emergent patients simultaneously and may be unable to
12 immediately avail themselves to the patient desiring to leave; and
13
14 WHEREAS, Leaving the emergency department against medical advice prior to completion of care does not
15 allow the emergency provider to completely evaluate the patient, order indicated tests and imaging, review and act on
16 results, discuss all results with the patient including incidental findings that require follow up, obtain appropriate
17 consults, admit or transfer the patient, nor prepare a complete list of discharge diagnoses, prescriptions, instructions
18 and referrals; and
19
20 WHEREAS, Emergency physicians do not usually practice in a setting where they may schedule a follow up
21 appointment with a patient; and
22
23 WHEREAS, The expectation of patients who utilize emergency departments expect their episodes of care and
24 discharge paperwork to be complete; therefore be it
25
26 RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department
27 prior to completion of care may not have received a complete evaluation, results of all ancillary testing including
28 incidental findings, all indicated therapies, and all indicated consults; and be it further
29
30 RESOLVED, That ACEP create a document acknowledging that physicians and hospitals/systems share a
31 joint responsibility to notify patients who have left prior to the completion of care regarding testing requiring
32 intervention that results after their departure and develop reasonable systems to help communicate these results; and
33 be it further

34 RESOLVED, That ACEP create a document acknowledging that patients leaving the emergency department
35 prior to completion of care may not have all medication recommendations and prescriptions, nor a complete list of
36 discharge diagnoses, incidental findings requiring follow up, instructions, and referrals upon departure.

Background

This resolution asks ACEP to create a document acknowledging that patients leaving the emergency department (ED) prior to the completion of care and those leaving against medical advice (AMA) may 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. It further calls for ACEP to advocate that emergency physicians and hospital systems jointly share responsibility for developing systems to communicate such information to patients who leave prior to the completion of ED care and/or leave AMA. A similar resolution was submitted to the Council last year that was not adopted. The 2022 resolution used the terminology "will not" instead of "may not" in the first and third resolved statements. The second resolved statement is an addition to the resolution.

Patients who leave the ED do so for a variety of reasons.. 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] The rates of those leaving prior to the completion of care but do not have an AMA disposition is unknown.

Patients who leave the ED AMA must have the decisional capacity, understand, and acknowledge the risks of leaving. There may be limitations in the ability of the emergency physician to provide the patient with a complete ED evaluation, result discussions, correct disposition including diagnosis, mediation recommendation and reconciliation, discharge coordination for after-visit following up or return precautions when a patient leaves prior to completion of treatment. Patients who leave AMA often leave with short notice or leave with no notice so there may be limited opportunity for the emergency physician to intervene.

There is significant medical-legal risk associated with the failure of the patient to receive a complete ED evaluation, discharge information and follow-up when the patient leaves prior to completion of treatment. There is concern that emergency physicians may be held to an expectation of providing a complete discharge process including treatment plans and referrals for follow-up to patients who have left prior to the completion of ED care and/or AMA, even if the results return after patient departure. This expectation could expose emergency physicians to increased liability for failure to provide this information.

CPT codes encompass some of these concepts, but there are no ACEP documents that acknowledge the implications or their potential impacts of leaving AMA. ACEP's current policy statement "Interpretation of Diagnostic Imaging Tests" states (in part):

> "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."

Background 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

Resolution 55(22) Patients Leaving the Emergency Department Prior to Completion of Care Against Medical Advice not adopted.

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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 50(23)

SUBMITTED BY: American Association of Women Emergency Physicians Section
Government Services Chapter

SUBJECT: Metric Shaming

PURPOSE: Develop practices and policies to prevent the publishing, transmitting, and releasing of unblinded metric-related information about individual emergency physician performance to safeguard the welfare of our membership.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement and/or other resources for physicians local to present to their administration. Efforts beyond a policy statement would require significant advocacy efforts at a national and state level and are not included in current budgeted and prioritized work of the College. Resources would need to be reallocated from other strategic priority projects.

1 WHEREAS, Performance metrics of individual emergency physicians are frequently collected in a variety of
2 practice settings, including and not limited to door to doctor time, time to admission, total RVUs produced, and total
3 CPTs performed; and
4
5 WHEREAS, There are instances that the metrics of individual emergency physicians are publicly displayed or
6 electronically transmitted unblinded which identify physicians by name; and
7
8 WHEREAS, Unblinded performance metric reports may lack appropriate context to clinical performance
9 without consideration for acuity, time of shift, patients received from provider handoffs, language barriers,
10 complexity, available clinical personnel, bed capacity, and other factors which confound the association of such
11 metrics with relative emergency physicians' performance; and
12
13 WHEREAS, Unnecessary dissemination of raw metrics of emergency physicians without adequate context
14 could negatively impact the collegial practice environment or future employability of an emergency physician; and
15
16 WHEREAS, Individual emergency physicians may feel shame and experience lower self-esteem as a result of
17 about poor rankings when unblinded raw metrics of emergency physicians are disseminated publicly; and
18
19 WHEREAS, Lower self-esteem and unnecessary shame may worsen burnout, depression, anxiety, and even
20 suicide; therefore be it
21
22 RESOLVED, That ACEP develop practices and policies to prevent the publishing, transmitting, and releasing
23 of unblinded metric-related information about individual emergency physician performance to safeguard the welfare
24 of our membership.

Background

This resolution calls for ACEP to develop practices and policies to prevent the publishing, transmitting, and releasing of unblinded metric-related information about individual emergency physician performance.

ACEP's policy statement "Patient Experience of Care Surveys" reviews the methodological and statistical issues with existing patient experience surveys. It states that many factors that lead to poor patient experience scores, such as wait

times and boarding, are beyond the control of the individual emergency physician. The policy specifically states that patience experience of care survey scores should not be used for credentialing, contract renewal, or incentive bonus programs and that rank ordered percentiles should be abandoned.

ACEP's policy statement "Compensation Arrangements for Emergency Physicians" recognizes that "quality emergency medical care is provided by physicians under different methods of compensation. Specific arrangements may also include performance incentives based on measures such as productivity, patient experience, and other measurable variables."

Most of these individual metrics are gathered and held at the local level. Reporting identified metrics at the local level would require local cooperation. ACEP could create additional policy and develop materials to open the discussion with the medical staff and C-Suite within an institution. Such actions may or may not be successful at the local level. ACEPs Emergency Department Accreditation Program could, in the near future, consider a standard regarding such reporting.

Reporting of this data at a regional, state, or national level would require significant state and federal advocacy. Such reporting has far more impact on non-hospital based physicians whose patients have time and options in the selection of their physician. Therefore, reporting at this level may be achieved through efforts by the AMA rather than ACEP.

CMS has worked with the RAND Corporation since 2010 on what was initially called the ED PEC survey and later called the ED CAHPS survey. Several ACEP leaders were members of the Technical Expert Panel that modified the original ED PEC survey and made it much more friendly to physicians. CMS has decided to not make the ED CAHPS survey mandatory. It should be noted that in its revised format, the survey still has 24 questions and an additional 11 demographic questions. In response to Amended Resolution 55(21) Patient Experience Scores, ACEP included specific recommendations about modifying the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) survey along with the ED CAHPS survey in response to the Calendar Year (CY) 2023 Physician Fee Schedule proposed rule. Specifically, ACEP cautioned CMS that most current vendors that would administer ED CAHPS do not survey a large enough sample size to allow for statistically valid individual physician attribution. ACEP further urged CMS that the patient engagement module ACEP offers for all participants in the Clinical Emergency Data Registry (CEDR) is superior to ED CAHPS and advocated that performance improvement cannot be accomplished without the capability to give individual clinicians feedback and resultant skills training to improve physician-patient communication.

Quality metrics are used as a means to measure "quality." While every attempt is made to make these metrics as fair as possible, often there are ways to "game" the measure. Additionally, there can be obstacles outside of the physician's control that interfere with the ability to meet a metric, such as boarding.

During the pandemic, and in the post pandemic era, with massive boarding and workplace stress, many emergency physicians have been deeply affected by low scores on patient experience surveys or quality metrics. All physicians want to do the best for their patients. Social media such as EM Docs have revealed that many physicians feel ashamed, depressed, or angry about poor scores, particularly when they are working very hard in very difficult situations.

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 professional.

Fiscal Impact

Budgeted committee and staff resources for development of a policy statement and/or other resources for physicians local to present to their administration. Efforts beyond a policy statement would require significant advocacy efforts at

a national and state level and are not included in current budgeted and prioritized work of the College. Resources would need to be reallocated from other strategic priority projects.

Prior Council Action

Amended Resolution 55(21) Patient Experience Scores adopted. Called for the College to 1) Acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy. 2) Define standardized inclusion and exclusion criteria for patient experience survey populations. 3) Define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias and appropriate power calculations so that sufficient surveys are collected to yield more statistically valid results. 4) Advocate for patient experience survey validity and work with CMS and other stakeholders to implement change to current ED practices.

Resolution 39(15) Patient Satisfaction Surveys in Emergency Medicine referred to the Board. Called for the College to acknowledge that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, many components of medical care not under physician control, and to oppose the use of patient satisfaction surveys for physician credentialing or for emergency medicine financial incentives or disincentives.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non -evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Resolution 43(13) Patient Satisfaction Scores not adopted. Called for the College to take a clear public stance to reject the continued use of non-valid patient satisfaction scoring tools in emergency medicine and that current patient satisfaction surveys should not be used to determine ED physician compensation and reimbursement. Referred to the Board of Directors.

Resolution 26(12) Patient Satisfaction Scores and Pain Management not adopted. Called for the College to work with appropriate agencies and organizations to exclude complaints from ED patients with chronic non -cancer pain from patient satisfaction surveys; to oppose new core measures that relate to chronic pain management in the ED; to continue to promote timely, effective treatment of acute pain while supporting treating physicians' rights to determine individualized care plans for patients with pain; and to bring the subject of patient satisfaction scores and pain management to the American Medical Association for national action.

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted. Directed ACEP to disseminate information to educate members about patient satisfaction surveys, including how emergency physicians armed with more knowledge can assist hospital leaders with appropriate interpretation of the scores and encourage hospital and emergency physician partnership to create an environment conducive to patient satisfaction.

Substitute Resolution 12(98) Benchmarking adopted. Directed ACEP to study and develop appropriate criteria for methodology and implementation of statistically valid patient satisfaction surveys in the ED.

Resolution 51(95) Criteria for Assessment of EPs adopted. States that ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by an individual emergency physician.

Prior Board Action

February 2023, approved the revised policy statement "Patient Experience of Care Surveys;" revised and approved June 2016 with current title; originally approved September 2010 titled "Patient Satisfaction Surveys."

Amended Resolution 55(21) Patient Experience Scores adopted.

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

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

June 2013, reviewed the information paper "Patient Satisfaction Surveys."

February 2013, approved "Crowding" policy statement. Originally approved January 2006.

June 2011, reviewed the information paper "Emergency Department Patient Satisfaction Surveys."

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted.

Substitute Resolution 12(98) Benchmarking adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted

Background Information Prepared by: Sandy Schneider, MD, FACEP
Senior Vice President, Clinical Affairs

Reviewed by: 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 51(23)

SUBMITTED BY: Ohio Chapter

SUBJECT: Quality Measures and Patient Satisfaction Scores

PURPOSE: 1) Advocate that patient experience surveys be extend to all categories of ED patients; 2) oppose reimbursement metrics or employment decisions based on patient experience surveys until they are shown to be valid and their effect on patient outcomes is known; and 3) work with stakeholders to study the relationship between MIPS quality measures and patient experience.

FISCAL IMPACT: Budgeted committee and staff resources for updating the current policy statement. Unbudgeted staff resources for federal advocacy. Unbudgeted expenses of potentially $150,000 – $250,000 for ACEP to fund research on association of MIPS Quality Measures, Patient Satisfaction, and outcomes.

1 WHEREAS, Emergency physicians are often assessed by their hospital and healthcare system by their patient
2 satisfaction scores; and
3
4 WHEREAS, There is limited objective data linking patient satisfaction to quality patient care; and
5
6 WHEREAS, Compensation tied to patient satisfaction alone can lead to increased job dissatisfaction and burn
7 out, negatively impacting both physicians and patients; and
8
9 WHEREAS, Current measures for patient satisfaction surveying of Emergency Department patients fall short
10 of recommendations put forth in ACEP's current Policy Statement "Patient Experience of Care Surveys;" and
11
12 WHEREAS, Quality measures and databases such as CEDR, E-QUAL initiatives, MIPS, etc are based on
13 empiric data proven to improve patient outcomes; and
14
15 WHEREAS, Reimbursement is increasingly tied to patient outcomes; and
16
17 WHEREAS, The current CMS Merit-based Incentive Payment System (MIPS) program has been established
18 with potential negative payment adjustments in future years for emergency medicine physicians; and
19
20 WHEREAS, MIPS is largely based upon care delivered to patients who would be discharged safely from the
21 Emergency Department; and
22
23 WHEREAS, MIPS criteria involve areas where there frequently exist patient expectations about care that
24 would be received prior to arrival in the Emergency Department; therefore be it
25
26 RESOLVED, That ACEP advocate for alignment with current policy and previous recommendations that
27 patient satisfaction surveys be extended to all categories of emergency department patients for true validity; and be it
28 further
29
30 RESOLVED, That ACEP oppose reimbursement metrics and employment decisions correlated with or
31 dependent on patient satisfaction surveys until external validity can be established and their effect on patient outcomes
32 is known; and be it further

33 RESOLVED, That ACEP work with appropriate stakeholders to study the correlation (or lack of) between
34 following Merit-based Incentive Payment System (MIPS) quality measures and patient satisfaction.

Background

This resolution calls for ACEP to advocate that patient experience survey be extended for all categories of ED patients and not just discharged patient and oppose reimbursement metrics or employment decision based on patient experience survey until they are shown to be valid and lead to improved outcomes like other quality metrics. ACEP is further directed to work with stakeholders to study the relationship between MIPS quality measures and patient experience.

ACEP's policy statement "Patient Experience of Care Surveys" states:

> "The American College of Emergency Physicians (ACEP) recognizes that patient experience of care surveys that are methodologically and statistically sound can be reflective of the patient's perception of their health care experience, and that patient outcomes can be related to perceived patient experience of care."
>
> "ACEP holds that patient experience of care survey tools should be:
> - Administered to all categories of ED patients regardless of location seen or admission/discharge/ observation/transfer status to create a broad representation of patient experiences without marginalizing certain populations."
>
> "Due to the difficulty in refining whether patient experience of care scores are the result of physician performance or due to demands and restrictions on the current health care system, implicit bias, or other factors out of the control of the physician, patient experience of care metrics should not be used in isolation for purposes such as credentialing, contract renewal, or incentive bonus programs."

The policy statement would need to be updated to reflect the intent of the resolution.

In the past, and with input from ACEP members, CMS worked with the RAND Corporation on the Emergency Department Patient Experience of Care (EDPEC) survey, now renamed the Emergency Department Consumer Assessment of Healthcare Providers & Systems (ED CAHPS) survey. The program was introduced by CMS in the mid-2000s as part of the overall shift of healthcare from a fee-for-service to a pay-for-performance model. The program was designed to assess the experiences of adult ED patients who were subsequently discharged home. Importantly, acutely ill or injured patients who are admitted to the hospital are typically excluded. ACEP members were appointed to the Technical Expert Panel that modified the original ED PEC survey, making it more physician friendly. Even in its revised format, it was 24 questions long with an additional 11 demographic questions. CMS decided to not make the ED CAHPS survey mandatory. The current ACEP policy defines standardized inclusion and exclusion criteria for the patient populations and define improved methodologies.

In response to Amended Resolution 55(21) Patient Experience Scores, ACEP included specific recommendations about modifying the Consumer Assessment of Healthcare Providers & Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) survey along with the ED CAHPS survey in response to the Calendar Year (CY) 2023 Physician Fee Schedule proposed rule. Specifically, ACEP cautioned CMS that most current vendors that would administer ED CAHPS do not survey a large enough sample size to allow for statistically valid individual physician attribution. We further urged CMS that we believe the patient engagement module ACEP offers for all participants of our qualified clinical data registry (QCDR), the Clinical Emergency Data Registry (CEDR) is superior to ED CAHPS and advocated that we believe strongly that performance improvement cannot be accomplished without the capability to give individual clinicians feedback and resultant skills training to improve physician-patient communication.

Hospitals and survey vendors may sample or receive responses from a small percentage of the patients seen in the emergency department (ED) potentially leading to results with poor validity. Currently, CMS states the minimum number is 30, and recommend 50, however that standard is not applied uniformly by physician groups and hospitals when they act on these scores. Press Ganey reports a response rate of 16.5%.

It should be noted that the use of patient experience scores during the pandemic had greater detrimental effect. It is widely known that boarding and crowding affect patient experience scores, particularly when they include the question “did you receive timely care.”[1]

A 2013 JAMA study comparing CAHPS data and mortality, found that higher patient satisfaction was associated with lower emergency department utilization, higher inpatient utilization, greater total health care expenditures, and higher expenditures on prescription drugs. The most satisfied patients also had statistically significantly greater mortality risk compared with the least satisfied patients.[2]

Background References

[1]Pines JM, Iyer S, Disbot M, Hollander JE, Shofer FS, Datner EM. The effect of emergency department crowding on patient satisfaction for admitted patients. Acad Emerg Med. 2008 Sep;15(9):825-31.
[2]Fenton JJ, Jerant AF, Bertakis KD, Franks P. The Cost of Satisfaction: A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality. *Arch Intern Med.* 2012;172(5):405–411. doi:10.1001/archinternmed.2011.1662

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 professional.

Fiscal Impact

Budgeted committee and staff resources for updating the current policy statement. Unbudgeted staff resources for federal advocacy. Unbudgeted expenses of potentially $150,000 – $250,000 for ACEP to fund research on association of MIPS Quality Measures, Patient Satisfaction, and outcomes.

Prior Council Action

Amended Resolution 55(21) Patient Experience Scores adopted. Directed ACEP to acknowledge and affirm that some patient satisfaction instruments are in clear violation of existing ACEP policy. Define standardized inclusion and exclusion criteria for patient experience survey populations. Define improved methodologies for patient experience surveys, including wording to reduce or eliminate bias and appropriate power calculations so that sufficient surveys are collected to yield more statistically valid results. Advocate for patient experience survey validity and work with CMS and other stakeholders to implement change to current ED practices.

Resolution 39(15) Patient Satisfaction Surveys in Emergency Medicine referred to the Board. Called for the College to acknowledge that higher patient satisfaction scores are associated with many indicators of poor quality of medical care, many factors unrelated to medical care, many components of medical care not under physician control, and to oppose the use of patient satisfaction surveys for physician credentialing or for emergency medicine financial incentives or disincentives.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted. Directed ACEP to oppose any non -evidence based financial incentives for patient satisfaction scores; work with stakeholders to create a quality measure related to safe prescribing of controlled substances; and that the AMA Section Council on Emergency Medicine support and advocate our position to the AMA regarding patient satisfaction scores and safe prescribing.

Resolution 43(13) Patient Satisfaction Scores not adopted. Called for the College to take a clear public stance to reject the continued use of non-valid patient satisfaction scoring tools in emergency medicine and that current patient satisfaction surveys should not be used to determine ED physician compensation and reimbursement. Referred to the Board of Directors.

Resolution 26(12) Patient Satisfaction Scores and Pain Management not adopted. Called for the College to work with appropriate agencies and organizations to exclude complaints from ED patients with chronic non -cancer pain from patient satisfaction surveys; to oppose new core measures that relate to chronic pain management in the ED; to continue to promote timely, effective treatment of acute pain while supporting treating physicians' rights to determine individualized care plans for patients with pain; and to bring the subject of patient satisfaction scores and pain management to the American Medical Association for national action.

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted. Directed ACEP to disseminate information to educate members about patient satisfaction surveys, including how emergency physicians armed with more knowledge can assist hospital leaders with appropriate interpretation of the scores and encourage hospital and emergency physician partnership to create an environment conducive to patient satisfaction.

Substitute Resolution 12(98) Benchmarking adopted. Directed ACEP to study and develop appropriate criteria for methodology and implementation of statistically valid patient satisfaction surveys in the ED.

Resolution 51(95) Criteria for Assessment of EPs adopted. States that ACEP believes that multiple criteria can be used to assess the professional competency and quality of care provided by an individual emergency physician.

Prior Board Action

February 2023, approved the revised policy statement "Patient Experience of Care Surveys;" revised and approved June 2016; originally approved September 2010 titled "Patient Satisfaction Surveys."

Amended Resolution 55(2) Patient Experience Scores adopted.

Amended Resolution 38(15) Patient Satisfaction Scores and Safe Prescribing adopted.

June 2013, reviewed the information paper "Patient Satisfaction Surveys."

June 2011, reviewed the information paper "Emergency Department Patient Satisfaction Surveys."

Substitute Resolution 22(09) Patient Satisfaction Surveys adopted.

Substitute Resolution 12(98) Benchmarking adopted.

Resolution 51(95) Criteria for Assessment of EPs adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
Senior Director, Workforce & 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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RESOLUTION: 52(23)

SUBMITTED BY: New York Chapter

SUBJECT: Summit and New Tools for Transforming Acute Care

PURPOSE: Convene a task force to focus on developing new strategies, quality care, and performance metrics for creating new alternative care models and provide a report to the 2024 Council meeting with a strategy for expanding and transforming acute care delivery in the community setting.

FISCAL IMPACT: This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources for federal and state advocacy initiatives to support these efforts, potentially additional unbudgeted and unknown costs for consultant resources, unbudgeted staff resources for supporting a task force, and unbudgeted funds of a minimum of $10,000 (depending on the size of the task force) for convening an in-person task force meeting.

1 WHEREAS, The U.S. Centers for Medicare and Medicaid Services (CMS) has lifted restrictions on the
2 originating site of care, approving new services since the onset of COVID-19; and
3
4 WHEREAS, ACEP members create diversified health systems that often entail advanced care models; and
5
6 WHEREAS, ACEP hopes to contribute to novel acute care delivery methods given some studies show
7 patients value acute services even outside of the emergency department; and
8
9 WHEREAS, Key stakeholders including payors, health systems, and medical organizations in emergency
10 medicine must network, build the professional reputation and present the latest advancements involving acute,
11 unscheduled alternative care models; and
12
13 WHEREAS, Value-Based Care – a critical health care delivery and payment approach for emergency
14 medicine – will depend upon prioritizing and building models that achieve true cost savings and improve clinical care
15 quality; therefore be it
16
17 RESOLVED, That ACEP convene a task force focused on crafting new strategies, quality care, and
18 performance metrics for creating new alternative care models; and be it further
19
20 RESOLVED, That ACEP report back to the 2024 Council meeting with a strategy for expanding and
21 transforming acute care delivery in the community setting.

Background

This resolution requests ACEP to convene a task force to focus on developing new strategies, quality care, and performance metrics for creating new alternative care models and provide a report to the 2024 Council meeting with a strategy for expanding and transforming acute care delivery in the community setting. The resolution follows the trend to shift from traditional fee-for-service reimbursement to innovative, value-based care payment models facilitated by the Medicare Access and CHIP Reauthorization Act (MACRA), which made sweeping changes to Medicare reimbursement, creating opportunities to create new alternative care models.

An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. The APM landscape consists of a continuum of risk-assuming models based on quality

and value. Currently, individual emergency physicians and emergency medicine groups do not have any opportunities to directly participate in APMs. To fill the gap in available APMs for emergency physicians, ACEP first convened an APM Task Force in 2015 that considered several options for constructing an emergency medicine-focused APM. The task force considered several models and ultimately developed the Acute Unscheduled Care Model (AUCM)..

The goal of the AUCM is to provide a voluntary alternative to the traditional fee-for-service payments for Medicare patients who receive emergency care. It is structured as a bundled payment model, focusing on specific "episodes" of unscheduled acute care. Under a bundled payment approach, if the cost of an episode of care is less than a pre-determined price for that episode, then a participating provider or group can keep that difference. However, if the cost winds up being more than the pre-determined price, participants would be responsible for those losses and owe Medicare the difference.

A deliverable from the AUCM work is to improve the ability of emergency physicians to reduce inpatient admissions and observation stays when appropriate through enhanced care coordination. Emergency physicians would become key members of the continuum of care as the model focuses on ensuring follow-up care for emergency patients, minimizing redundant post-emergency department (ED) services, and avoiding post-ED discharge safety events that lead to follow-up ED visits or inpatient admissions.

The AUCM has not been fully implemented. ACEP submitted its AUCM proposal to a federal government advisory committee called the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in 2017. The AUCM model was ultimately recommended by the PTAC to the HHS Secretary for full implementation in late 2018, including in its official report a designation of "Deserves Priority Consideration," as the PTAC believed the model filled an enormous gap in terms of available APMs to emergency physicians and groups. The HHS Secretary formally responded to the PTAC's recommendation in September 2019, noting he believes that core concepts of the AUCM should be incorporated into other APMs that the Center for Medicare & Medicaid Innovation Center (CMMI) is developing. Highlights of the response can be found here.

Within HHS, the Centers for Medicare & Medicaid Services (CMS)' Center for Medicare & Medicaid Innovation Center (CMMI) is primarily responsible for testing APMs. Despite many attempts to work with CMMI on model implementation, CMMI has yet to implement the model in any meaningful way.

Since CMMI has not incorporated the AUCM into the Medicare APMs it is developing, ACEP started an initiative in 2020 to promote participation in emergency medicine-focused APMs being offered by other payors like Medicaid and private insurers. Through this initiative, ACEP created background materials about the AUCM and toolkits to help emergency physicians participate in APMs.

The Alternative Payment Models Task Force centered around developments of alternative care models that culminated exclusively in the creation of the AUCM. The task force was appointed following adoption of Substitute Resolution 31(14) Financing Health Insurance and the task force continued its work through 2017.

ACEP Strategic Plan Reference

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care.

Fiscal Impact

This is not a current initiative of the College and is unbudgeted. It would require diverting current budgeted staff resources for federal and state advocacy initiatives to support these efforts, potentially additional unbudgeted and unknown costs for consultant resources, unbudgeted staff resources for supporting a task force, and unbudgeted funds of a minimum of $10,000 (depending on the size of the task force) for convening an in-person task force meeting.

Prior Council Action

Amended Resolution 19(16) Health Care Financing Task Force adopted. Directed ACEP to study alternative health care financing models, including single-payer, that foster competition and preserve patient choice and that the task

force report to the 2017 ACEP Council regarding its investigation.

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

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

Substitute Resolution 21(10) Medicare-for-All Health Insurance referred to the Board. The resolution directed the Board to appoint a task force to investigate alternative models of health care financing.

Prior Board Action

September 2018, reviewed the Health Care Financing Task Force report and approved distributing it to the 2018 Council. .

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

October 2016, the Board reviewed a status report of the Alternate Payment Models task force created by Resolution 31(14).

Substitute Resolution 31(14) Financing Health Insurance adopted.

October 2009, reviewed the Value Based Emergency Care Task Force report.

Background Information Prepared by: Erin Grossmann
Regulatory & External Affairs 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 53(23)

SUBMITTED BY: Andrew Fenton, MD, FACEP
Roneet Lev, MD, FACEP
Aimee Moulin, MD, FACEP
California Chapter

SUBJECT: Treating Physician Determines Patient Stability

PURPOSE: Create a policy that the treating emergency physician at the patient's bedside is best qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient; and amend ACEP's "Code of Ethics for Emergency Physicians" policy statement such that it is unethical for an emergency physician, who has not personally evaluated the patient, to coerce or threaten financial penalties to the treating emergency physician.

FISCAL IMPACT: Budgeted committee and staff resources for development of a policy statement and revising the "Code of Ethics for Emergency Physicians" policy statement.

1 WHEREAS, Emergency department (ED) patients are often transferred between EDs for either higher level of
2 care, or to a similar level of care (lateral transfer) at the request of the patient's insurance carrier; and
3
4 WHEREAS, Lateral transfer requests by insurance carriers are becoming more common and will increase
5 nationwide with the expansion of Accountable Care Organizations/Health Maintenance Organizations who care for
6 capitated patients; and
7
8 WHEREAS, A key piece of the decision to transfer a patient is the bedside emergency physician's assessment
9 of the patient's clinical needs and stability for transfer, which often includes a complex clinical and logistical
10 decision-making of the risks and benefits to the patient; and
11
12 WHEREAS, EMTALA law states that a patient with an emergency medical condition who is unstable cannot
13 be transferred without a physician certification that benefits outweigh the risk of transfer; and
14
15 WHEREAS, There may be a difference of opinion on whether a patient is stable for transfer between the
16 treating emergency physician at the bedside and a physician limited to evaluating the patient's stability without
17 personal evaluation; and
18
19 WHEREAS, The treating emergency physician at the bedside is the physician who is best qualified, and who
20 is legally liable, to determine a patient's stability; and
21
22 WHEREAS, Physicians acting as representatives of insurance carriers who overrule the treating emergency
23 physician's determination of stability may threaten patient safety; and
24
25 WHEREAS, ACEP policy statement "EMTALA and On-call Responsibility for Emergency Department
26 Patients" states: "Physician services (including medically necessary post-stabilization care), when provided in
27 response to the request for emergency care, should be recognized as emergency services for reimbursement purposes
28 and should be compensated in a fair and equitable manner."; and
29
30 WHEREAS, There have been occurrences of financial coercion to transfer a patient that a treating emergency
31 physician deems to be unstable, such as refusing to reimburse physician services or to hold a patient financially
32 responsible; therefore be it

33 RESOLVED, That ACEP enact policy that the treating emergency physician at the patient's bedside is best
34 qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a
35 non-physician practitioner who has not personally evaluated the patient; and be it further
36
37 RESOLVED, That ACEP amend its "Code of Ethics for Emergency Physicians" policy statement to state that
38 it is unethical for an emergency physician, who has not personally evaluated the patient, to coerce a treating
39 emergency physician, to transfer a patient when the treating physician believes the patient is unstable for transfer and
40 that a transfer may compromise a patient's safety; and be it further
41
42 RESOLVED, That ACEP amend its "Code of Ethics for Emergency Physicians" policy statement to state that
43 it is unethical for an emergency physician, who has not personally evaluated the patient, to threaten a financial penalty
44 for further treating the patient claiming treatment constitutes "post-stabilization care" when the treating emergency
45 physician believes a transfer or discontinuation of care may compromise a patient's safety.

Background

This resolution call upon ACEP to create a policy that the treating emergency physician at the patient's bedside is best qualified to determine a patient's stability for transfer and their decision should not be overruled by a physician or a non-physician practitioner who has not personally evaluated the patient. It further requires that ACEP amend its Code of Ethics such that it is unethical for an emergency physician, who has not personally evaluated the patient, to coerce or threaten financial penalties to the treating emergency physician regarding the transfer of patients.

Emergency patients who present to hospitals may not be covered by in-network insurance. When the treating physician calls for authorization to admit the patient, they may experience pressures to transfer the patient to in-network hospitals that could be in the form of perceived, implied, or actual administrative, financial or other penalties.

Section II.D.3.b. (page 12) of the "Code of Ethics for Emergency Physicians" entitled "Adequate in-hospital and outpatient resources must be available to protect emergency patient interests" states the following:

> "Patients requiring hospitalization for further care should not be denied access to an appropriate medical facility on the basis of financial considerations. Transfer to an appropriate accepting medical facility for financial reasons may be effected if a) the patient provides consent and b) there is no undue risk to the patient. Admission or transfer decisions should be made on the basis of a patient's best interest.
>
> It is unethical for an emergency physician to participate in the transfer of an emergency patient to another medical facility unless the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the risks of the transfer or unless a competent patient, or a legally responsible person acting on the patient's behalf, gives informed consent for the transfer. Emergency physicians should be knowledgeable about applicable federal and state laws regarding the transfer of patients between health care facilities.
>
> Although the care and disposition of the patient are primarily the responsibility of the emergency physician, on-call consultants should share equitably in the care of indigent patients. This may include an on-site evaluation by the consultant if requested by the emergency physician.
>
> For patients who do not require immediate hospitalization but need medical follow-up, adequate outpatient medical resources should be available both to continue proper treatment of the patient's medical condition and to prevent the development of subsequent foreseeable emergencies resulting from the original medical problem."

ACEP's policy statements are reviewed on a 5-year cycle as part of the policy sunset review process. The "Code of Ethics for Emergency Physicians" is currently being reviewed by the Ethics Committee for potential revisions.

In 1986, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) (42 U.S.C. §1395dd) to ensure public access to emergency services regardless of insurance status or ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

EMTALA governs how unstable patients are transferred from one hospital to another. Under the law, a patient is considered stable for transfer if the treating physician determines that no material deterioration is reasonably likely to occur during or as a result of the transfer between facilities. EMTALA does not apply to the transfer of stable patients; however, if the patient is unstable, then the hospital may not transfer the patient unless: A physician certifies the medical benefits expected from the transfer outweigh the risks OR a patient makes a transfer request in writing after being informed of the hospital's obligations under EMTALA and the risks of transfer.

In addition, the transfer of unstable patients must be "appropriate" under the law, such that: 1) the transferring hospital must provide ongoing care within it capability until transfer to minimize transfer risks; 2) provide copies of medical records; 3) must confirm that the receiving facility has space and qualified personnel to treat the condition and has agreed to accept the transfer; and 4) the transfer must be made with qualified personnel and appropriate medical equipment.

As noted in the resolution, ACEP's policy statement "EMTALA and On-call Responsibility for Emergency Department Patients" states:

> "Physician services (including medically necessary post-stabilization care), when provided in response to the request for emergency care, should be recognized as emergency services for reimbursement purposes and should be compensated in a fair and equitable manner."

Further, ACEP's policy statement on "Appropriate Interfacility Patient Transfer" addresses some of the issues raised in the first resolved, specifically who is qualified to qualified to determine a patient's stability for transfer, although it does not address such decisions being overruled by a physician or a non-physician practitioner who has not personally evaluated the patient. The policy states:

> "The medical facility's policies and procedures and/or medical staff bylaws should identify the individuals responsible for and qualified to perform MSEs. The policies and procedures or bylaws must define who is responsible for accepting and transferring patients on behalf of the hospital. The examining physician at the transferring hospital should use his or her best judgment regarding the condition of the patient when determining the timing of transfer, mode of transportation, level of care provided during transfer, and the destination of the patient."

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 for development of a policy statement and amending the "Code of Ethics for Emergency Physicians" policy statement.

Prior Council Action

Amended Resolution 23(11) EMTALA adopted. Directed ACEP to submit recommendations to CMS regarding uniform interpretation and fair application of EMTALA; work with CMS to institute confidential, peer-reviewed process for complaints; work with CMS and others to require that complaints be investigated consistently according to

ACEP-developed standards and investigators required to adhere to principles of due process and fairness during investigations; and provide a report to the 2012 Council on this issue.

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

Amended Substitute Resolution 15(00) EMTALA adopted. Directed ACEP to work with appropriate organizations and agencies to improve EMTALA and for the Board to provide a report to members in 2001.

Prior Board Action

June 2023, reviewed draft revisions to the "Code of Ethics for Emergency Physicians" policy statement and referred the policy back to the Ethics Committee for further work.

January 2022, approved the revised policy statement "Appropriate Interfacility Patient Transfer;" revised and approved January 2016 with the current title; revised and approved February 2009, February 2002, and June 1997; revised and approved September 1992 titled " Appropriate Inter-Hospital Patient Transfer;" originally approved September 1989 titled " Principles of Appropriate Patient Transfer."

January 2019, approved the revised policy statement "EMTALA and On-call Responsibility for Emergency Department Patients;" revised and approved June 2013, April 2006 replacing "Hospital, Medical Staff, and Payer Responsibility for Emergency Department Patients" (1999), "Medical Staff Responsibility for Emergency Department Patients" (1997), and "Medical Staff Call Schedule" (1987).

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

Amended Resolution 23(11) EMTALA adopted.

Amended Substitute Resolution 30(01) Inconsistent EMTALA Enforcement adopted.

Amended Substitute Resolution 15(00) EMTALA adopted.

Background Information Prepared by: Jonathan Fisher MD, MPH, FACEP
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Leslie P. 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 54(23)

SUBMITTED BY: Michigan College of Emergency Physicians

SUBJECT: Opposition to The Joint Commission Credentialing Requirements for Individual Emergency Conditions

PURPOSE: Discuss with TJC ACEP's opposition to credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

FISCAL IMPACT: Budgeted staff resources for ongoing communications with TJC. Potential unbudgeted travel costs of $3,200 for an in-person meeting with The Joint Commission.

1 WHEREAS, Emergency medicine is a broad-based specialty involving the diagnosis and treatment of
2 emergency conditions; and
3
4 WHEREAS, Board certification in emergency medicine verifies proficiency in the diagnosis and treatment of
5 emergency conditions; and
6
7 WHEREAS, Residency training in emergency medicine includes training and education in the diagnosis and
8 treatment of emergency conditions; and
9
10 WHEREAS, ACEP maintains that physician board certification in emergency medicine encompasses the
11 knowledge requirements for physician credentialing; and
12
13 WHEREAS, ACEP opposes "medical merit badges" for credentialing requirements; and
14
15 WHEREAS, ACEP has guidelines regarding credentialing and delineation of clinical privileges in emergency
16 medicine ("Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" and "Guidelines
17 for Credentialing and Delineation of Clinical Privileges in Emergency Medicine" Policy Resource and Education
18 Paper); and
19
20 WHEREAS, The Joint Commission creates policies requiring credentialing committees to include language
21 regarding the diagnosis and treatment of individual emergency conditions, such as ischemic stroke, in delineation of
22 clinical privileges; and
23
24 WHEREAS, The Joint Commission may, by such precedent, proceed to require delineation of clinical
25 privileges language for numerous other specific emergency conditions; and
26
27 WHEREAS, Hospitals are required to include this language in order to maintain Joint Commission
28 certification; and
29
30 WHEREAS, The imposition of a requirement of any credentialing or certification process imposed by the
31 Joint Commission represents a threat to the independent practice of Emergency Medicine, recognized board-
32 certification processes, and is a violation of ACEP guidelines; therefore be it
33
34 RESOLVED, That ACEP engage with The Joint Commission to oppose credentialing policies that require
35 new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency
36 conditions.

Background

This resolution calls for ACEP to engage with The Joint Commission to oppose credentialing policies that require new language or changes to delineation of clinical privileges for the diagnosis and treatment of individual emergency conditions.

The Joint Commission does not set specialty specific requirements for physician credentialing. The Joint Commission holds hospitals and medical staff credentialing boards to the specifications delineated in facility policies and/or facility delineated standards. ACEP has engaged in many efforts to educate hospitals and medical staff credentialing entities on the training, core competencies and scope of care that is encompassed in accredited emergency medicine residency training and validated via subsequent board certification by the American Boards of Emergency Medicine (ABEM), Osteopathic Emergency Medicine (AOBEM), or Pediatrics (ABP) and ABEM partner boards for dual/subspecialties.

Emergency physicians are trained in a broad range of acute medical conditions during residency and must complete an intensive written and oral examination demonstrating mastery of the skills necessary to diagnose and treat these conditions. To maintain certification, emergency physicians must complete their Maintenance of Certification which tests these skills on an ongoing basis.

ACEP has a number of existing policies regarding required CME and short courses. The policy statement "CME Burden" discusses the increasing burden of required courses. The policy states

> "The American College of Emergency Physicians (ACEP) believes that continuous board certification by the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, skills, and current understanding in the practice of emergency medicine regardless of any additional CME mandated or obtained."

ACEP's policy statement "Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment" states:

> "The American College of Emergency Physicians (ACEP) believes that board certification by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, knowledge, and skill in the practice of emergency medicine." It goes on to say that ACEP strongly opposes required completion of courses such as "Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), and Basic Trauma Life Support (BTLS), or a specified number of CME hours in a sub-area of emergency medicine, as conditions for privileges, renewal of privileges, employment, qualification by hospitals, government agencies, or any other credentialing organization's standards to provide care for designated disease entities."

ACEP's policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine" states:

> "ACEP believes that the ED medical director* should be responsible for assessing and making recommendations to the hospital's credentialing body related to the qualifications of providers of emergency care with respect to the clinical privileges granted to them. At a minimum, those applying for privileges as emergency physicians should be eligible for ACEP membership. Board certification by ABEM or AOBEM, or pediatric emergency medicine subspecialty certification by the American Board of Pediatrics is an excellent, but not the sole benchmark for decisions regarding an individual's ability to practice emergency medicine. Especially in rural areas, physicians who trained in other specialties may provide emergency care and be granted privileges by an objective measurement of care provided, sufficient experience, prior training, and evidence of continuing medical education."
>
> "*ED medical director refers to the chair, medical director, or their designee."

ACEP provides a set of personalized cards that attest that they are currently board certified by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (ABOEM) and have expertise in procedural sedation, cardiac resuscitation, and trauma. ABEM also offers a personalized letter attesting to these same areas of expertise.

ACEP also is a CME partner for an ABEM MyEMCert module on resuscitation, for which physicians receive a certificate of completion.

ACEP is heavily involved with other emergency medicine organizations opposing such requirements, particularly when the material is already part of emergency medicine certification/maintenance of certification. In early the Coalition Opposing Medical Merit Badges (COMMB, now called COBCEP – the Coalition of Board Certified Emergency Physicians) was formed with the following members: American Academy of Emergency Medicine (AAEM), AAEM/RSA, ABEM, ACEP, Association of Academic Chairs in Emergency Medicine (AACEM), Council of Residency Directors in Emergency Medicine (CORD), Emergency Medicine Residents' Association (EMRA), and the Society for Academic Emergency Medicine (SAEM). SAEM/RAMS has subsequently joined the coalition. The purpose of the coalition states:

> "Board-certified emergency physicians who actively maintain their board certification should not be required to complete short-course certification in advanced resuscitation, trauma care, stroke care, cardiovascular care, or pediatric care in order to obtain or maintain medical staff privileges to work in an emergency department. Similarly, mandatory targeted continuing medical education (CME) requirements do not offer any meaningful value for the public or for the emergency physician who has achieved and maintained board certification. Such requirements are often promulgated by others who incompletely understand the foundation of knowledge and skills acquired by successfully completing an Accreditation Council for Graduate Medical Education–accredited Emergency Medicine residency program. These "merit badges" add no additional value for board-certified emergency physicians. Instead, they devalue the board certification process, failing to recognize the rigor of the ABEM Maintenance of Certification (MOC) Program. In essence, medical merit badges set a lower bar than a diplomate's education, training, and ongoing learning, as measured by initial board certification and maintenance of certification. **The Coalition finds no rational justification to require medical merit badges for board-certified emergency physicians who maintain their board certification.** Our committed professional organizations provide the best opportunities for continuous professional development and medical merit badges dismiss the quality of those educational efforts."

The coalition has met at least quarterly since 2017. Through the years the group has created the aforementioned letter from ABEM and cards from ACEP and AAEM, worked to clarify the requirements of The Joint Commission (TJC), worked with the American College of Surgeons Committee on Trauma (ACS-COT) which ultimately removed the requirement for Advanced Trauma Life Support (ATLS) for ABEM/AOBEM certified emergency physicians, worked with the VA hospital and American Society of Anesthesiology on a procedural sedation policy, clarification of the Pediatric Emergency Care Coordinator as part of the Pediatric Readiness Project, sent multiple letters and personal contacts regarding the NY State requirement for Pediatric Advanced Life Support/Advanced Pediatric Life Support (PALS/APLS), created a letter regarding a waiver of required CLIA competency assessments for point of care testing, and opposed Pennsylvania Department of Health requirement for Basic Cardiac Life Support (BCLS) training. In 2019, COMMB changed its name to the Coalition of Board Certified Emergency Physicians (COBCEP) and they continue to work on the military requirement for Basic Life Support (BLS) and requirements for BLS, ACLS, and PALS for emergency physicians who practice in Puerto Rico. The group is currently working on the impact of state required physician education. After ACEP assisted with pilot testing through the Emergency Medicine Practice Research Network, ABEM sent a survey to their diplomates regarding the types of courses required, the estimated time to complete these requirements, the estimated cost of meeting these requirements, and the usefulness of the material required. Several thousand individuals completed the survey and the results are currently being analyzed.

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 professional.

Fiscal Impact

Budgeted staff resources for ongoing communications with TJC. Potential unbudgeted travel costs of $3,200 for an in-person meeting with The Joint Commission.

Prior Council Action

Amended Resolution 43(15) Required CME Burden adopted. Called for the College to address annual requirements for CME in specific areas that could lead to reduced ongoing education in other clinical area and work with other organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to care for all ED patients.

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

Resolution 21(09) Opposition to Credentialing, Certification, or "Signing-Off" Processes by Other Specialties adopted. Directed ACEP to establish College liaisons and relationships with other medical specialty societies, the American Medical Association, the Alliance for Specialty Medicine, the Coalition for Patient -Centric Imaging, and other interested parties actively and fully opposes the imposition upon the specialty of Emergency Medicine of a requirement of any credentialing, certification, or "signing -off' process by other specialties for any core skill within the scope of practice of emergency medicine.

Resolution 51(05) Emergency Physician Autonomy in the Performance and Interpretation of Diagnostic Imaging Studies adopted. Called for the College to work with the house of medicine and other certification and standard setting bodies to reaffirm and promote appropriate training and educations standards for all physicians who perform and interpret diagnostic imaging and to oppose any MedPac recommendation that would limit any physician other than a radiologist to provide diagnostic imaging.

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

Amended Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted. This resolution called for the College to open dialogue with the American Hospital Association, third party payers, and accreditation entities regarding the inappropriate use of ACLS and similar courses for credentialing of board-certified emergency physicians.

Amended Resolution 14(98) Merit Badge Medicine referred to the Board. This resolution called for the College policy on "Merit Badge Medicine" to read as follows: The ACEP believes that certification of knowledge and skills in emergency medicine can result only from successful completion of examinations administered by a recognized board in emergency medicine. The successful completion of any course, or series of courses, or a specified number of CME hours in a sub-area of emergency medicine, may serve as evidence of knowledge and skill of a certain sub-area of medicine. However, the completion of such does not serve as an acceptable substitute for certification of knowledge

and skills to practice emergency medicine. Therefore, ACEP opposes the use of certificates of completion of courses such as ATLS, ACLS, PALS, BTLS or a specified number of CME hours in a sub-area of emergency medicine as requirements for credentialing or employment of any physician certified in emergency medicine by the ABEM or the AOBEM.

Substitute Resolution 9(91) Merit Badge Medicine adopted. The resolution called for the College to request ABEM provide a statement that board certification supersedes successful completion of courses taught in ACLS, ATLS, APLS, etc., and that ACEP disseminate its current policy on "Merit Badge Medicine" with recommendations on methods for their use by membership.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted. This resolution called for the College to develop appropriate language that can be incorporated into legislation and regulations that would reflect the College's position opposing the use of certificates of completion of short courses in special areas relating to emergency medicine as criteria for employment, staff appointment, licensure, or facility designations when such physicians are board certified in emergency medicine.

Prior Board Action

July 2022, approved the revised policy statement, "2022 Model of the Clinical Practice of Emergency Medicine." Joint policy with American Academy of Emergency Medicine (AAEM), American Board of Emergency Medicine (ABEM), Council of Emergency Medicine Residency Directors (CORD), Emergency Medicine Residents' Association (EMRA), Residency Review Committee for Emergency Medicine (RRC-EM), Society for Academic Emergency Medicine (SAEM).

January 2022, approved the revised policy statement, "Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment" revised and approved January 2016 and April 2012; reaffirmed September 2005; Revised in June 1999, June 1997, August 1992; originally approved January 1984 titled "Certification in Emergency Medicine.

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

August 2017, reviewed the Policy Resource & Education Paper (PREP) "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" originally reviewed June 2006. This PREP is an adjunct to the policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine

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

Amended Resolution 43(15) Required CME Burden adopted.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted.

Resolution 21(09) Opposition to Credentialing, Certification, or "Signing -Off' Processes by Other Specialties adopted.

Resolution 51(05) Emergency Physician Autonomy in the Performance and Interpretation of Diagnostic Imaging Studies adopted.

Amended Resolution 15(03) Granting Clinical Privileges adopted.

Amended Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted.

Substitute Resolution 9(91) Merit Badge Medicine adopted.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted.

Background Information Prepared by: Sandy 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 55(23)

SUBMITTED BY: American Association of Women Emergency Physicians Section
Government Services Chapter

SUBJECT: Uncompensated Required Training

PURPOSE: Convene a working group to evaluate supporting fair compensation for required training, including accurate estimates of the time to completion, time to completion is fairly compensated, and in employed physician compensation models, the appropriate time is protected to allow for training without requiring completion during off hours; and explore opportunities to partner with other like-minded organizations to reduce unnecessary or redundant annual or onboarding training for physician employment.

FISCAL IMPACT: Unbudgeted staff resources and unbudgeted funds of approximately $10,000 for an in-person task force meeting for 10 people and approximately $20,000 to conduct a survey.

1 WHEREAS, There is an increasing amount of pre-employment and annual training required of board-certified
2 emergency physicians by various hospitals, organizations, and entities; and
3
4 WHEREAS, Many emergency physicians are independent contractors and compensated on an hourly basis;
5 and
6
7 WHEREAS, Most emergency physicians are required to complete institution-specific training required for
8 employment or other privileges; and
9
10 WHEREAS, Employed emergency physicians frequently are uncompensated for time completing such
11 training; and
12
13 WHEREAS, Training required by institutions is often reported to be redundant and less rigorous than required
14 continued medical education for medical licensure, board certification, maintenance of certification, and examinations
15 for emergency physicians; therefore be it
16
17 RESOLVED, That ACEP convene a working group to evaluate supporting fair compensation for required
18 training, including accurate estimates of the time to completion, time to completion is fairly compensated, and in
19 employed physician compensation models, the appropriate time is protected to allow for training without requiring
20 completion during off hours; and be it further
21
22 RESOLVED, That ACEP explore opportunities to partner with other like-minded organizations to reduce
23 unnecessary or redundant annual or onboarding training for physician employment.

Background

This resolution calls for ACEP to convene a working group to evaluate fair compensation for required training, including accurate estimates of the time to completion, time to completion is fairly compensated, and in employed physician compensation models, the appropriate time is protected to allow for training without requiring completion during off hours. In addition it asks that ACEP partner with other organizations to reduce annual or onboarding training for physician employment.

ACEP has a number of existing policies regarding required CME and short courses. The policy statement "CME Burden" discusses the increasing burden of required courses. The policy states:

> "The American College of Emergency Physicians (ACEP) believes that continuous board certification by the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, skills, and current understanding in the practice of emergency medicine regardless of any additional CME mandated or obtained."

ACEP's policy statement "Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment" states:

> "The American College of Emergency Physicians (ACEP) believes that board certification by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) demonstrates comprehensive training, knowledge, and skill in the practice of emergency medicine." It goes on to say that ACEP strongly opposes required completion of courses such as "Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), and Basic Trauma Life Support (BTLS), or a specified number of CME hours in a sub-area of emergency medicine, as conditions for privileges, renewal of privileges, employment, qualification by hospitals, government agencies, or any other credentialing organization's standards to provide care for designated disease entities."

ACEP provides a set of personalized cards that attest that they are currently board certified by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (ABOEM) and have expertise in procedural sedation, cardiac resuscitation, and trauma. ABEM also offers a personalized letter attesting to these same areas of expertise.

ACEP also is a CME partner for an ABEM MyEMCert module on resuscitation, for which physicians receive a certificate of completion.

Regarding the second resolved, ACEP is heavily involved with other emergency medicine organizations opposing such requirements, particularly when the material is already part of emergency medicine certification/maintenance of certification. In early the Coalition Opposing Medical Merit Badges (COMMB, now called COBCEP – the Coalition of Board Certified Emergency Physicians) was formed with the following members: American Academy of Emergency Medicine (AAEM), AAEM/RSA, ABEM, ACEP, Association of Academic Chairs in Emergency Medicine (AACEM), Council of Residency Directors in Emergency Medicine (CORD), Emergency Medicine Residents' Association (EMRA), and the Society for Academic Emergency Medicine (SAEM). SAEM/RAMS has subsequently joined the coalition. The purpose of the coalition states:

> "Board-certified emergency physicians who actively maintain their board certification should not be required to complete short-course certification in advanced resuscitation, trauma care, stroke care, cardiovascular care, or pediatric care in order to obtain or maintain medical staff privileges to work in an emergency department. Similarly, mandatory targeted continuing medical education (CME) requirements do not offer any meaningful value for the public or for the emergency physician who has achieved and maintained board certification. Such requirements are often promulgated by others who incompletely understand the foundation of knowledge and skills acquired by successfully completing an Accreditation Council for Graduate Medical Education–accredited Emergency Medicine residency program. These "merit badges" add no additional value for board-certified emergency physicians. Instead, they devalue the board certification process, failing to recognize the rigor of the ABEM Maintenance of Certification (MOC) Program. In essence, medical merit badges set a lower bar than a diplomate's education, training, and ongoing learning, as measured by initial board certification and maintenance of certification. **The Coalition finds no rational justification to require medical merit badges for board-certified emergency physicians who maintain their board certification.** Our committed professional organizations provide the best opportunities for

continuous professional development and medical merit badges dismiss the quality of those educational efforts."

The coalition has met at least quarterly since 2017. Through the years the group has created the aforementioned letter from ABEM and cards from ACEP and AAEM, worked to clarify the requirements of The Joint Commission (TJC), worked with the American College of Surgeons Committee on Trauma (ACS-COT) which ultimately removed the requirement for Advanced Trauma Life Support (ATLS) for ABEM/AOBEM certified emergency physicians, worked with the VA hospital and American Society of Anesthesiology on a procedural sedation policy, clarification of the Pediatric Emergency Care Coordinator as part of the Pediatric Readiness Project, sent multiple letters and personal contacts regarding the NY State requirement for Pediatric Advanced Life Support/Advanced Pediatric Life Support (PALS/APLS), created a letter regarding a waiver of required CLIA competency assessments for point of care testing, and opposed Pennsylvania Department of Health requirement for Basic Cardiac Life Support (BCLS) training. In 2019, COMMB changed its name to the Coalition of Board Certified Emergency Physicians (COBCEP) and they continue to work on the military requirement for Basic Life Support (BLS) and requirements for BLS, ACLS, and PALS for emergency physicians who practice in Puerto Rico. The group is currently working on the impact of state required physician education. After ACEP assisted with pilot testing through the Emergency Medicine Practice Research Network, ABEM sent a survey to their diplomates regarding the types of courses required, the estimated time to complete these requirements, the estimated cost of meeting these requirements, and the usefulness of the material required. Several thousand individuals completed the survey and the results are currently being analyzed.

In addition, there have been numerous resolutions submitted to the American Medical Association (AMA) regarding required continuing medical education (CME). For example, current AMA policy "supports physician autonomy by partnering with relevant organizations to encourage medical organizations or institutions that employ physicians and offer financial support towards continuing medical education (CME) to avoid prioritizing institutional goals over individual physician educational needs in the choice of CME coursework." Another AMA policy states that "the medical profession alone has the responsibility for setting standards and determining curricula in continuing medical education. State medical societies in states which already have a content-specific CME requirement should consider appropriate ways of rescinding or amending the mandate."

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 professional.

Fiscal Impact

Unbudgeted staff resources and unbudgeted funds of approximately $10,000 for an in-person task force meeting for 10 people and approximately $20,000 to conduct a survey.

Prior Council Action

Amended Resolution 43(15) Required CME Burden adopted. Called for the College to address annual requirements for CME in specific areas that could lead to reduced ongoing education in other clinical area and work with other organizations, regulatory bodies, and credentialing agencies to provide resources, support, and understanding of the comprehensiveness of board certified/eligible emergency physicians to care for all ED patients.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted. Directed ACEP to adopt a position that board certification in emergency medicine through the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, and/or sub-board on Pediatric Emergency Medicine of the American Board of Pediatrics, along with participation in Maintenance of Certification programs currently required by these Boards is sufficient for practicing emergency physicians to maintain hospital privileges, health plan participation and medical group inclusion, and Maintenance of Licensure, and requiring additional

certifications beyond board certification for emergency physicians, such as Basic Life Support, Advanced Cardiac Life Support, Advanced Trauma Life Support, and Pediatric Advanced Life Support, and other maintenance programs is redundant and unnecessary.

Amended Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted. This resolution called for the College to open dialogue with the American Hospital Association, third party payers, and accreditation entities regarding the inappropriate use of ACLS and similar courses for credentialing of board-certified emergency physicians.

Amended Resolution 14(98) Merit Badge Medicine referred to the Board. This resolution called for the College policy on "Merit Badge Medicine" to read as follows: The ACEP believes that certification of knowledge and skills in emergency medicine can result only from successful completion of examinations administered by a recognized board in emergency medicine. The successful completion of any course, or series of courses, or a specified number of CME hours in a sub-area of emergency medicine, may serve as evidence of knowledge and skill of a certain sub-area of medicine. However, the completion of such does not serve as an acceptable substitute for certification of knowledge and skills to practice emergency medicine. Therefore, ACEP opposes the use of certificates of completion of courses such as ATLS, ACLS, PALS, BTLS or a specified number of CME hours in a sub-area of emergency medicine as requirements for credentialing or employment of any physician certified in emergency medicine by the ABEM or the AOBEM.

Substitute Resolution 9(91) Merit Badge Medicine adopted. The resolution called for the College to request ABEM provide a statement that board certification supersedes successful completion of courses taught in ACLS, ATLS, APLS, etc., and that ACEP disseminate its current policy on "Merit Badge Medicine" with recommendations on methods for their use by membership.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted. This resolution called for the College to develop appropriate language that can be incorporated into legislation and regulations that would reflect the College's position opposing the use of certificates of completion of short courses in special areas relating to emergency medicine as criteria for employment, staff appointment, licensure, or facility designations when such physicians are board certified in emergency medicine.

Prior Board Action

July 2022, approved the revised policy statement, "2022 Model of the Clinical Practice of Emergency Medicine." Joint policy with American Academy of Emergency Medicine (AAEM), American Board of Emergency Medicine (ABEM), Council of Emergency Medicine Residency Directors (CORD), Emergency Medicine Residents' Association (EMRA), Residency Review Committee for Emergency Medicine (RRC-EM), Society for Academic Emergency Medicine (SAEM).

January 2022, approved the revised policy statement, "Use of Short Courses in Emergency Medicine as Criteria for Privileging or Employment;" revised and approved January 2016 and April 2012; Reaffirmed September 2005; Revised in June 1999, June 1997, August 1992 and originally approved January 1984 titled "Certification in Emergency Medicine.

January 2022, approved the revised policy statement, "CME Burden;" originally approved April 2016.

June 2019, approved the policy statement, "Compensated Time for Faculty Academic Administration and Teaching Involvement."

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

August 2017, reviewed the Policy Resource & Education Paper (PREP) "Guidelines for Credentialing and Delineation of Clinical Privileges in Emergency Medicine;" originally reviewed June 2006. This PREP is an adjunct to the policy statement "Physician Credentialing and Delineation of Clinical Privileges in Emergency Medicine

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

Amended Resolution 43(15) Required CME Burden adopted.

Amended Resolution 35(13) Credentials for Hospital Privileges and Maintenance of Licensure adopted.
Resolution 19(00) ACLS, and Similar Courses for Credentialing Emergency Physicians adopted.

Substitute Resolution 9(91) Merit Badge Medicine adopted.

Substitute Resolution 20(89) ABEM Certification and Merit Badge Courses adopted.

Background Information Prepared by: Sandy 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 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Late Resolution

RESOLUTION: 56(23)

SUBMITTED BY: Indiana Chapter

SUBJECT: In Memory of William A. Nice, MD

1 WHEREAS, Emergency medicine lost a beloved leader of our specialty in the passing of William A. Nice,
2 MD, who died March 4, 2023; and
3
4 WHEREAS, Dr. Nice earned his medical degree from Indiana University School of Medicine in 1968 and
5 was vice-president of the Christian Medical Society chapter and he then completed a transitional year at South Bend
6 Memorial Hospital; and
7
8 WHEREAS, After completing his transitional year, Dr. Nice went to Rhodesia (now Zimbabwe) and was the
9 only physician at Chidamoyo Christian Hospital in the bush of the north part of the country for three years; and
10
11 WHEREAS, Dr. Nice returned to the U.S. and settled in Bloomington, Indiana, in early 1973 and began his
12 practice of emergency medicine more than six years before emergency medicine was a specialty; and
13
14 WHEREAS, Dr. Nice was a founding member of Unity Physician Group and the Director of the Emergency
15 Department at the Bloomington Hospital for over 25 years, as well as being on staff at several other Indiana hospitals
16 and immediate care centers; and
17
18 WHEREAS, Dr. Nice was one of the first emergency physicians certified by the American Board of
19 Emergency Medicine and soon became an oral examiner for the Board; and
20
21 WHEREAS, Dr. Nice was an early member of the American College of Emergency Physicians and was
22 President of the Indiana Chapter in the mid-1970s and he was instrumental in hiring the first two executive directors
23 of the Indiana Chapter; and
24
25 WHEREAS, Dr. Nice was an active councillor from Indiana for many years in the 1970s and 1980s and
26 served on the Tellers, Credentials, & Elections Committee for several of those years; and
27
28 WHEREAS, Dr. Nice is a legacy physician in Indiana and on behalf of emergency medicine at the national
29 level; therefore be it
30
31 RESOLVED, That the American College of Emergency Physicians recognizes the outstanding contributions
32 of William A. Nice, MD, to emergency medicine and extends the College's condolences to his family and his life-
33 long medical group partners.

PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2023 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

Late Resolution

RESOLUTION: 57(23)

SUBMITTED BY: Angela Cornelius MD, MA, FACEP
D. Mark Courtney, MD, FACEP
Angela F. Gardner, MD, FACEP
Jeffrey M. Goodloe MD, FACEP
Andrew Hogan, MD
S. Marshal Isaacs, MD, FACEP
Jeff Jarvis MD, MS, FACEP
Jeffery C. Metzger, MD, MBA, FACEP
Brian L. Miller MD, FACEP
Brandon Morshedi, MD, DPT, FACEP
Kathy Rinnert, MD, MPH, FACEP
John J. Rogers MD, FACEP
Gilberto A. Salazar, MD, FACEP
Robert E. Suter, DO, MHA, FACEP
Raymond E. Swienton, MD, FACEP
Dustin Williams, MD, FACEP
Georgia College of Emergency Physicians
Texas College of Emergency Physicians

SUBJECT: Commendation for Raymond L. Fowler, MD, FACEP, FAEMS

1 WHEREAS, Raymond Logan Fowler, MD, FACEP, FAEMS, has practiced for a half century as an
2 enthusiastic and beloved frontline emergency physician and is a talented educator of paramedics, nurses, medical
3 students, and residents; and
4
5 WHEREAS, For the last two decades, Dr. Fowler has served as a highly published Professor of Emergency
6 Medicine and Chief of the Emergency Medical Services/Disaster/Global Health Division at UT Southwestern Medical
7 Center, and a brilliant attending in the nation's busiest emergency department, Parkland Hospital in Dallas, TX; and
8
9 WHEREAS, Dr. Fowler served as the president of the Georgia Chapter of ACEP and president of the
10 National Association of EMS Physicians and he has received numerous awards including ACEP's Award for
11 Outstanding Contribution in EMS in 2012; and
12
13 WHEREAS, Dr. Fowler is the author of numerous articles and textbooks including serving as one of the
14 Editors in Chief for the text *Emergency Medical Services: Clinical Practice and Systems Oversight*; and
15
16 WHEREAS, Dr. Fowler served as the inaugural Program Director for the ACEP-affiliated International
17 Trauma Life Support Course; therefore be it
18
19 RESOLVED, That the American College of Emergency Physicians commends Raymond Logan Fowler, MD,
20 FACEP, FAEMS, for his outstanding service and commitment to the College, the specialty of emergency medicine,
21 the subspecialty of EMS medicine, and his patients.